**EVIDENCE OF COVERAGE**

**ATTACHMENT C: HDHP SCHEDULE OF BENEFITS**

**Group Name: Holston Conference of the United Methodist Church**
**Group Number: 88662**
**Annual Benefit Period: January 1, 2020, to December 31, 2020**

Benefit percentages apply to the BlueCross Maximum Allowable Charge. In-Network level applies to services received from Network Providers and Non-Contracted Providers.

Out-of-Network benefit percentages apply to BlueCross Maximum Allowable Charge. Member is responsible for any amount exceeding the Maximum Allowable Charge for services received from Out-of-Network Providers and Non-Contracted Providers.

| Covered Services | In-Network Benefits for Covered Services received from Network Providers | Out-of-Network Benefits for Covered Services received from Out-of-Network Providers |
|---|---|---|
| **Preventive Health Care Services** | | |
| Well Child Care (to age 6) | 100% | 50% of the Maximum Allowable Charge after Deductible |
| Well Woman Exam | 100% | 50% of the Maximum Allowable Charge after Deductible |
| Mammogram, Cervical cancer Screening and Prostate cancer Screening | 100% | 50% of the Maximum Allowable Charge after Deductible |
| Immunizations | 100% | 50% of the Maximum Allowable Charge after Deductible |
| Preventive/Well Care Services (ages 6 and up)<br>Includes Preventive Health Exam, screenings and counseling services. Tobacco use counseling performed in a primary care setting, limited to 8 visits per Annual Benefit Period; Alcohol misuse counseling performed in a primary care setting, limited to 8 visits per Annual Benefit Period; Dietary counseling for adults with hyperlipidemia, hypertension, obesity, Type 2 diabetes, coronary artery disease and/or congestive heart failure limited to 12 visits annually. | 100% | 50% of the Maximum Allowable Charge after Deductible |
| Other Well Care Screenings, age 6 and above, including flexible sigmoidoscopy or colonoscopy | 100% | 50% of the Maximum Allowable Charge after Deductible |
| Lactation counseling by a trained provider during pregnancy or in the post-partum period. Limited to one visit per pregnancy. | 100% | 50% of the Maximum Allowable Charge after Deductible |
| Manual Breast Pump, limited to one per pregnancy | 100% | 50% of the Maximum Allowable Charge after Deductible |
| FDA-approved contraceptive methods, sterilization procedures and counseling for women with reproductive capacity. | 100% | 50% of the Maximum Allowable Charge after Deductible |
| One (1) retinopathy screening for diabetics per Annual Benefit Period | 100% | Not Covered |

| Covered Services | In-Network Benefits for Covered Services received from Network Providers | Out-of-Network Benefits for Covered Services received from Out-of-Network Providers |
|---|---|---|
| Hemoglobin A1C test | 100% | 50% of the Maximum Allowable Charge after Deductible |
| **Services Received at the Practitioner's office** | | |
| **Office Exams and Consultations** | | |
| Office Services | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| Maternity care | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| **Injections and Immunizations** | | |
| Allergy injections and allergy extract | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| All other injections | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| **Diagnostic Services and Preventive Screenings (e.g. x-ray and labwork)** | | |
| Allergy Testing | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| Advanced Radiological Imaging<br>Includes CT scans, MRIs, PET scans, nuclear medicine and similar technologies | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| All Other Diagnostic Services for illness or injury, including medical and behavioral health conditions | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| Maternity care diagnostic services | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| **Other office procedures, services or supplies** | | |
| Office Surgery, including anesthesia<br>Some procedures require Prior Authorization. Call customer service to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits will be reduced by 10% for Out-of-Network Providers and by 10% for Network Providers outside Tennessee (BlueCard PPO Providers). Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.<br>Surgeries include invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy and endoscopy). | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| Therapy Services:<br>Physical, speech, occupational, and manipulative limited to 30 visits per therapy type per Annual Benefit Period;<br>Cardiac and pulmonary rehab limited to 36 visits per therapy type per Annual Benefit Period | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |

| Covered Services | In-Network Benefits for Covered Services received from Network Providers | Out-of-Network Benefits for Covered Services received from Out-of-Network Providers |
|---|---|---|
| Non-routine treatments:<br>Includes renal dialysis, radiation therapy, chemotherapy and infusions. | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| DME, Orthotics and Prosthetics | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| Supplies | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| All Other Office services | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| **Services Received at a Facility** | | |
| **Inpatient Hospital Stays and Behavioral Health Services:**<br>Inpatient hospital stays (except initial maternity admission) and Behavioral Health Services Prior Authorization. Benefits may be reduced by 10% for Out-of-Network Providers and by 10% for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. (See the Prior Authorization section for more information) Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization. | | |
| Facility charges | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| Practitioner charges (including global maternity delivery charges billed as inpatient service) | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| **Skilled Nursing or Rehab Facility stays**<br>(Limited to 100 days per Annual Benefit Period)<br>Prior Authorization required. Benefits may be reduced by 10% for Out-of-Network Providers and by 10% for Network Providers outside Tennessee (BlueCard PPO Providers) when Prior Authorization is not obtained. (See the Prior Authorization section for more information) Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization. | | |
| Facility charges | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| Practitioner charges | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| **Hospital Emergency Care Services (Whether the Practitioner is considered an Emergency physician and therefore reimbursable under this benefit is determined by the place of service on the claim.)** | | |
| Emergency Room charges | 70% after Deductible | 70% of the Maximum Allowable Charge after Deductible |
| Advanced Radiological Imaging Services | 70% after Deductible | 70% of the Maximum Allowable Charge after Deductible |
| All Other Hospital charges | 70% after Deductible | 70% of the Maximum Allowable Charge after Deductible |
| Practitioner Charges | 70% after Deductible | 70% of the Maximum Allowable Charge after Deductible |
| **Outpatient Facility Services including Behavioral Health Intensive Outpatient and Partial Hospitalization**<br>Some procedures require Prior Authorization. Call Our consumer advisors to determine if Prior Authorization is required. If Prior Authorization is required and not obtained, benefits may be reduced by 10% for Out-of-Network Providers and by 10% for Network Providers outside Tennessee (BlueCard PPO Providers). (See the Prior Authorization section for more information.) Network Providers in Tennessee are responsible for obtaining Prior Authorization; Member is not responsible for Penalty when Tennessee Network Providers do not obtain Prior Authorization.<br>Surgeries include invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy). | | |
| Facility charges | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |

| Covered Services | In-Network Benefits for Covered Services received from Network Providers | Out-of-Network Benefits for Covered Services received from Out-of-Network Providers |
|---|---|---|
| Practitioner charges | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| **Outpatient Diagnostic Services and Outpatient Preventive Screenings** | | |
| Advanced Radiological Imaging<br>Includes CT scans, MRIs, PET scans, nuclear medicine and similar technologies. | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| All other Diagnostic Services for illness or injury, including medical and behavioral health conditions | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| Maternity care diagnostic services | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| **Other Outpatient procedures services, or supplies** | | |
| Therapy Services:<br>Physical, speech, occupational, manipulative therapy, and acupuncture limited to 30 visits per therapy type per Annual Benefit Period;<br>Cardiac and pulmonary rehab limited to 36 visits per therapy type per Annual Benefit Period | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| DME, Orthotics and Prosthetics | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| Supplies | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| All Other services received at an Outpatient Facility, including chemotherapy, radiation therapy, injections, infusions, and dialysis | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| **Other Services** | | |
| Urgent Care Center charges | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| Ground Ambulance | 70% after Deductible | 70% of the Maximum Allowable Charge after Deductible |
| Air Ambulance | 70% after Deductible | 70% of the Billed Charges after Deductible |
| Home health care services, including home infusion therapy<br>Home health care may require Prior Authorization.<br>Physical, speech or occupational therapy provided in the home do not require Prior Authorization and are subject to the therapy services visit limits. | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| Hospice Care | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| DME, Orthotics and Prosthetics | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| Supplies | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |

| Covered Services | In-Network Benefits for Covered Services received from Network Providers | Out-of-Network Benefits for Covered Services received from Out-of-Network Providers |
|---|---|---|
| Hearing Aids for Members under age 18 Limited to one per ear every 3 years (as determined by Your Annual Benefit Period) | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| Evaluation and testing of infertility | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| PhysicianNow consultations via telephone, tablet or computer<br>See the "Health and Wellness" section of this EOC for more information | 70% after Deductible | Not Covered |
| **Medical Vision Care** | | |
| Vision exam for the treatment of injuries and diseases of the eye | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| Frames, lenses, and contacts Covered following treatment and surgery to repair certain injuries and diseases that impair vision | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |
| **Organ Transplant Services** | | |
| **All Transplant Services, except kidney transplants**<br>**All Transplant Services require Prior Authorization.**<br>Call customer service before any pre-transplant evaluation or other transplant service is performed to request Prior Authorization, and to determine if there are facilities available in the BDCT Network for Your specific transplant type.<br>See the "Prior Authorization, Care Management, Medical Policy and Patient Safety" and "Organ Transplants – All Organ Transplants, Excluding Kidney" sections of this EOC for more information. | **Blue Distinction Centers for Transplants (BDCT) Network:**<br>70% after Network Deductible, Network Out-of-Pocket Maximum applies.<br>**Transplant Network:**<br>70% after Network Deductible, Network Out-of-Pocket Maximum applies. | **Out-of-Network Providers**:<br>50% of the Maximum Allowable Charge after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies. |
| **Kidney Transplant Services**<br>**All Transplant Services require Prior Authorization.**<br>Call customer service before any pre-transplant evaluation or other transplant service is performed to request Prior Authorization. | **Network Providers:**<br>70% after Network Deductible; Network Out-of-Pocket Maximum applies. | **Out-of-Network Providers**:<br>50% of Maximum Allowable Charge (MAC), after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies, amounts over MAC do not apply to the Out-of-Pocket and are not covered. |

**Schedule of Pharmacy Prescription Drug Copayments**

| **Prescription Drugs for Retail Network and Home Delivery Network** | | | |
|---|---|---|---|
| | One month supply (Up to 30 days) | Two months' supply (31 to 60 days) | Three months' supply (61 to 90 days) |
| | Generic Drug/Preferred Brand Drug/Non-Preferred Brand Drug | | |
| RX04 retail network | $25/$40/$70 after Plan Deductible | N/A | N/A |
| Home Delivery Network | $25/$40/$70 after Plan Deductible | $50/$80/$140 after Plan Deductible | $50/$80/$140 after Plan Deductible |
| Plus90 Network | $25/$40/$70 after Plan Deductible | $50/$80/$140 after Plan Deductible | $50/$80/$140 after Plan Deductible |
| | | | |
| Out-of-Network | 50% after Plan Deductible | | |

| **Self-administered Specialty Drugs -** You have a distinct network for self-administered Specialty Drugs: the Preferred Specialty Pharmacy Network. To receive benefits for self-administered Specialty Drugs, You must use a Preferred Specialty Pharmacy Network Provider. For more information on benefits for Provider-administered Specialty Drugs, please refer to the "Specialty Drugs" section of this EOC. **Limited up to a 30-day supply per Prescription** | |
|---|---|
| | Generic Drug/Preferred Brand Drug/Non-Preferred Brand Drug |
| Specialty Pharmacy Network – Preferred | $70/$70/$70 after Plan Deductible |
| Out-of-Network | Not Covered |

**Additional Provisions**

90 day supplies are available through the Mail Order Network. See bcbst.com to locate network pharmacies and to learn more about the Mail Order Network.

At the Network Pharmacy, You will pay the lesser of Your applicable Copayment Coinsurance, the Maximum Allowable Charge, Our discounted rate or the Network Pharmacy's charge for the Prescription Drug.

If You have a Prescription filled at an Out-of-Network Pharmacy, You must pay all expenses and file a claim for reimbursement with the administrator. You will be reimbursed based on the Maximum Allowable Charge, less any applicable out-of-network Deductible, Coinsurance, and/or Drug Copayment amount.

In the Self-administered Specialty Drugs section, Out-of-Network refers to outside the Specialty Pharmacy Network, not outside the standard retail Pharmacy Network.

**Provider-Administered Specialty Drugs -** To receive benefits for Provider-administered Specialty Drugs, You must use a Preferred Pharmacy in Our Specialty Pharmacy Network.

Cost share listed for Provider-administered Specialty Drugs is for the medication only. Providers may bill additional charges for the administering of the drug; refer elsewhere in the schedule for applicable benefit (e.g., chemotherapy, labwork).

At the Specialty Pharmacy Network, You will pay the lesser of Your applicable Copayment or Coinsurance, the Maximum Allowable Charge, Our discounted rate or the Specialty Pharmacy Network's charge for the Prescription Drug.

| **Provider-administered Specialty Drugs** | **Preferred Specialty Pharmacy Network** | **Out-of-Network** |
|---|---|---|
| Provider-administered Specialty Drugs, as indicated in the Provider-administered Specialty Drug list | 70% after Deductible | 50% of the Maximum Allowable Charge after Deductible |

| **Miscellaneous Limits:** | **In-Network Providers** | **Out-of-Network Providers** |
|---|---|---|
| Lifetime Maximum | Unlimited | |
| **Deductible** | | |
| Individual | $2,800 | $5,600 |
| Family | $5,600 | $11,200 |
| **Out-of-Pocket Maximum** | | |
| Individual | $6,000 | $12,000 |
| Family | $12,000 | $24,000 |
| $4^{th}$ Quarter Deductible Carryover [1] | Excluded | |

1. Dollar amounts incurred during the last three (3) months of an Annual Benefit Period that are applied to the Deductible during that Annual Benefit Period will not apply to the Deductible for the next Annual Benefit Period.