



Evidence of Coverage

VISION BENEFIT PLAN

City of Cookeville
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VisionBlue™

VISION EVIDENCE OF COVERAGE



BlueCross BlueShield of Tennessee

BlueCross BlueShield of Tennessee, Inc.,
an Independent Licensee of the
BlueCross BlueShield Association

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If You have questions about this Evidence of Coverage or any matter related to Your membership in the Plan, please write or call us at:

Customer Service Department
BlueCross and BlueShield of Tennessee
1 Cameron Hill Circle
Chattanooga, Tennessee 37402
1-800-565-9140

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Please Read Your Evidence of Coverage

This Vision Evidence of Coverage (this “EOC”) is part of the Group Agreement between BlueCross BlueShield of Tennessee, Inc. (BCBST, or the “Plan”) and Your Group. References in this Vision EOC to “We,” “Us,” or “Our” also mean BlueCross BlueShield of Tennessee, Inc., or where appropriate, its vision claims administrator. This EOC describes the terms and conditions of Your Vision Coverage from the Plan through the Group, and includes all riders and attachments, which are incorporated herein by reference. It replaces and supersedes any Vision EOC that You have previously received from the Plan.

Please read this EOC carefully. It describes Your rights and duties as a Member. It is important to read the entire EOC. Certain services are not Covered by the Plan. Other Covered Services are limited. The Plan will not pay for any service not specifically listed as a Covered Service, even if a Provider recommends or orders that non-Covered Service. (See Attachments A – D.)

The Group has delegated discretionary authority to the Plan to make any benefit determinations. It has also granted the authority to construe the terms of Your Coverage to the Plan. The Plan or its vision claims administrator shall be deemed to have properly exercised that authority unless it abuses its discretion when making such determinations, whether or not the Group’s benefit plan is subject to ERISA. “ERISA” means the Employee Retirement Income Security Act. The Group retains the authority to determine whether You or Your dependents are eligible for Coverage.

Any Grievance related to Your Coverage under this EOC must be resolved in accordance with the Grievance Procedure section of this EOC.

Definitions: In order to make it easier to read and understand this EOC, defined words are capitalized. Those words are defined in the “DEFINITIONS” section of this EOC.

Questions: Please contact one of the Plan’s consumer advisors at the number listed on Your membership ID card, if You have any questions when reading this EOC. Our consumer advisors are also available to discuss any other matters related to Your Coverage from the Plan.

How a PPO Plan Works

You have a PPO plan. Through its vision claims administrator, BlueCross BlueShield of Tennessee has an arrangement with a national network of Ophthalmologists, Optometrists and Opticians. These Providers, called Network Providers, agree to special pricing arrangements. Your PPO plan has two levels of benefits. By using Network Providers, You receive the highest level of benefits. However, You can choose to use Providers that are not Network Providers. These Providers are called Out-of-Network Providers. When You use Out-of-Network Providers, Your benefits will be lower. You will also be responsible for the full amount that an Out-of-Network Provider bills and will be reimbursed up to the amount of Your Out-of-Network Allowance.

The Attachment C: Schedule of Benefits, shows how Your benefits vary for services received from Network and Out-of-Network Providers. Attachment A details Covered Services, and Attachment B lists services excluded under the Plan.

Get the Most from Your Benefits

1. Always **carry Your membership ID card** and show it before receiving care.
2. **Always use Network Providers.** See Attachment A for an explanation of a Network Provider. Call the customer service department to verify that a Provider is a Network Provider.
3. Notify the Employer if changes in the following occur for You or any of Your dependents:
 - Name.
 - Address.
 - Telephone number.
 - Employment (change companies or terminate employment).
 - Status of any other vision insurance You might have.
 - Birth of additional dependents.
 - Marriage or divorce.
 - Death.
 - Adoption.
 - Change in student status.

Your BlueCross BlueShield of Tennessee Identification Card

Once Your Coverage becomes effective, You will receive a BlueCross BlueShield of Tennessee, Inc. membership identification (ID) card. Providers nationwide recognize it. The membership ID card is the key to receiving the benefits of the vision care plan. Carry it at all times. Please be sure to show the membership ID card each time You receive vision care services.

Our customer service number is on Your membership ID card. This is an important phone number. Call this number if You have any questions.

If a membership ID card is lost or stolen, or another card is needed for a Covered Dependent not living with the Subscriber, please visit bcbst.com, or call the toll-free number listed on the front page of this EOC. We will help You get a new one. You may want to record Your identification number in this book.

Enrolling in the Plan

Eligible Employees may enroll for Coverage for themselves and their eligible dependents as set forth in this section. No person is eligible to re-enroll if the Plan previously terminated his or her Coverage for cause. Your Group chooses the classes of Employees who are eligible for Coverage under the Plan. Please refer to Attachment D: Eligibility for details.

A. Initial Enrollment Period

Eligible Employees may enroll for Coverage for themselves and their eligible dependents within the first 31 days after becoming eligible for Coverage. The Subscriber must: (1) include all requested information; (2) sign; and (3) submit an Enrollment Form to the Plan during that initial enrollment period.

B. Open Enrollment Period

Eligible Employees shall be entitled to apply for Coverage for themselves and eligible dependents during the Group's Open Enrollment Period. The Subscriber must: (1) include all requested information; (2) sign; and (3) submit an Enrollment Form to the Plan during that Open Enrollment Period. Employees who become eligible for Coverage other than during an Open Enrollment Period may apply for Coverage for themselves and eligible dependents within 31 days of becoming eligible for Coverage, or during a subsequent Open Enrollment Period.

C. Adding Dependents

After the Subscriber is Covered, he or she may apply to add a dependent, who became eligible after the Subscriber enrolled as follows:

1. A newborn child of the Subscriber or the Subscriber's spouse is Covered from the moment of birth. A legally adopted child (including children placed with You for the purposes of adoption) will be Covered as of the date of adoption or placement for adoption. Children for whom the Subscriber or the Subscriber's spouse has been appointed legal guardian by a court of competent jurisdiction will be Covered from the moment the child is placed in the Subscriber's physical custody. The Subscriber must enroll the child within 31 days from the date that the Subscriber acquires the child.

If the Subscriber fails to do so, and an additional Premium is required to cover the child, the Plan will not cover the child after 31 days from the date the Subscriber acquired the child. If no additional Premium is required to provide Coverage to the child, the Subscriber's failure to enroll the child does not make the child ineligible for Coverage.

However, the Plan cannot add the newly acquired child to the Subscriber's Coverage until notified of the child's birth. This may delay claims processing.

2. Any other new family dependent, (e.g. if the Subscriber marries) may be added as a Covered Dependent if the Subscriber completes and submits a signed Enrollment Form to the Group representative within 31 days of the date that person first becomes eligible for Coverage.
3. An Employee or eligible dependent who did not apply for Coverage within 31 days of first becoming eligible for Coverage under this Plan may enroll if:
 - a. he or she had other coverage at the time Coverage under this Plan was previously offered; and

- b. he or she stated, in writing, at the time Coverage under this Plan was previously offered, that such other coverage was the reason for declining Coverage under this Plan; and
- c. such other coverage is exhausted (if the other coverage was continuation coverage under COBRA) or the other coverage was terminated because he or she ceased to be eligible due to involuntary termination or employer contributions for such coverage ended; and
- d. he or she applies for Coverage under this Plan and the administrator receives the change form within 31 days after the loss of the other coverage.

D. Late Enrollment

Employees or their family dependents who do not enroll when becoming eligible for Coverage under (A), (B) or (C), above, may be enrolled:

1. During a subsequent Open Enrollment Period; or
2. If the Employee acquires a new dependent, and the Employee applies for Coverage within 31 days.

E. Enrollment Upon Change in Status

If You qualify for a change in status, as outlined below, You may be eligible to change Your Coverage other than during the Open Enrollment Period. You must request the change within 31 days of the change in status. Any change in Your elections must be consistent with the change in status.

Subscribers must submit a change form to the Group representative to notify the Plan of any changes in their status or the status of a Covered Dependent within thirty-one (31) days from the date of the event causing that change of status. Such events include, but are not limited to: (1) marriage or divorce; (2) death of the Employee's spouse or dependent; (3) dependency status; (4) Medicare eligibility; (5) coverage by another Payor; (6) birth or adoption of a child of the Employee; (7) termination of employment, or commencement of employment, of the Employee's spouse; (8) switching from part-time to full-time, or from full-time to part-time status by the Employee or the Employee's spouse;

When Coverage Begins

If You are eligible, have enrolled and have paid or had the Premium for Coverage paid on Your behalf, Coverage under this EOC shall become effective on the earliest of the following dates, subject to the Actively at Work Rule set out below:

A. Effective Date of Group Agreement

Initial Coverage through the Plan shall be effective on the effective date of the Group Agreement, if all eligibility requirements are met as of that date; or

B. Enrollment During an Open Enrollment Period

Coverage shall be effective on the first day of the month following the Open Enrollment Period, unless otherwise agreed to by the Group and the Plan; or

C. Enrollment During an Initial Enrollment Period

Coverage shall be effective on the first day of the month following the Plan's receipt of the eligible Employee's Enrollment Form, unless otherwise agreed to by the Group and the Plan; or

D. Newly Eligible Employees

Coverage will be effective on the date of eligibility as specified in the Group Agreement; or

E. Newly Eligible Dependents

- (1) Dependents acquired as the result of a marriage – Coverage will be effective on the day of the marriage unless otherwise agreed to by Group and the Plan;
- (2) Newborn children of the Subscriber or the Subscriber's spouse - Coverage will be effective as of the date of birth;
- (3) Dependents adopted or placed for adoption – Coverage will be effective as of the date of adoption or placement for adoption, whichever is first.

For Coverage to be effective, the dependent must be enrolled, and the Plan must receive any required Premium for the Coverage, as set out in the "Enrollment" section; or

F. Actively at Work Rule

If an eligible Employee, other than a retiree (who is otherwise eligible), is not Actively at Work on the date Coverage would otherwise become effective, Coverage for the Employee and all of his or her Covered Dependents will be deferred until the date the Employee is Actively at Work.

When Coverage Ends

A. Termination or Modification of Coverage by the Plan or the Group

The Plan or the Group may modify or terminate the Group Agreement. Notice to the Group of the termination or modification of the Group Agreement is deemed to be notice to all Members of the Group. The Group is responsible for notifying You of such a termination or modification of Your Coverage.

All Members' Coverage through the Agreement will change or terminate at 12:00 midnight on the date of such modification or termination. The Group's failure to notify You of the modification or termination of Your Coverage shall not be deemed to continue or extend Your Coverage beyond the date that the Group Agreement is modified or terminated. You have no vested right to Coverage under this EOC following the date of the termination of the Group Agreement.

B. Loss of Eligibility

Your Coverage will terminate if You do not continue to meet the eligibility requirements agreed to by the Group and the Plan during the term of the Group Agreement. See Attachment D for details regarding Loss of Eligibility.

C. Termination of Coverage For Cause

The Plan may terminate Your Coverage for cause, if:

1. The Plan does not receive the required Premium for Your Coverage when it is due. The fact that You have paid a Premium contribution to the Group will not prevent the Plan from terminating Your Coverage if the Group fails to submit the full Premium for Your Coverage to the Plan when due, or
2. You fail to make a required Member Payment; or
3. You fail to cooperate with the Plan as required by this EOC; or
4. You have made a material misrepresentation or committed fraud against the Plan. This provision includes, but is not limited to, furnishing incorrect or misleading information or permitting the improper use of the membership ID card.

D. Right To Request A Hearing

You may appeal the termination of Your membership for cause, as explained in the Grievance Procedure section of this EOC. The fact that You have appealed shall not postpone or prevent the Plan from terminating Your Coverage. If Your Coverage is reinstated as part of the Grievance Procedure, You may submit any claims for services rendered after Your Coverage was terminated to the Plan for consideration, in accordance with the "Claims Procedure" section of this EOC.

E. Payment For Services Rendered After Termination of Coverage

Services received after Coverage terminates are not Covered, even if those services are part of a series of treatments that started before Coverage terminated. If You receive Covered Services after the Coverage terminated, the Plan, the Provider who rendered those services, or Your Employer, may recover any charges for such services from You, plus any costs of recovering such charges, including attorney's fees.

Continuation of Coverage

A. Continuation of Coverage - Federal Law

If the Group Agreement remains in effect, but Your Coverage under this EOC would otherwise terminate, the Group may be required to offer You the right to continue Coverage. This right is referred to as “Continuation Coverage” and may occur for a limited time subject to the terms of this Section and the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

1. Eligibility

If You have been Covered by the Plan on the day before a qualifying event, You and Your dependents may be eligible for COBRA Continuation Coverage. The following are qualifying events for such Coverage:

a. Subscribers

Loss of Coverage because of:

- (1) The termination of employment except for gross misconduct.
- (2) A reduction in the number of hours worked by the Subscriber.

b. Covered Dependents

Loss of Coverage because of:

- (1) The termination of the Subscriber’s Coverage as explained in subsection (a), above.
- (2) The death of the Subscriber.
- (3) Divorce or legal separation from the Subscriber.
- (4) The Subscriber becomes entitled to Medicare.
- (5) A Covered Dependent reaches the limiting age.

2. Enrolling for COBRA Continuation Coverage

The Group shall notify You of Your rights to enroll for COBRA Continuation Coverage after:

- a. the Subscriber’s termination of employment, reduction in hours worked, death or entitlement to Medicare Coverage; or
- b. the Subscriber or Covered Dependent notifies the Group, in writing, within 60 days after any other qualifying event set out above.

You have 60 days from the later of the date of the qualifying event or the date that You receive notice of Your right to COBRA Continuation Coverage to enroll for such Coverage. The Group will send You the forms that should be used to enroll for COBRA Continuation Coverage. If You do not send the Enrollment Form to the Group within that 60--day period, You will lose Your right to COBRA Continuation Coverage under this Section. If You are qualified for COBRA Continuation Coverage and receive services that would be Covered Services, before enrolling and paying the Premium for such Coverage, You will be required to pay for those services. The Plan will reimburse You for Covered Services, less required Member Payments, after You enroll and pay the Premium for Coverage, and submit a claim for those Covered Services as set forth in this EOC.

3. Premium Payment

You must pay any Premium required for COBRA Continuation Coverage to the Group, which will send that Premium to the Plan. The Group may also direct You to send Your Premium directly to the Plan, or a third party. If You do not enroll when first becoming eligible, the Premium due for the period between the date You first become eligible and the date You enroll for COBRA Continuation Coverage must be paid to the Group within 45 days after the date You enroll for COBRA Continuation Coverage. After enrolling for COBRA Continuation Coverage, all Premiums are due and payable on a monthly basis as required by the Group. If the Premium is not received by the Plan on or before the due date, whether or not the Premium was paid to the Group, Coverage will be terminated, for cause, effective as of the last day for which Premium was received as explained in the Termination of Coverage Section.

4. Coverage Provided

If You enroll for COBRA Continuation Coverage You will continue to be Covered under the Group Agreement and this EOC. The COBRA Continuation Coverage is subject to the conditions, limitations and exclusions of this EOC and the Group Agreement. The Plan and the Group may agree to change the Group Agreement, and/or this EOC, and the Group may also decide to change insurers. If this happens after You enroll for COBRA Continuation Coverage, Your Coverage will be subject to such changes.

5. Duration of Eligibility for COBRA Continuation Coverage

COBRA Continuation Coverage is available for a maximum of:

- a. 18 months if the loss of Coverage is caused by termination of employment or reduction in hours of employment; or
- b. 29 months of Coverage. If, as a qualified beneficiary who has elected 18 months of COBRA Continuation Coverage, You are determined to be disabled within the first 60 days of COBRA Continuation Coverage, You can extend Your COBRA Continuation Coverage for an additional 11 months, up to 29 months. Also, the 29 months of COBRA Continuation Coverage is available to all non-disabled qualified beneficiaries in connection with the same qualifying event. "Disabled" means disabled as determined under Title II or XVI of the Social Security Act. In addition, the disabled qualified beneficiary must:
 - (1) Notify the Employer or the administrator of the disability determination within 60 days after the determination of disability and before the close of the initial 18-month Coverage period; and
 - (2) Notify the Employer or the administrator within 30 days of the date of a final determination that the qualified beneficiary is no longer disabled; or
- c. 36 months of Coverage if the loss of Coverage is caused by:
 - (1) the death of the Subscriber;
 - (2) loss of dependent child status under the Plan;
 - (3) the Subscriber becomes entitled to Medicare; or
 - (4) divorce or legal separation from the Subscriber; or
- d. 36 months for other qualifying events. If, a Covered Dependent is eligible for 18 months of COBRA Continuation Coverage as described above, and there is a second

qualifying event (e.g. divorce), You may be eligible for 36 months of COBRA Continuation Coverage from the date of the first qualifying event.

6. Termination of COBRA Continuation Coverage

After You have elected COBRA Coverage, Your COBRA Coverage will terminate either at the end of the applicable 18-, 29- or 36-month eligibility period or, before the end of that period, upon the date that:

- a. The Premium for such Coverage is not paid when due; or
 - b. You become Covered as either a Subscriber or dependent by another group vision care plan, that does not exclude or limit coverage of Your Pre-existing Condition, if any; or
 - c. The Group Agreement is terminated; or
 - d. You become entitled to Medicare Coverage; or
 - e. The date that a disabled Member, who is otherwise eligible for 29 months of COBRA Coverage, is determined to no longer be disabled for purposes of the COBRA law.
7. The Trade Adjustment Assistance Reform Act of 2002 (TAARA) may have added to Your COBRA rights. If You lost Your job because of import competition or shifts of production to other countries, You may have a second COBRA Continuation election period. If You think this may apply to You, check with Your Employer or the Department of Labor.

B. State Continuation Coverage

If the Group Agreement remains in effect, but Your Coverage under this EOC would otherwise terminate, the Group may offer You the right to continue Coverage for a limited period of time according to State law (“State Continuation Coverage”). If You are eligible for COBRA Continuation Coverage, You may elect either COBRA continuation or State Continuation Coverage, but not both.

1. Eligibility

You have been continuously covered under the Group’s plan, or a plan that the Group’s plan replaced, for at least 3 months prior to the date prior to the termination of Your Coverage under the Group Agreement, for any reason, except for the termination of the Group Agreement.

2. Enrolling for State Continuation Coverage

The Group will notify Members eligible for State Continuation Coverage about how to enroll for such Coverage on or before the date their Coverage would otherwise terminate under the Group Agreement. You must request State Continuation Coverage, in writing, and pay the Premium for that Coverage, in advance, as required by the Group.

3. Premium Payment

You must pay the monthly Premium for State Continuation Coverage to the Group at the time and place specified by the Group.

4. Coverage Provided

Members enrolled for State Continuation Coverage will continue to be Covered under the Group Agreement and this EOC, for the remainder of the month during which Coverage under the Group Agreement would otherwise end and the greater of:

- a. 3 months; or
- b. If Your Coverage under the Group Agreement would end while You are pregnant, 6 months after that pregnancy ends; or
- c. If Your Coverage under the Group Agreement would end because of divorce or the death of the Subscriber, 15 months.

5. Termination State Continuation Coverage

State Continuation Coverage will terminate upon the earliest of the following:

- a. The end of the applicable period specified in subsection 4, above;
- b. The end of the period for which You paid the Premium for Coverage; or
- c. The termination date of the Group Agreement; or
- d. The date You become eligible for coverage under another group benefits plan; or
- e. The date You become entitled to Medicare coverage.

C. Continued Coverage During a Family and Medical Leave Act (FMLA) Leave of Absence

Under the Family and Medical Leave Act, You may be able to take:

- up to 12 weeks of unpaid leave from employment due to certain family or medical circumstances; or
- in some instances, up to 26 weeks of unpaid leave if related to certain family members' military service related hardships.

Contact the Employer to find out if this provision applies. If it does, Members may continue Coverage during the leave, but must continue to pay the conversion options portion of the Premium that the Subscriber would pay if he or she were actively working. Coverage will be subject to suspension or cancellation if the Subscriber fails to pay the Premium on time. If the Subscriber takes a leave and Coverage is cancelled for any reason during that leave, Members may resume Coverage when the Subscriber returns to work without waiting for an Open Enrollment Period.

D. Continued Coverage During a Military Leave of Absence

A Subscriber may continue his or her Coverage and Coverage for his or her Dependents during military leave of absence in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994. When the Subscriber returns to work from a military leave of absence, the Subscriber will be given credit for the time the Subscriber was Covered under the Plan prior to the leave. Check with the Employer to see if this provision applies. If it does, Members may continue Coverage during the leave, but must continue to pay the conversion options portion of the Premium that the Subscriber would pay if he or she were actively working. Coverage will be subject to suspension or cancellation if the Subscriber fails to pay the Premium on time.

E. Continued Coverage During Other Leaves of Absence

Your Employer may allow Subscribers to continue their Coverage during other leaves of absence. Continuous Coverage during such leave of absence is permitted for up to 6 months. A Subscriber will also have to meet these criteria to have continuous Coverage during a leave of absence:

1. Your Employer continues to consider the Subscriber an Employee, and all other Employee benefits are continued;
2. The leave is for a specific period of time established in advance; and
3. The purpose of the leave is documented.

You may apply for Federal or State Continuation or Conversion, if the Subscriber's leave lasts longer than the permitted amount of time.

Members may continue Coverage during the leave, but must continue to pay the conversion options portion of the Premium that the Subscriber would pay if he or she were actively working. Coverage will be subject to suspension or cancellation if the Subscriber fails to pay the Premium on time.

Claims and Payment

When You receive Covered Services from a Network Provider, the Provider will submit a claim to the Plan. If You receive Covered Services from an Out-of-Network Provider, You must submit a claim form to the Plan. We will review the claim, and let You, or the Provider, know if We need more information, before We pay or deny the claim.

A. Claims Billing

1. You should not be billed or charged for Covered Services rendered by Network Providers, except for required Member Payments. The Network Provider will submit the claim directly to Us.
2. You will be charged or billed by an Out-of-Network Provider for Covered Services rendered by that Provider. If You use an Out-of-Network Provider, You are responsible for payment of all charges and must submit an Out-of-Network claim form, including itemized receipts, to be reimbursed up to the Out-of-Network Allowance.

To be reimbursed, You must submit the claim within 1 year from the date proof is otherwise required. If You do not submit a claim, within the 1 year time period, it will not be paid.

3. You may request a claim form from our customer service department. We will send You a claim form within 15 days. You must submit Your itemized receipt to Us with the claim form. We may also request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.
4. A Network Provider or an Out-of-Network Provider may refuse to render a service, or reduce or terminate a service that has been rendered, or require You to pay for what You believe should be a Covered Service. If this occurs:
 - a. You may submit a claim to Us to obtain a Coverage decision concerning whether the Plan will Cover that service.
 - b. You may request a claim form from Our customer service department. We will send You a claim form within 15 days. We may request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.

B. Payment

1. If You received Covered Services from a Network Provider, We will pay the Network Provider directly. These payments are made according to the Plan's agreement with that Network Provider. You authorize assignment of benefits to that Network Provider. Covered Services will be paid at the Network Benefit level.
2. If You received Covered Services from an Out-of-Network Provider, You must submit, in a timely manner, a completed claim form for Covered Services. If the claim does not require further investigation, We will reimburse You. Our payment fully discharges Our obligation related to that claim.
3. If the Group Agreement is terminated, all claims for Covered Services rendered prior to the termination date, must be submitted to the Plan within 1 year from the date the Covered Services was received.

4. We will pay benefits within 30 days after we receive a claim form that is complete. Claims are processed in accordance with current industry standards, and based on Our information at the time We receive the claim form.
5. When a claim is paid or denied, in whole or part, You will receive an Explanation of Benefits (EOB). This will describe how much was paid to the Provider, and Your out-of-pocket costs paid to the Provider. The Plan will send the EOB to the last address on file for You.
6. You are responsible for paying any applicable Copayment amount and amounts above the Plan allowance to the Provider. If We pay such amounts to a healthcare provider on Your behalf, We may collect those cost-sharing amounts directly from You.

Payment for Covered Services is more fully described in Attachment C: Schedule of Benefits.

C. Complete Information

Whenever You need to file a claim Yourself, We can process it for You more efficiently if You complete a claim form. This will ensure that You provide all the information needed. Most Providers will have claim forms or You can request them from Us by calling Our customer service department at the number listed on Your membership ID card.

Mail all claim forms to BCBST's vision claims administrator:

EyeMed Vision Care ®

ATTN.: OON CLAIMS

P.O. Box 8504

Mason, OH 45040

Grievance Procedure

I. INTRODUCTION

Our Grievance procedure (the “Procedure”) is intended to provide a fair, quick and inexpensive method of resolving any and all Disputes with the Plan. Such Disputes include: any matters that cause You to be dissatisfied with any aspect of Your relationship with the Plan; any Adverse Benefit Determination concerning a Claim; or any other claim, controversy, or potential cause of action You may have against the Plan. Please contact the Customer Care Center, at the number listed on Your membership ID card: (1) to ask questions about a Claim; (2) if You have any questions about this EOC or other documents that You receive from Us (e.g. an explanation of benefits); or (3) to initiate a Grievance concerning a Dispute.

1. This Procedure is the exclusive method of resolving any Dispute. Exemplary or punitive damages are not available in any Grievance or litigation, pursuant to the terms of this EOC. Any decision to award damages must be based upon the terms of this EOC.
2. The Procedure can only resolve Disputes that are subject to Our control.
3. You cannot use this Procedure to resolve a claim that a Provider was negligent. Network Providers are independent contractors. They are solely responsible for making treatment decisions in consultation with their patients. You may contact the Plan, however, to complain about any matter related to the quality or availability of services, or any other aspect of Your relationship with Providers.
4. This Procedure incorporates the definitions of: (1) Adverse Benefit Determination; (2) urgent care; and (3) pre-service and post-service claims (“Claims”), that are in the *Employee Retirement Income Security Act of 1974* (“ERISA”); *Rules and Regulations for Administration and Enforcement; Claims Procedure* (the “Claims Regulation”).

An Adverse Benefit Determination is any denial, reduction, termination or failure to provide or make payment for what You believe should be a Covered Service.

- a. If a Provider does not render a service, or reduces or terminates a service that has been rendered, or requires You to pay for what You believe should be a Covered Service, You may submit a Claim to the Plan to obtain a determination concerning whether the Plan will cover that service. As an example, if a pharmacy does not provide You with a prescribed medication or requires You to pay for that prescription, You may submit a Claim to the Plan to obtain a determination about whether it is Covered by the Plan. Providers may be required to hold You harmless for the cost of services in some circumstances.
 - b. Providers may also appeal an Adverse Benefit Determination through the Plan's Provider dispute resolution procedure.
 - c. A Plan determination will not be an Adverse Benefit Determination if: (1) a Provider is required to hold You harmless for the cost of services rendered; or (2) until the Plan has rendered a final Adverse Benefit Determination in a matter being appealed through the Provider dispute resolution procedure.
5. You may authorize another person to act on Your behalf concerning a Dispute.
 6. Any Dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, the Group Agreement and this EOC.

II. DESCRIPTION OF THE REVIEW PROCEDURES

A. Inquiry

An Inquiry is an informal process that may answer questions or resolve a potential Dispute. You should contact a Customer Care Agent if You have any questions about how to file a Claim or to attempt to resolve any Dispute. Making an Inquiry does not stop the time period for filing a Claim or beginning a Dispute. You do not have to make an Inquiry before filing a Grievance.

B. Grievance

You must submit a written request asking the Plan to reconsider an Adverse Benefit Determination, or take a requested action to resolve another type of Dispute (Your "Grievance"). You must begin the Dispute process within 180 days from the date We issue notice of an Adverse Benefit Determination from the Plan or from the date of the event that is otherwise causing You to be dissatisfied with the Plan. If You do not initiate a Grievance within 180 days of when We issue an Adverse Benefit Determination, You may give up the right to take any action related to that Dispute.

Contact the Customer Care Center at the number listed on Your membership ID card for assistance in preparing and submitting Your Grievance. They can provide You with the appropriate form to use in submitting a Grievance. This is the first level Grievance procedure and is mandatory.

1. Grievance Hearing

After the Plan has received and reviewed Your Grievance, the Plan will review the Grievance and any additional information that You or others submit concerning that Grievance. In Grievances concerning urgent care or pre-service Claims, the Plan will appoint one or more qualified reviewer(s) to consider such Grievances. Individuals involved in making prior determinations concerning Your Dispute are not eligible to be voting members of the first level Grievance committee or reviewers. The reviewers have full discretionary authority to make eligibility, benefit and/or claim determinations, pursuant to the Group Agreement. Such determinations shall be subject to the review standards applicable to ERISA plans, even if the Group Agreement is not otherwise governed by ERISA.

2. Written Decision

The reviewers will consider the information presented, and You will receive a written decision concerning Your Grievance within 30 days of Your request for review.

The decision will be sent to You in writing and will contain:

- (a) A statement of the Plan's understanding of Your Grievance;
- (b) The basis of the decision; and
- (c) Reference to the documentation or information upon which the Plan based its decision. The Plan will send You a copy of such documentation or information, without charge, upon written request.

No action at law or in equity shall be brought to recover on this EOC until 60 days after written proof of loss has been furnished as required by this EOC. No such action shall be brought beyond 3 years after the time written proof of loss is required to be furnished.

Definitions

Defined terms are capitalized. When defined words are used in this EOC, they have the meaning set forth in this section. Words that are defined in the Plan's Medical Policies and Procedures have the same meaning if used in this EOC.

1. **Actively At Work** - The performance of all of an Employee's regular duties for the Group on a regularly scheduled workday at the location where such duties are normally performed. An Employee will be considered to be Actively At Work on a non-scheduled work day (which would include a scheduled vacation day) only if he or she was Actively At Work on the last regularly scheduled workday. An Employee who is not at work due to a health-related factor shall be treated as Actively At Work for purposes of determining Eligibility.
2. **Benefit Period** –a 12-month period based on the last date of service during which any benefit limits accumulate/are counted.
3. **Billed Charges** – The amount that a Provider charges for services rendered.
4. **Coated Lenses** – A substance added to a finished lens on one or both surfaces.
5. **Contact Lenses:**
 - a. **Cosmetic** – Contact Lenses that are not Medically Necessary and are constructed solely for cosmetic and/or convenience reasons.
 - b. **Medically Necessary** – Contact Lenses that are constructed for the Medically Necessary conditions listed below: Reimbursement for these lenses will be considered as payment in full.
 - Aphakia (after cataract surgery). A pair of single vision lenses or multi-focal lenses and frames can be provided with the Contact Lenses.
 - When the visual acuity cannot be corrected to 20/70 in the better eye except through the use of Contact Lenses (must be 20/60 or better).
 - Anisometropia of 4.0 diopters or more, provided visual acuity improves to 20/60 or better in the weaker eye.
 - Keratoconus.
6. **Copayment** – The dollar amount specified in Attachment C: Schedule of Benefits that You are required to pay directly to a Provider for certain Covered Services. You must pay such Copayments at the time You receive those Services.
7. **Covered Dependent** - A Subscriber's family members who: (1) meet the eligibility requirements of this EOC, (2) have been enrolled for Coverage; and (3) for whom the Plan has received the applicable Premium for Coverage.
8. **Covered Family Members** – A Subscriber and his or her Covered Dependents.
9. **Covered Services, Coverage or Covered** - Those Medically Necessary and Appropriate vision services and supplies that are set forth in Attachment A of this EOC, (that is incorporated by reference). Covered Services are subject to all the terms, conditions, exclusions and limitations of the Group Agreement and this EOC.
10. **Employee** - A person who fulfills all eligibility requirements established by the Group and the Plan.

11. **Enrollment Form** – A form or application that must be completed in full by the eligible Employee before he/she will be considered for Coverage under the Plan. Your Group may have You use an electric form to enroll, rather than a paper form.
12. **ERISA** - The Employee Retirement Income Security Act of 1974, as amended.
13. **Full-time Student** - A student who is enrolled in and attending an accredited or licensed high school, vocational or technical school, college or university, on a full time basis. The number of hours required for full-time status is dependent on that school's published requirements.
14. **Group Agreement or Agreement** – The arrangements between the Plan and the Group, including this EOC, the Employer Group Application, any Riders, any amendments, and any attachments to the Agreement or this EOC. If there is any conflict between the Group Agreement and this EOC, the Group Agreement shall be controlling.
15. **Group or Employer** – A corporation, partnership, union or other entity that is eligible for Group Coverage under State and Federal laws, and the Plan's Underwriting Guidelines; and that enters into an Agreement with the Plan to provide Coverage to its Employees and their eligible Dependents.
16. **Incapacitated Child** – an unmarried child who is, and continues to be, both (1) incapable of self-sustaining employment by reason of intellectual or physical disability (what used to be called mental retardation or physical handicap); and (2) chiefly dependent upon the Subscriber or Subscriber's spouse for economic support and maintenance.
 - a. If the child reaches this Plan's limiting age while Covered under this Plan, proof of such incapacity and dependency must be furnished within 31 days of when the child reaches the limiting age.
 - b. Incapacitated dependents of Subscribers of new groups, or of Subscribers who are newly eligible under this Plan, are eligible for Coverage if they were covered under the Subscriber's or the Subscriber's spouse's previous health benefit plan. We may ask You to furnish proof of the incapacity and dependency upon enrollment and for proof that the child continues to meet the conditions of incapacity and dependency, but not more frequently than annually.
17. **Late Enrollee** – An Employee or eligible Dependent who fails to apply for Coverage within: (1) 31 days after such person first became eligible for Coverage under this EOC; or (2) within a subsequent Open Enrollment Period.
18. **Medicare** - Title XVIII of the Social Security Act, as amended, and Coverage under this program.
19. **Member, You, Your** - Any person enrolled as a Subscriber or Covered Dependent under a Group Agreement.
20. **Member Payment** – The dollar amounts for Covered Services that You are responsible for as set forth in Attachment C: Schedule of Benefits, including Copayments. The Plan may require proof that You have made any required Member Payment.
21. **Network Benefit** – The Plan's payment level that applies to Covered Services received from a Network Provider. See Attachment C: Schedule of Benefits.
22. **Network Provider** - An Ophthalmologist, Optometrist or Optician who has contracted with the Plan to provide access to benefits to Members at specified rates.

23. **Open Enrollment Period** - Those periods of time agreed to by the Plan and the Group during which eligible Employees and their dependents may enroll as Members.
24. **Ophthalmologist** – A person or a doctor of medicine (M.D.) or osteopathy (D.O.) who specializes in the comprehensive care of the eyes and visual system to prevent, diagnose, and treat any eye disease, disorder, or injury.
25. **Optician** – One who is licensed to fit, adjust, and dispense eyeglasses and other optical devices on the written prescription of a licensed Ophthalmologist or Optometrist.
26. **Optometrist** – A doctor of Optometry (O.D.) who is trained to detect and correct vision problems primarily by prescribing eyeglasses or Contact Lenses.
27. **Oversized Lens** – Any lens with an eyesize of 61mm or greater.
28. **Out-of-Network Allowance** – The total dollar amount, as stated in Attachment C: Schedule of Benefits that You receive for services rendered by an Out-of-Network Provider.
29. **Out-of-Network Provider** – Any Provider who is an Eligible Provider type but who does not have a contract with the Plan to provide Covered Services.
30. **Payor(s)** - An insurer, health maintenance organization, no-fault liability insurer, self-insured group, or other entity that provides or pays for a Member’s health care benefits.
31. **Premium** – The total payment for Coverage under the Group Agreement, including amounts paid by You and the Group for such Coverage.
32. **Prescription Change** – At least one of the following standards must be met to qualify as a Covered Prescription Change:
 - A change of 0.50 diopters minimum in one eye, or 0.50 diopters minimum total in both eyes.
 - A difference in vertical prism of greater than 1 prism diopter.
 - A change in axis or astigmatism of a minimum of 15 degrees.
33. **Provider** – A person or entity engaged in the delivery of vision care services who, or that is licensed, certified or practicing in accordance with applicable State or Federal laws.
34. **Qualified Medical Child Support Order** – A medical child support order, issued by a court of competent jurisdiction, that creates or recognizes the existence of a child’s right to receive benefits for which a Subscriber is eligible under the Group Agreement. Such order shall identify the Subscriber and each such child by name and last known mailing address; give a description of the type and duration of coverage to be provided to each child; and identify each health plan to which such order applies.
35. **Standard Lens** – Standard glass or plastic (CR39) in clear or Rose Tint #1 or #2. Any lens that will fit any frame with an eyesize less than 61 mm.
36. **Standard Frame** – Any frame that has a retail value of \$100.00 or less.
37. **Subscriber** – An Employee who meets all applicable eligibility requirements, has enrolled for Coverage and for whom the Plan has received the applicable Premium for Coverage from the Group.
38. **Vision Examination** – A comprehensive Ophthalmologic service as defined in the Current Procedural Technology (CPT) and the Documentation Guidelines listed under “Eyes – examination items.” Comprehensive Ophthalmologic service describes a general evaluation

of the complete visual system. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and Ophthalmologic examinations, gross visual fields and basic sensorimotor examination. It often includes, as indicated, biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes initiation of diagnostic and treatment programs.

Evidence of Coverage

ATTACHMENT A: COVERED SERVICES

Plan benefits are based on the services and supplies described in this Attachment A and provided in accordance with the benefit schedules set forth in this EOC's Attachment C: Schedule of Benefits.

Please also read Attachment B: Exclusions.

Your benefits are greater when You use Network Providers. The Plan contracts with Network Providers. Network Providers have agreed to accept the Network amounts as stated in Attachment C: Schedule of Benefits as the basis for payment to the Provider for Covered Services. Network Providers have also agreed not to bill You for amounts above the Network amounts for Covered Services. However, if You select non-standard optional services or features, You will be required to pay for them, even if the amount exceeds the Network amounts stated in Attachment C: Schedule of Benefits.

Out-of-Network Providers do not have a contract with the Plan. This means they may be able to charge You more than the Maximum Allowable Charge (the amount set by the Plan in its contracts with Network Providers). When You use an Out-of-Network Provider for Covered Services, You will be responsible for any difference between what the Plan pays and what the Out-of-Network Provider charges. **This means that You may owe the Out-of-Network Provider a large amount of money.**

Obtaining services not listed as a Covered Service in this Attachment or not in accordance with the Plan's health Care Management policies and procedures may result in the denial of benefits or a reduction in reimbursement for otherwise eligible Covered Services.

Benefits paid under this Vision EOC do not apply to any maximums paid or owed for any other coverage You may have.

A. Vision Care

Medically Necessary and Appropriate routine vision care services.

1. Covered Services
 - a. Routine vision services, including services and supplies to detect or correct refractive errors of the eyes.
2. Restrictions
 - a. Sunglasses will be handled as any other lens.
 - b. Benefits are not available more frequently than as specified in Attachment C: Schedule of Benefits.
 - c. Allowances represent the maximum amount available to You for a Covered Service listed in Attachment C: Schedule of Benefits. If You do not use the entire allowance in a single instance, You will not be able to use any remaining balance for the rest of the Benefit Period.
 - d. Discounts do not apply for benefits provided by other Group benefit plans.

EVIDENCE OF COVERAGE
ATTACHMENT B: EXCLUSIONS

This EOC does not provide benefits for the following services, supplies or charges:

1. Medical and/or surgical treatment of the eye, eyes, or supporting structure, including surgeries to detect or correct refractive errors of the eyes.
2. Eye exercises and/or therapy.
3. Visual training.
4. Charges for vision testing examinations, lenses and frames ordered while insured but not delivered within 60 days after Coverage is terminated.
5. Charges for sunglasses, photosensitive, anti-reflective or other optional charges when the charge exceeds the amount allowable for regular lenses.
6. Charges filed for procedures determined by the Plan to be special or unusual, (i.e. orthoptics, vision training, subnormal vision aids, aniseikonic lenses, tonography, corneal refractive therapy, etc.)
7. Charges for lenses that do not meet the Z80.1 or Z80.2 standards of the American National Standards Institute.
8. Charges in excess of the Out-of-Network Allowance as established by the Plan.
9. Oversized Lenses.
10. Corrected eyewear required by an employer as a condition of employment, and safety eyewear unless specifically Covered under the plan.
11. Non-prescription lenses and frames, and non-prescription sunglasses (except for 20% discount).
12. Services or materials provided by any other group benefit providing vision care.
13. Two pairs of glasses in lieu of bifocals.
14. Services or supplies not listed as Covered Services under Attachment A, Covered Service.
15. Services or supplies that are determined to be not Medically Necessary and Appropriate.
16. Self treatment or training.
17. Services that are free.
18. Services or supplies for the treatment of work related illness or injury, regardless of the presence or absence of workers' compensation coverage. This exclusion does not apply to injuries or illnesses of an employee who is (1) a sole-proprietor of the Group, unless required by law to carry worker's compensation insurance; (2) a partner of the Group, unless required by law to carry worker's compensation insurance; or (3) a corporate officer of the Group, provided the officer filed an election not to accept Workers' Compensation with the appropriate government department.
19. Services or supplies received before Your effective date for Coverage with this Plan.
20. Services or supplies received after Your Coverage under this Plan ceases, even if those expenses relate to a condition that began while You were Covered, except that this Plan will Cover charges for vision materials that were ordered before Your Coverage ended and are delivered within 31 days from the date of such order.
21. Services or charges to complete a claim form or to provide medical records or other administrative functions. We will not charge You or Your legal representative for statutorily required copying charges.
22. Charges for failure to keep a scheduled appointment.

23. Charges for telephone consultations, e-mail or web based consultations, or telemedicine services.
24. Court ordered examinations and treatment, unless Medically Necessary.
25. Charges for services performed by You or Your spouse, or Your or Your spouse's parent, sister, brother or child.
26. Any charges for handling fees.
27. Safety items, or items to affect performance primarily in sports-related activities.
28. Charges for replacement of broken, lost, or stolen lenses, Contact Lenses, or frames.
29. Charges for services or materials from an Ophthalmologist, Optometrist or Optician acting within the scope of his or her license.
30. Charges for any additional service required outside basic vision analyses for Contact Lenses, except fitting fees

ATTACHMENT C: SCHEDULE OF BENEFITS

Group Name: City of Cookeville

Group Number: 106949

Effective Date: July 1, 2019

Members have the right to obtain vision care from the Provider of their choice. However, payment of benefits varies depending on the type of Provider chosen. Benefits are payable as shown in the following Schedule of Benefits:

<u>Benefit</u>	<u>In-Network</u>	<u>Out-of-Network Allowance</u>	<u>Benefit Frequency</u>
VISION EXAMINATION			
Comprehensive Eye Examination	\$10 Copayment	up to \$35	Subscriber 12 months Dependent Spouse 12 months Dependent Children 12 months
Retinal Imaging and	Up to \$39	Up to \$0	
Contact Lenses Fit And Follow-Up			Subscriber 12 months Dependent Spouse 12 months Dependent Children 12 months
Standard	\$55 Copayment	up to \$0	
Premium	10% off retail price	up to \$0	
VISION MATERIALS¹			
<i>Standard Plastic Lenses</i>			Subscriber 12 months Dependent Spouse 12 months Dependent Children 12 months
Single Vision	\$25 Copayment	up to \$30	
Bifocal	\$25 Copayment	up to \$45	
Trifocal	\$25 Copayment	up to \$60	
<i>Frames²</i>	\$0 Copayment up to \$120 allowance	up to \$60	Subscriber 24 months Dependent Spouse 24 months Dependent Children 24 months
<i>Contacts In lieu of eyeglasses, frames and lenses³</i>			Subscriber 12 months Dependent Spouse 12 months Dependent Children 12 months
Conventional	\$0 Copayment up to \$120 allowance	up to \$96	
Disposable	\$0 Copayment up to \$120 allowance	up to \$96	
Medically Necessary	Paid in full	up to \$200	

<i>Lens Options</i>			Subscriber 12 months Dependent Spouse 12 months Dependent Children 12 months
Standard Polycarbonate	\$40 Copayment	up to \$0	
Standard Polycarbonate (For Covered Dependent children under 19 years of age.)	\$0 Copayment	up to \$5	
UV Treatment	\$15 Copayment	up to \$0	
Tint	\$15 Copayment	up to \$0	
Standard Plastic Scratch Coating	\$15 Copayment	up to \$0	
Standard Progressive Lenses (add on to Bifocal)	\$65 Copayment	up to \$0	
Premium Progressive Lenses (add on to Bifocal)	\$65 Copayment 20% off retail price up to \$120 allowance	up to \$0	
Standard Anti-Reflective Coating	\$45 Copayment	up to \$0	
DIABETIC EYE CARE			Care and testing for diabetic members Up to two services per 12 month benefit period for each listed service.
Exam	\$0 Copayment	up to \$77	
Retinal Imaging	\$0 Copayment	up to \$50	
Extended Ophthalmoscopy	\$0 Copayment	up to \$15	
Gonioscopy	\$0 Copayment	up to \$15	
Scanner Laser	\$0 Copayment	up to \$33	

1. Additional complete pair eyeglasses purchases (frame, lens and lens options) receive 40% off retail price at Network Providers once benefit used.
2. Additional 20% off retail cost above allowance.
3. Additional 15% off balance over allowance on conventional Contact Lenses.

EVIDENCE OF COVERAGE

ATTACHMENT D: ELIGIBILITY

Any Employee of the Group and his/her family dependents, who meet the eligibility requirements of this Section, will be eligible for Coverage under the Group Agreement if properly enrolled for Coverage and upon payment of the required Premium for such Coverage. If there is any question about whether a person is eligible for Coverage, the Employer shall make final eligibility determinations in accordance with the requirements of this EOC and the Group Agreement. At the Group or Employer's request, this Plan may not cover Spouses or dependent children. If You qualify as a retiree, You may still be an eligible Employee under this EOC after You leave employment. Check with Your benefits representative for full details.

A. Subscriber

To be eligible to enroll as a Subscriber, You must:

1. Be a full-time Employee of the Group who is Actively at Work; and
2. Satisfy all eligibility requirements of the Employer and Group Agreement; and
3. Enroll for Coverage from the Plan by submitting a completed and signed Enrollment Form or other required documentation to Your Group representative;

For leaves of absence, please refer to the Continuation of Coverage section of this EOC.

B. Covered Dependents

You can apply for Coverage for Your dependents. You must list Your dependents on the Enrollment Form. To qualify as a Covered Dependent, each dependent must meet all dependent eligibility criteria established by the Employer, satisfy all eligibility requirements of the Group Agreement, and be either:

1. The Subscriber's current spouse as defined by the Employer, which may include a Domestic Partner;
2. The Subscriber's or Subscriber's spouse's: (1) natural child; (2) legally adopted child (including children placed with You for the purpose of adoption); (3) step-child(ren); or (4) children for whom You or Your spouse are legal guardians; who are less than 26 years old; or
3. A child of the Subscriber or the Subscriber's spouse for whom a Qualified Medical Child Support Order has been issued; or
4. An Incapacitated Child of the Subscriber or Subscriber's spouse.

Dependents who permanently reside outside the United States are not eligible for Coverage under the EOC.

Subscribers who are not U.S. citizens, do not reside in the United States, and work at an Employer's location not located in the United States, are not eligible for Coverage under the EOC.

The Employer's determination of eligibility under the terms of this provision shall be conclusive.

The Plan reserves the right to require proof of eligibility including, but not limited to, a certified copy of any Qualified Medical Child Support Order or certification of full-time student status.

C. Loss of Eligibility

Coverage for a Member who has lost his/her eligibility shall automatically terminate at 12:00 midnight on the day that loss of eligibility occurred.

ATTACHMENT E

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH PLAN INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

LEGAL OBLIGATIONS

BlueCross BlueShield of Tennessee, Inc. and some subsidiaries and affiliates (BlueCross) are required to maintain the privacy of all health plan information, which may include Your: name, address, diagnosis codes, etc. as required by applicable laws and regulations (hereafter referred to as “legal obligations”); provide this notice of privacy practices to all members, inform members of the company’s legal obligations; and advise members of additional rights concerning their health plan information. BlueCross must follow the privacy practices contained in this notice from its effective date, until this notice is changed or replaced.

BlueCross reserves the right to change privacy practices and the terms of this notice at any time, as permitted by the legal obligations. Any changes made in these privacy practices will be effective for all health plan information that is maintained, including health plan information created or received before the changes are made. All members will be notified of any changes by receiving a new notice of the company’s privacy practices.

You may request a copy of this notice of privacy practices at any time by contacting BlueCross at the address on the back of this notice.

ORGANIZATIONS COVERED BY THIS NOTICE

This notice applies to the privacy practices of BlueCross BlueShield of Tennessee, Inc. and its subsidiaries or affiliated covered entities. Medical information about Our subscribers and members may be shared with each other as needed for treatment, payment or health care operations.

USES AND DISCLOSURES OF MEDICAL INFORMATION

Your health plan information may be used and disclosed for treatment, payment, and health care operations, for example:

TREATMENT: Your health plan information may be disclosed to a health care provider that asks for it to provide treatment.

PAYMENT: Your health plan information may be used or disclosed to pay claims for services or to coordinate benefits, which are covered under Your health insurance policy.

HEALTH CARE OPERATIONS: Your health plan information may be used and disclosed to determine premiums, conduct quality assessment and improvement activities, to engage in care coordination or case management, accreditation, conducting and arranging legal services, fraud prevention and investigation, wellness, disease management, and for other similar administrative purposes.

AUTHORIZATIONS: You may provide written authorization to use Your medical information or to disclose it to anyone for any purpose. You may revoke Your authorization in writing at any time. That revocation will not affect any use or disclosure permitted by Your authorization while it was in effect. BlueCross cannot use or disclose Your health plan information except those described in this notice, without Your written authorization. Examples of where an authorization would be required: Most uses and disclosures of psychotherapy notes (if recorded by a covered entity), uses and disclosures for marketing purposes, disclosures that constitute a sale of PHI, other uses and disclosures not described in this notice.

PERSONAL REPRESENTATIVE: Your health plan information may be disclosed to a family member, friend or other person as necessary to help with Your health care or with payment for Your health care. You must agree that the company may do so, as described in the Individual Rights section of this notice.

PLAN SPONSORS: Your health plan information, and the health plan information of others enrolled in Your group health plan, may be disclosed to Your Plan sponsor in order to perform Plan administration functions. Please see Your Plan documents for a full description of the uses and disclosures the Plan sponsor may make of Your health plan information in such circumstances.

UNDERWRITING: Your health plan information may be received for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a health insurance or benefits contract. If the company does not issue that contract, Your health plan information will not be used or further disclosed for any other purpose, except as required by law; Additionally, health plans are prohibited from using or disclosing genetic information of an individual for underwriting purposes pursuant to the Genetic Information Nondiscrimination Act of 2008 (GINA).

MARKETING: Your health plan information may be used to provide information about health-related benefits, services or treatment alternatives that may be of interest to You. Your health plan information may be disclosed to a business associate assisting Us in providing that information to You. We will not market products or services other than health-related products or services to You unless You affirmatively opt-in to receive information about non-health products or services We may be offering. You have the right to opt out of fundraising communications.

RESEARCH: Your health plan information may be used or disclosed for research purposes, as allowed by law.

YOUR DEATH: If You die, Your health plan information may be disclosed to a coroner, medical examiner, funeral director or organ procurement organization.

AS REQUIRED BY LAW: Your health plan information may be used or disclosed as required by state or federal laws.

COURT OR ADMINISTRATIVE ORDER: Health plan information may be disclosed in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances.

VICTIM OF ABUSE: If You are reasonably believed to be a victim of abuse, neglect, domestic violence or other crimes, health plan information may be released to the extent necessary to avert a serious threat to Your health or safety or to the health or safety of others. Health plan information may be disclosed, when necessary, to assist law

enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

MILITARY AUTHORITIES: Health plan information of Armed Forces personnel may be disclosed to Military authorities under certain circumstances. Health plan information may be disclosed to authorized federal officials as required for lawful intelligence, counterintelligence, and other national security activities.

INDIVIDUAL RIGHTS

1. **DESIGNATED RECORD SET:** You have the right to look at or get copies of Your health plan information, with limited exceptions. You must make a written request, using a form available from the Privacy Office, to obtain access to Your health plan information. If You request copies of Your health plan information, You will be charged \$.25 per page, \$10 per hour for staff time required to copy that information, and postage if You want the copies mailed to You. If You request an alternative format, the charge will be based upon the cost of providing Your health plan information in the requested format. If You prefer, the company will prepare a summary or explanation of Your health plan information for a fee. For a more detailed explanation of the fee structure, please contact the Privacy Office. The company requires advance payment before copying Your health plan information.
2. **ACCOUNTING OF DISCLOSURES:** You have the right to receive an accounting of any disclosures of Your health plan information made by the company or a business associate for any reason, other than treatment, payment, or health care operations purposes within the past six years. This accounting will include the date the disclosure was made, the name of the person or entity the disclosure was made to, a description of the health plan information disclosed, the reason for the disclosure, and certain other information. If You request an accounting more than once in a 12-month period, there may be a reasonable cost-based charge for responding to those additional requests. Please contact the Privacy Office for a more detailed explanation of the fees charged for such accountings.
3. **RESTRICTION REQUESTS:** You have the right to request restrictions on the company's use or disclosure of Your health plan information. The company is not required to agree to such requests. The company will only restrict the use or disclosure of Your health plan information as set forth in a written agreement that is signed by a representative of the Privacy Office on behalf of the company.
4. **BREACH NOTICE:** You have the right to notice following a breach of unsecured protected health information. The notice of a breach of unsecured protected health information shall at a minimum include the following: The date of the breach, the type of data disclosed in the breach, who made the non-permitted access, use or disclosure of unsecured protected health information and who received the non-permitted disclosure, and what corrective business action was or will be taken to prevent further non-permitted access, uses or disclosures of unsecured protected health information.
5. **CONFIDENTIAL COMMUNICATIONS:** If You reasonably believe that sending health plan information to You in the normal manner will endanger You, You have the right to make a written request that the company communicate that information to You by a different method or to a different address. If there is an

immediate threat, You may make that request by calling a BlueCross BlueShield of Tennessee Customer Service Representative or the Privacy Officer at 1-888-455-3824. Follow up with a written request is required as soon as possible. The company must accommodate Your request if it is reasonable, specifies how and where to communicate with You, and continues to permit collection of Premium and payment of claims under Your health plan.

6. **AMENDMENT REQUESTS:** You have the right to make a written request that the company amend Your health plan information. Your request must explain why the information should be amended. The company may deny Your request if the health plan information You seek to amend was not created by the company or for other reasons permitted by its legal obligations. If Your request is denied, the company will provide a written explanation of the denial. If You disagree, You may submit a written statement that will be included with Your health plan information. If the company accepts Your request, reasonable efforts will be made to inform the people that You designate about that amendment. Any future disclosures of that information will be amended.
7. **RIGHT TO REQUEST WRITTEN NOTICE:** If You receive this notice on the company's web site or by electronic mail (e-mail), You may request a written copy of this notice, by contacting the Privacy Office.

QUESTIONS AND COMPLAINTS

If You want more information concerning the company's privacy practices or have questions or concerns, please contact the Privacy Office.

If You are concerned that: (1) the company has violated Your privacy rights; (2) You disagree with a decision made about access to Your health plan information or in response to a request You made to amend or restrict the use or disclosure of Your health plan information; (3) to request that the company communicate with You by alternative means or at alternative locations; please contact the privacy office.

You may also submit a written complaint to the U.S. Department of Health and Human Services. The company will furnish the address where You can file a complaint with the U.S. Department of Health and Human Services upon request.

The company supports Your right to protect the privacy of Your health plan information. There will be no retaliation in any way if You choose to file a complaint with BlueCross BlueShield of Tennessee or subsidiaries or affiliates, or with the U.S. Department of Health and Human Services.

BlueCross BlueShield of Tennessee, Inc.
The Privacy Office
1 Cameron Hill Circle
Chattanooga, TN 37402
(888) 455-3824
(423) 535-1976 FAX
privacy_office@bcbst.com

General Legal Provisions

The Plan is an Independent Licensee of the BlueCross BlueShield Association

The Plan is an independent corporation operating under a license from the BlueCross Blue Shield Association (the “Association”). That license permits the Plan to use the Association’s service marks within its assigned geographical location. The Plan is not a joint venturer, agent or representative of the Association nor any other independent licensee of the Association.

Relationship with Network Providers

Network Providers are Independent Contractors and are not employees, agents or representatives of the Plan. Such Providers contract with the Plan, which has agreed to pay them for rendering Covered Services to You. Network Providers are solely responsible for making all medical treatment decisions in consultation with their Member-patients. The Plan does not make medical treatment decisions under any circumstances.

The Plan has the discretionary authority to make benefit or eligibility determinations and interpret the terms of Your Coverage to the Plan (“Coverage Decisions”). It makes those Coverage Decisions based on the terms of this EOC, the Group Agreement, its participation agreements with Network Providers and applicable State or Federal laws.

The Plan’s participation agreements permit Network Providers to dispute the Plan’s Coverage decisions if they disagree with those decisions. If Your Network Provider does not dispute a Coverage decision, You may request reconsideration of that decision as explained in the grievance procedure section of this EOC. The participation agreement requires Network Providers to fully and fairly explain the Plan’s Coverage decisions to You, upon request, if You decide to request that the Plan reconsider a Coverage decision.

The Plan or a Network Provider may end their relationship with each other at any time. A Network Provider may also limit the number of Members that he, she or it will accept as patients during the term of this Agreement. The Plan does not promise that any specific Network Provider will be available to render services while You are Covered by the Plan.

Governing Laws

Tennessee laws govern Your benefits; however, if the extraterritorial laws of another state apply to Your benefits, We will administer Your benefits accordingly.

Nondiscrimination Notice

BlueCross BlueShield of Tennessee (BlueCross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

BlueCross:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language services to people whose primary language is not English, such as: (1) qualified interpreters and (2) written information in other languages.

If you need these services, contact a consumer advisor at the number on the back of your Member ID card (for TTY help, call 1-800-848-0298 or 711).

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance (“Nondiscrimination Grievance”). For help with preparing and submitting your Nondiscrimination Grievance, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Compliance Coordinator; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

