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, 2019, to December 31, 2019

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) 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
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 Includes CT scans, MRIs, PET scans, nuclear medicine and other similar technologies	70% after Deductible	50% of the Maximum Allowable Charge after Deductible
All Other Diagnostic Services for illness or injury	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 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. Surgeries include invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy and endoscopy).	70% after Deductible	50% of the Maximum Allowable Charge after Deductible
Therapy Services: Physical, speech, occupational, and manipulative limited to 30 visits per therapy type per Annual Benefit Period; 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
Non-routine treatments: Includes renal dialysis, radiation therapy, chemotherapy and infusions.	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
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: 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 (Limited to 100 days per Annual Benefit Period) 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 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. Surgeries include invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy).		
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

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
Outpatient Diagnostic Services and Outpatient Preventive Screenings		
Advanced Radiological Imaging Includes CT scans, MRIs, PET scans, nuclear medicine and other similar technologies.	70% after Deductible	50% of the Maximum Allowable Charge after Deductible
All other Diagnostic Services for illness or injury	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: Physical, speech, occupational, manipulative therapy, and acupuncture limited to 30 visits per therapy type per Annual Benefit Period; 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 Prior Authorization is required for skilled nurse visits in the home. Therapy provided in the home does not require Prior Authorization. Limited to 60 visits per Annual Benefit Period	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
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

<table>
<tr><th>Covered Services</th><th colspan="2">In-Network Benefits for Covered Services received from Network Providers</th><th>Out-of-Network Benefits for Covered Services received from Out-of-Network Providers</th></tr>
<tr><td>PhysicianNow consultations via telephone, tablet or computer
See the “Health and Wellness” section of this EOC for more information</td><td colspan="2">70% after Deductible</td><td>Not Covered</td></tr>
<tr><td colspan="4">Medical Vision Care</td></tr>
<tr><td>Vision exam for the treatment of injuries and diseases of the eye</td><td colspan="2">70% after Deductible</td><td>50% of the Maximum Allowable Charge after Deductible</td></tr>
<tr><td>Frames, lenses, and contacts Covered following treatment and surgery to repair certain injuries and diseases that impair vision</td><td colspan="2">70% after Deductible</td><td>50% of the Maximum Allowable Charge after Deductible</td></tr>
<tr><td colspan="4">Organ Transplant Services</td></tr>
<tr><td>All Transplant Services, except kidney transplants
All Transplant Services require Prior Authorization.
If You use a facility outside of the Blue Distinction Centers for Transplants (BDCT) Network, benefits will be limited to the Transplant Maximum Allowable Charge (TMAC) unless the BDCT Network does not include a facility that performs Your specific transplant type. 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.
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.</td><td>Blue Distinction Centers for Transplants (BDCT) Network:
70% after Network Deductible, Network Out-of-Pocket Maximum applies.</td><td>Transplant Network:
70% of the Transplant Maximum Allowable Charge (TMAC) after Network Deductible, Network Out-of-Pocket Maximum applies, amounts over TMAC do not apply to the Out-of-Pocket Maximum and are not covered.</td><td>Out-of-Network Providers:
50% of the Transplant Maximum Allowable Charge (TMAC), after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies, amounts over TMAC do not apply to the Out-of-Pocket and are not covered.</td></tr>
<tr><td>Kidney Transplant Services
All Transplant Services require Prior Authorization.
Call customer service before any pre-transplant evaluation or other transplant service is performed to request Prior Authorization.</td><td colspan="2">Network Providers:
70% after Network Deductible; Network Out-of-Pocket Maximum applies.</td><td>Out-of-Network Providers:
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.</td></tr>
</table>

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.

Miscellaneous Limits:	**In-Network Providers**	**Out-of-Network Providers**
Lifetime Maximum	Unlimited	
Deductible		
Individual	$2,600	$5,200
Family	$5,200	$10,400
Out-of-Pocket Maximum		

Individual	$6,000	$12,000
Family	$12,000	$24,000
4th 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.