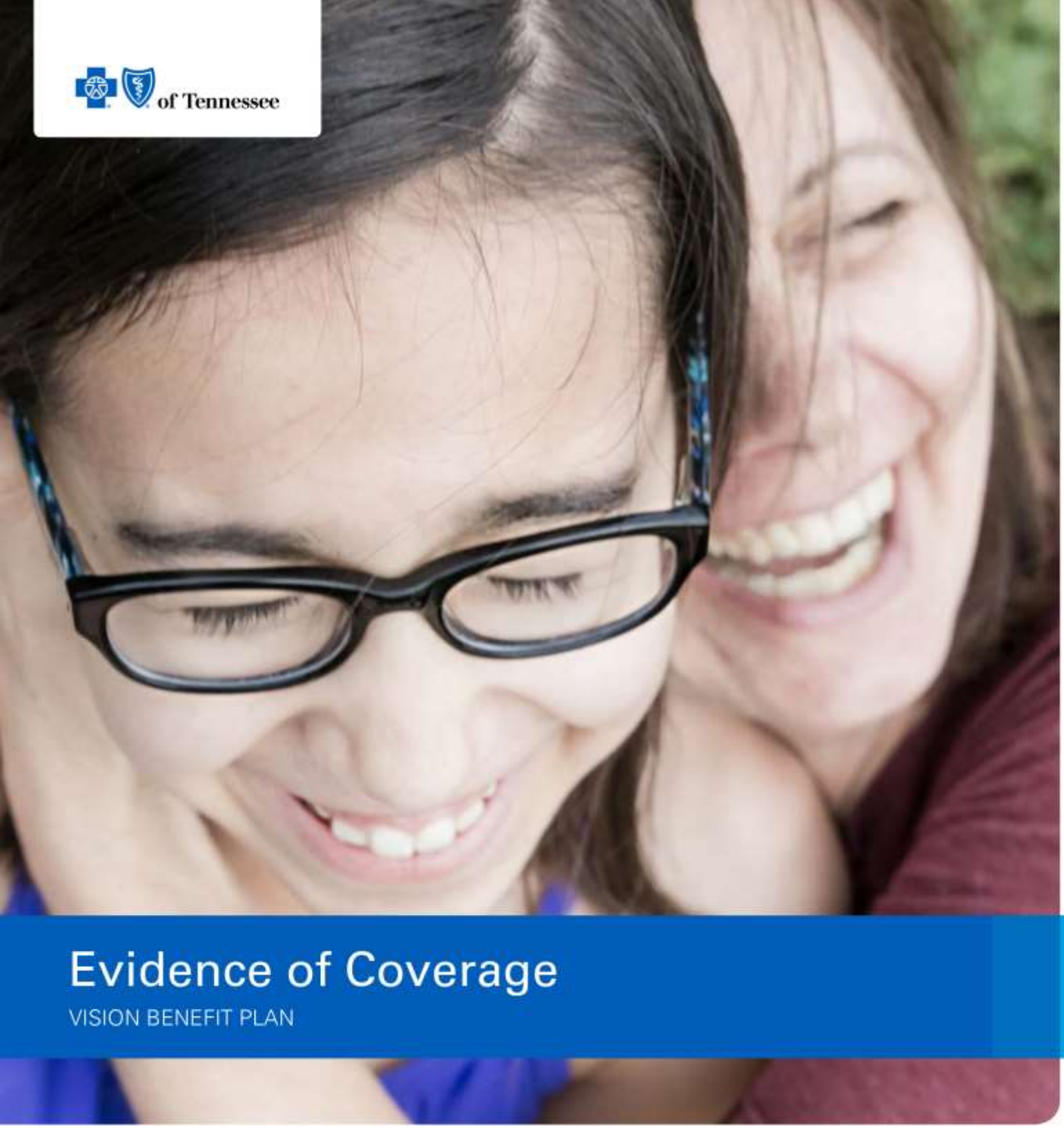

Sumner County Employees
2022

COMM-682 (8/16)
Health EOC - Members

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*.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-565-9140 (TTY: 1-800-848-0298).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-565-9140 (رقم هاتف الصم والبكم: 1-800-848-0298

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-565-9140 (TTY:1-800-848-0298) 。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-565-9140 (TTY:1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-565-9140 (TTY: 1-800-848-0298) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-565-9140 (ATS : 1-800-848-0298).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ ທ່ານ. ໂທຣ 1-800-565-9140 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-565-9140 (መስማት ለተሳናቸው: 1-800-848-0298).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-565-9140 (TTY: 1-800-848-0298).

સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-565-9140 (TTY:1-800-848-0298)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-565-9140 (TTY:1-800-848-0298) まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-565-9140 (TTY:1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-565-9140 (TTY:1-800-848-0298) पर कॉल करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-565-9140 (телетайп: 1-800-848-0298).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-565-9140 (TTY:1-800-848-0298) تماس بگیرید .

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-565-9140 (TTY: 1-800-848-0298).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-565-9140 (TTY: 1-800-848-0298).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-565-9140 (TTY: 1-800-848-0298).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti.Chiamare il numero 1-800-565-9140 (TTY: 1-800-848-0298).

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-565-9140 (TTY: 1-800-848-0298).

NOTICE

PLEASE READ THIS EVIDENCE OF COVERAGE CAREFULLY AND KEEP IT IN A SAFE PLACE FOR FUTURE REFERENCE. IT EXPLAINS YOUR BENEFITS AS ADMINISTERED BY BLUECROSS BLUESHIELD OF TENNESSEE, INC. IF YOU HAVE ANY QUESTIONS ABOUT THIS EVIDENCE OF COVERAGE OR ANY OTHER MATTER RELATED TO YOUR MEMBERSHIP IN THE PLAN, PLEASE WRITE OR CALL US AT:

CUSTOMER SERVICE DEPARTMENT
BLUECROSS BLUESHIELD OF TENNESSEE, INC.,
ADMINISTRATOR
1 CAMERON HILL CIRCLE
CHATTANOOGA, TENNESSEE 37402
(800) 565-9140

TABLE OF CONTENTS

INTRODUCTION

This Evidence of Vision Coverage (this "Vision EOC") was created for the Employer (listed on the cover of this Vision EOC) as part of its employee welfare benefit plan (the "Plan"). References in this Vision EOC to "administrator," "We," "Us," "Our," or "BlueCross" mean BlueCross BlueShield of Tennessee, Inc. The Employer has entered into an Administrative Services Agreement (ASA) with BlueCross for it to administer the claims Payments under the terms of the EOC, and to provide other services. BlueCross does not assume any financial risk or obligation with respect to Plan claims. BlueCross is not the Plan Sponsor, the Plan Administrator or the Plan Fiduciary, as those terms are defined in ERISA. The Employer is the Plan Fiduciary, the Plan Sponsor and the Plan Administrator. These ERISA terms are used in this Vision EOC to clarify their meaning, even though the Plan is not subject to ERISA. Other federal laws may also affect Your Coverage. To the extent applicable, the Plan complies with federal requirements.

This Vision EOC describes the terms and conditions of Your Vision Coverage through the Plan. It replaces and supersedes any Vision EOC or other description of Vision benefits You have previously received from the Plan.

PLEASE READ THIS VISION EOC CAREFULLY. IT DESCRIBES THE RIGHTS AND DUTIES OF MEMBERS. IT IS IMPORTANT TO READ THE ENTIRE VISION 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 HEALTH CARE PROVIDER RECOMMENDS OR ORDERS THAT NON-COVERED SERVICE. (SEE ATTACHMENTS A-D.)

Employer has delegated discretionary authority to make any benefit determinations to the administrator, the Employer also has the authority to make any final Plan determination. The Employer, as the Plan Administrator, and BlueCross also have the authority to construe the terms of Your Coverage. The Plan and BlueCross shall be deemed to have properly exercised that authority unless it abuses its discretion when making such determinations, whether or not the Employer's benefit plan is subject to ERISA.

ANY GRIEVANCE RELATED TO YOUR COVERAGE UNDER THIS VISION EOC SHALL BE RESOLVED IN ACCORDANCE WITH THE "GRIEVANCE PROCEDURE" SECTION OF THIS VISION EOC.

In order to make it easier to read and understand this Vision EOC, defined words are capitalized. Those words are defined in the "DEFINITIONS" section of this Vision EOC.

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

BENEFIT ADMINISTRATION ERROR

If the administrator makes an error in administering the benefits under this Vision EOC, the Plan may provide additional benefits or recover any overpayments from any person, insurance company, or plan. No such error may be used to demand more benefits than those otherwise due under this Vision EOC.

INDEPENDENT LICENSEE OF THE BLUECROSS BLUESHIELD ASSOCIATION

BlueCross is an independent corporation operating under a license from the BlueCross BlueShield Association ("Association.") That license permits BlueCross to use the Association's service marks within its assigned geographical location. BlueCross is not a joint venturer, agent or representative of the Association nor any other independent licensee of the Association.

RELATIONSHIP WITH NETWORK PROVIDERS

A. Independent Contractors

Network Providers are not employees, agents or representatives of the administrator. Such Providers contract with the administrator, 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 Employer and the administrator do not make medical treatment decisions under any circumstances.

While the administrator has the authority to make benefit and eligibility determinations and interpret the terms of Your Coverage, the Employer, as the Plan Administrator as that term is defined in ERISA, has the discretionary authority to make the final determination regarding the terms of Your Coverage ("Coverage Decisions.") Both the administrator and the Employer make Coverage Decisions based on the terms of this Vision EOC, the ASA, the administrator's participation agreements with Network Providers, the administrator's internal guidelines, policies, procedures and applicable State or Federal laws.

The administrator's participation agreements permit Network Providers to dispute the administrator'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 Vision EOC. The participation agreement requires Network Providers to fully and fairly explain the administrator's Coverage decisions to You, upon request, if You decide to request that the administrator reconsider a Coverage decision.

The administrator has established various incentive arrangements to encourage Network Providers to provide Covered Services to You in an appropriate and cost-effective manner. You may request information about Your Provider's payment arrangement by contacting the administrator's customer service department.

B. Termination of Providers' Participation

The administrator 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 administrator does not promise that any specific Network Provider will be available to render services while You are Covered.

C. Provider Directory

A Directory of Network Providers is available at no additional charge to You. You may also check to see if a Provider is in Your Plan's Network by going online to www.bcbst.com.

NOTIFICATION OF CHANGE IN STATUS

Changes in Your status can affect the service under the Plan. To make sure the Plan works correctly, please notify the customer service department at the number listed on the Subscriber's membership ID card when a Member changes:

- name;
- address;
- telephone number;
- employment; or
- status of any other health coverage the Member has.

Subscribers must notify the administrator of any eligibility or status changes for themselves or Covered Dependents, including:

- the marriage or death of a family member;
- divorce;
- adoption;
- birth of additional dependents;
- termination of employment; or
- change in student status.

COVERAGE FOR YOU

This EOC describes the benefits You may receive under Your health care program. You are called the Subscriber or Member.

COVERAGE FOR YOUR DEPENDENTS

If You are covered by this program, You may enroll Your Eligible Dependents. Your covered Dependents are also called Members. The names of Dependents for whom application for coverage is made must be listed on the application on file in our records. Subsequent applications for Dependents must be submitted to BlueCross in writing.

TYPES OF COVERAGE AVAILABLE

Individual - Employee only

Two-Person - Employee and one Eligible Dependent

Family - Employee and all eligible Dependents

ELIGIBLE EMPLOYEES

To be eligible for coverage an Employee must:

- Employees who are new enrollees, have loss of other Coverage, or are participating in open enrollment to the Sumner County Employees Insurance Trust Benefit Plan on or after January 1, 2006, must participate in the One to One Health Risk Assessment before health Coverage becomes effective.
- Health Coverage will become effective as outlined in the Plan only after participation in the One to One Risk Assessment by the eligible employee.
- be a full-time Employee scheduled to work at least 32 or more hours per week, or
- be an eligible Dependent of Employees; or
- be an Employee who was covered by insurance through one of the various Employers at the inception of the Trust; or
- be an Employee, who at the inception of employment was covered by insurance, but who has his/her weekly work hours cut to less than 32 due to lack of funds in a particular department.

ELIGIBLE EARLY RETIREES AND DISABLED EMPLOYEES – COUNTY GENERAL AND HIGHWAY DEPARTMENT-RETIREE COVERAGE WILL BE DISCONTINUED AND EMPLOYEES HIRED JANUARY 1, 2018 OR AFTER WILL NOT BE OFFERED THIS BENEFIT.

To be eligible for coverage as an Early Retiree or Disabled Employee, an Employee must meet the eligibility criteria that became effective January 1, 2006, shown below and is not retroactive. Sumner County will pay 75% of the cost of medical insurance premiums for an eligible employee at retirement if the employee meets the following qualifications:

- the eligible Employee must be at least 60 years of age and have 20 years or more of service with Sumner County; or
- the eligible employee, of any age, obtains 30 years of service with Sumner County; and
- the employee must be eligible for medical insurance coverage for the last 5 years of their employment with Sumner County **(1)**; however
- at the time of retirement, if the employee has 5 years continuous employment and the dependent has been eligible to participate in the plan for that five year period, then the dependent can retain coverage as part of the retiree's plan but the dependent must pay 100% of the additional premium cost.

(1) (This does not mean the employee has participated in the insurance plan, but would have been eligible for coverage.)

- due to the restrictions placed by reinsurance: if the employee and/or dependent has not had coverage but has been eligible for the last 5 years and elects to take County Insurance at Retirement, that retiree and/or dependent will be required to answer a questionnaire in order to qualify for health care.
- a Disabled Employee must be certified as disabled by the Social Security Administration, must have been enrolled in the County Insurance Program at the time of disability, and must have 10 or more years of County service at the time of disability.

The retired Employee is responsible for payment of 25% of the cost of this coverage. Programs to share in the cost for the retired Employee's coverage are the responsibility of the County Group offering the program and not the Insurance Trust.

Coverage under the Sumner County Employees Early Retirement Group ends when the retired Employee attains age 65 or becomes eligible for Medicare.

If, at the time of retirement, the retired Employee has 5 years of continuous employment with Sumner County, and a dependent has been eligible to participate in the Plan for that 5-year period, the dependent can continue coverage as part of the retired Employee's Plan. However, the dependent must pay the entire contribution for this coverage.

Retiree Insurance must be taken at time of retirement. Years of service with Sumner County BOE will count toward total years of service with Sumner County if there was no lapse in service between leaving BOE and coming to work with Sumner County Government.

EFFECTIVE DATE

The different types of coverage available to You are shown above.

If You have met the eligibility requirements and You and Your Eligible Dependents apply when first eligible (or within 31 days), Your coverage will be effective the first day of the month following your 30 day waiting period. If You and Your Eligible Dependents do not apply when first eligible, You will be subject to the requirements explained in "If You Did Not Enroll On Time" shown on a following page.

You and Your Dependents will not be covered until Your completed application for coverage, listing all eligible Dependents, has been received by BlueCross and You have been issued an identification card or have received other written notice that Your coverage is in effect.

APPLYING FOR COVERAGE

After meeting the eligibility requirements, You may apply for one of the types of coverage shown above.

To be eligible to enroll as a Dependent, a person must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria established by the Employer, and be:

1. The Subscriber's current legal spouse who meets all requirements of a valid marriage contract in the state of residence, but will not include a domestic partner; or

2. The unmarried, natural, legally adopted, foster or step-child(ren) of the Subscriber or the Subscriber's spouse who is under the age limit stated on the Schedule of Benefits and is dependent upon Subscriber or Subscriber's spouse for at least 50% of his or her support. In addition, Eligible Dependents shall include children placed with the Subscriber or the Subscriber's spouse pending adoption and children for whom the Subscriber or Subscriber's spouse is court-appointed legal guardian; or

3. A child of Subscriber or Subscriber's spouse for whom a Qualified Medical Child Support Order has been issued; or

4. An Incapacitated child of the Subscriber or the Subscribers spouse.

5. Adult children (age 18 and over) who have access to their own employer group coverage may not be eligible. Check with Your Employer to find out if this provision applies.

The Plan'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.

Employer agrees to defend or settle, and hold BlueCross harmless from claims, losses, or suits relating to eligibility or insurability of any applicant, Subscriber, Employee or Dependent in administering this provision.

CHANGING COVERAGE

If Your marital status changes (marriage or divorce) or if there is a change in the number of Your children (birth, adoption), You may want to change Your coverage to one of the other options available.

When You need to make a change, You should (1) tell Your employer, and (2) apply for any needed change within 31 days of the change in family status, date the new Dependent is acquired, etc.

A newborn child of the Subscriber or Subscriber's spouse is a Covered Dependent from the moment of birth. The Subscriber must enroll that child within 31 days of the date of birth. If the Subscriber fails to do so, and an additional Payment is required to cover that child, the Plan will not provide Coverage for that child after 31 days from the child's date of birth.

Changes in coverage will begin on the next Effective Date BlueCross bills Your employer for this coverage (normally the first day of the month). Coverage for new Dependents added begins on the date the Dependent is acquired if the application is received within 31 days after that date.

If You Did Not Enroll On Time

If You wait more than 31 days from the date You are first eligible to apply or add a Dependent You and or the Dependent will be considered a Late Enrollee. Coverage for You or the Dependent will be effective on the next billing date following our receipt of the application for Coverage.

However, a person will <u>not</u> be considered a Late Enrollee if:

- he or she already had other health care coverage at the time coverage under this plan was previously offered; and
- he or she stated in writing at that time that such other coverage was the reason for declining coverage under this plan; and
- such other coverage is:

(1) COBRA and the COBRA coverage is exhausted; or

(2) Non-COBRA and

(a) You lose eligibility under the other coverage (other than for a failure to pay premiums); or

(b) Employer contributions for the other coverage ended; and

- he or she applies for coverage under this plan within 31 days after the loss of the other coverage.

Dependents who become eligible for coverage under this plan by reason of marriage, birth, adoption or placement for adoption after the Subscriber's Effective Date will not be considered Late Enrollees, provided application is made by the Subscriber on behalf of such person(s) within 31 days of the marriage, birth, adoption or placement for adoption.

Enrollment upon Change in Status

An Employee may be eligible to change his or her Coverage other than during the Open Enrollment Period when he or she has a change in status event. The Employee must request the change within 31 days of the change in status.

Any change in the Subscriber's elections must be consistent with the change in status.

To notify the Plan of a change in status event, the Subscriber must submit a change form to the Group representative within 31 days from the date of the event causing that change of status. Such events may include, but are not limited to: (1) marriage or divorce; (2) death of the Subscriber's spouse or dependent; (3) dependency status; (4) Medicare eligibility; (5) coverage by another Payor; (6) birth or adoption of a child; (7) termination of employment, or commencement of employment, of the Subscriber's spouse; (8) switching from part-time to full-time, or from full-time to part-time status by the Subscriber or the Subscriber's spouse; (9) the Subscriber or the Subscriber's spouse taking an unpaid leave of absence, or returning from unpaid leave of absence; (10) significant change in the health coverage of the Subscriber's or the Subscriber's spouse attributable to the spouse's employment.

ANNUAL OPEN ENROLLMENT

An Open Enrollment Period is established for a one-month period each year whereby Employees can elect coverage without furnishing proof of insurability.

CONTINUATION OF COVERAGE

A. Federal Law

If the ASA remains in effect, but Your Coverage under this Vision EOC would otherwise terminate, the Employer may offer You the right to continue Coverage. This right is referred to as "COBRA 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 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 administrator, acting on behalf of the Employer, 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 Employer, 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 the right to COBRA Continuation Coverage to enroll for such Coverage. The Employer or the administrator will send the forms that should be used to enroll for COBRA Continuation Coverage. If You do not send the Enrollment Form to the Employer 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 submitting the Payment 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 submit the Payment for Coverage, and submit a claim for those Covered Services as set forth in the Claim Procedure section of this Vision EOC.

3. Payment

   You must submit any Payment required for COBRA Continuation Coverage to the administrator at the address indicated on Your Payment notice. If You do not enroll when first becoming eligible, the Payment 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 Employer (or to the administrator, if so directed by the Employer) within 45 days after the date You enroll for COBRA Continuation Coverage. After enrolling for COBRA Continuation Coverage, all Payments are due and payable

on a monthly basis as required by the Employer. If the Payment is not received by the administrator on or before the due date, Coverage will be terminated, for cause, effective as of the last day for which Payment was received as explained in the Termination of Coverage Section. The administrator may use a third party vendor to collect the COBRA Payment.

4. Coverage Provided

If You enroll for COBRA Continuation Coverage You will continue to be Covered under the Plan and this Vision EOC. The COBRA Continuation Coverage is subject to the conditions, limitations and exclusions of this Vision EOC and the Plan. The Plan and the Employer may agree to change the ASA and/or this Vision EOC. The Employer may also decide to change administrators. 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 or any other non-disabled qualified beneficiary affected by the termination of employment qualifying event 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 Continuation Coverage, that 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 Payment for such Coverage is not submitted when due; or

b. You become Covered as either a Subscriber or dependent by another group health care plan, and that coverage is as good as or better than the COBRA Continuation Coverage; or

c. The ASA is terminated; or

d. You become entitled to Medicare Coverage; or

e. The date that You, otherwise eligible for 29 months of COBRA Continuation Coverage, are determined to no longer be disabled for purposes of the COBRA law.

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

Under the Family and Medical Leave Act, Subscribers 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 health 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.

8. 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 health 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.

9. Continued Coverage During Other Leaves of Absence

The 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.

Subscribers also have to meet these criteria to have continuous Coverage during a leave of absence:

1. The 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.

A Subscriber may apply for COBRA Continuation if the leave lasts longer than allowed by the Employer.

10. The Trade Adjustment Assistance Reform Act of 2002

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 the Employer or the Department of Labor.

CLAIMS AND PAYMENT

When You receive Covered Services, either You or the Provider must submit a claim form to Us. We will review the claim, and let You, or the Provider, know if We need more information before We pay or deny the claim. We follow Our internal administration procedures when We adjudicate claims.

A. Claims.

Due to federal regulations, there are several terms to describe a claim: pre-service claim; post-service claim; and a claim for Urgent Care.

1. A pre-service claim is any claim that requires approval of a Covered Service in advance of obtaining medical care as a condition of receipt of a Covered Service, in whole or in part.
2. A post-service claim is a claim for a Covered Service that is not a pre-service claim – the medical care has already been provided to the Member. Only post-service claims can be billed to the Plan, or You.
3. Urgent Care is medical care or treatment that, if delayed or denied, could seriously jeopardize: (1) the life or health of the claimant; or (2) the claimant's ability to regain maximum function. Urgent Care is also medical care or treatment that, if delayed or denied, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the medical care or treatment. A claim for denied Urgent Care is always a pre-service claim.

B. 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 may 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 the difference between Billed Charges and the Maximum Allowable Charge for a Covered Service. You are also responsible for complying with any of the Plan's medical management policies or procedures (including, obtaining Prior Authorization of such Services, when necessary).
    a. If You are charged, or receive a bill, You must submit a claim to Us.
    b. To be reimbursed, You must submit the claim within 1 year and 90 days from the date a Covered Service was received. If You do not submit a claim, within the 1 year and 90 day time period, it will not be paid. If it is not reasonably possible to submit the claim within the 1 year and 90 day time period, the claim will not be invalidated or reduced.
3. Not all Covered Services are available from Network Providers. There may be some Provider types that We do not contract with. These Providers are called Non-Contracted Providers. Claims for services received from Non-Contracted Providers are handled as described in sections 2. a. and b. above. You are also responsible for complying with any of the Plan's medical management policies or procedures (including, obtaining Prior Authorization of such Services, when necessary).
4. You may request a claim form from Our customer service department. We will send You a claim form within 15 days. You must submit proof of payment acceptable 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.
5. A Network Provider or an Out-of-Network Provider may refuse to render, 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. For example, if a pharmacy (1) does not provide You with a prescribed medication; or (2)

requires You to pay for that prescription, You may submit a claim to the Plan to obtain a Coverage decision about whether it is Covered by the Plan.

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.

C. Payment.

1. If You received Covered Services from a Network Provider, the Plan will pay the Network Provider directly. These payments are made according to Our agreement with that Network Provider. You authorize assignment of benefits to that Network Provider. Covered Services will be paid at the In-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, the Plan will reimburse You. The Plan may make payment for Covered Services either to the Provider or to You, at its discretion. The Plan's payment fully discharges its obligation related to that claim.
3. Non-Contracted Providers may or may not file Your claims for You. Either way, the In-Network Benefit level shown in Attachment C: Schedule of Benefits will apply to claims for Covered Services received from Non-Contracted Providers. However, You are responsible for the difference in the Billed Charge and the Maximum Allowable Charge for that Covered Service. The Plan's payment fully discharges its obligation related to that claim.
4. If the ASA is terminated, all claims for Covered Services rendered prior to the termination date, must be submitted to the Plan within 1 year and 90 days from the date the Covered Services were received.
5. Benefits will be paid according to the Plan 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. Neither the Plan nor We are responsible for over or under payment of claims if Our information is not complete or is inaccurate. We will make reasonable efforts to obtain and verify relevant facts when claim forms are submitted.
6. 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 also let You know if You owe an additional amount to that Provider. The administrator will send the EOB to the last address on file for You.
7. You are responsible for paying any applicable Copayments, Coinsurance, or Deductible amounts 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.

D. 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 obtain one online at bcbst.com or request them from Us by calling Our customer service department at the number listed on the membership ID card.

Submit claim forms on line or Mail them to:

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 service department at the number listed on the membership ID card: (1) to file a Claim; (2) if You have any questions about this EOC or other documents related to Your Coverage (e.g., an explanation of benefits or monthly claims statement); or (3) to initiate a Grievance concerning a Dispute.

1. This grievance procedure must be exhausted as required by ERISA. However, nothing in this EOC shall prevent You from filing a complaint with the Tennessee Department of Commerce and Insurance, but such complaint is outside of, separate from and in addition to this grievance procedure.
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 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 request a form from the Plan to authorize another person to act on Your behalf concerning a Dispute.
6. The Plan and You may agree to skip one or more of the steps of this Procedure if it will not help to resolve the Dispute.
7. Any Dispute will be resolved in accordance with applicable Tennessee or Federal laws and regulations, the ASA 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 consumer advisor 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 service department 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. BlueCross is a limited fiduciary for the first level Grievance.

1. Grievance Hearing

After the Plan has received and reviewed Your Grievance, Our first level Grievance committee will meet to consider Your 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 Committee or reviewers have full discretionary authority to make eligibility, benefit and/or claim determinations, pursuant to the ASA. Such determinations shall be subject to the review standards applicable to ERISA plans, even if the ASA is not otherwise governed by ERISA.

2. Written Decision

The committee or reviewers will consider the information presented, and You will receive a written decision concerning Your Grievance as follows:

(a) For a pre-service claim, within 30 days of receipt of Your request for review;

(b) For a post-service claim, within 60 days of receipt of Your request for review; and

(c) For a pre-service, urgent care claim, within 72 hours of receipt of Your request for review.

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

(d) A statement of the committee's understanding of Your Grievance;

(e) The basis of the committee's decision; and

(f) Reference to the documentation or information upon which the committee based its decision. The Plan will send You a copy of such documentation or information, without charge, upon written request.

C. Second Level Grievance Procedure

You may file a written request for reconsideration within ninety (90) days after We issue the first level Grievance committee's decision. This is called a second level Grievance. Information on how to submit a second level Grievance will be provided to You in the decision letter following the first level Grievance review.

If the Employer's ASA is governed by ERISA, You also have the right to bring a civil action against the Plan to obtain the remedies available pursuant to Sec. 502(a) of ERISA ("ERISA Actions") after completing the mandatory first level Grievance process.

The Plan may require You to exhaust each step of this Procedure in any Dispute that is not an ERISA Action:

Your decision concerning whether to file a second level Grievance has no effect on Your rights to any other benefits under the Plan. If You file a second level Grievance concerning an ERISA Action, the Plan agrees to toll any time defenses or restrictions affecting Your right to bring a civil action against the Plan until the second level committee makes its decision. Any person involved in making a decision concerning Your Dispute (e.g. first level committee members) will not be a voting member of the second level Grievance committee.

1. Grievance Hearing

You may request an in-person or telephonic hearing before the second level Grievance committee. You may also request that the second level Grievance committee reconsider the decision of the first level committee, even if You do not want to participate in a hearing concerning Your Grievance. If You wish to participate, Our representatives will contact You to explain the hearing process and schedule the time, date and place for that hearing.

In either case, the second level committee will meet and consider all relevant information presented about Your Grievance, including:

(a) Any new, relevant information that You submit for consideration; and

(b) Information presented during the hearing. Second level Grievance committee members and You will be permitted to question each other and any witnesses during the hearing. You will also be permitted to make a closing statement to the committee at the end of the hearing.

2. Written Decision

After the hearing, the second level committee will meet in closed session to make a decision concerning Your Grievance. That decision will be sent to You in writing. The written decision will contain:

(a) A statement of the second level committee's understanding of Your Grievance;

(b) The basis of the second level committee's decision; and

(c) Reference to the documentation or information upon which the second level committee based its decision. Upon written request, We will send You a copy of any such documentation or information, without charge.

D. Independent Review of Medical Necessity Determinations

If Your Grievance involves a Medical Necessity determination, then either: (1) after completion of the mandatory first level Grievance; or (2) after completion of the mandatory first level Grievance immediately followed by completion of the second level Grievance, You may request that the Dispute be submitted to a neutral third party, selected by the Employer, to independently review and resolve such Dispute(s). If You request an independent review following the mandatory first level Grievance, You waive Your right to a second level Grievance and Your right to present testimony during the Grievance Procedure. Your request for independent review must be submitted in writing within 180 days after the date You receive notice of the committee's decision. Receipt shall be deemed to have occurred no more than two days after the date of issuance of the committee's decision. Any person involved in making a decision concerning Your Dispute will not be a voting member of the independent review panel or committee.

Your decision concerning whether to request independent review has no effect on Your rights to any other benefits under the Plan. If You request independent review of an ERISA Action, We agree to toll any time defenses or restrictions affecting Your right to bring a civil action against the Employer or Employer's Plan, until the independent reviewer makes its decision.

The Employer or Employer's Plan will pay the fee charged by the independent review organization and its reviewers if You request that the Plan submit a Dispute to independent review. You will be responsible for any other costs that You incur to participate in the independent review process, including attorney's fees.

The Employer, as the Plan Administrator, will submit the necessary information to the independent review entity within 5 business days after receiving Your request for review. The Employer will provide copies of Your

file, excluding any proprietary information to You, upon written request. The reviewer may also request additional medical information from You. You must submit any requested information, or explain why that information is not being submitted, within 5 business days after receiving that request from the reviewer.

The reviewer must submit a written determination to the Employer and You within 45 days after receipt of the independent review request. In the case of a life threatening condition, the decision must be issued within 72 hours after receiving the review request. Except in cases involving a life-threatening condition, the reviewer may request an extension of up to 5 business days to issue a determination to consider additional information submitted by the Employer or You.

The reviewer's decision must state the reasons for the determination based upon: (1) the terms of this EOC and the ASA; (2) Your medical condition; and (3) information submitted to the reviewer. The reviewer's decision may not expand the terms of Coverage of the ASA.

No legal action shall be brought to recover under this EOC until 60 days after the claim has been filed. No such legal action shall be brought more than 3 years after the time the claim is required to be filed.

DEFINITIONS

Defined terms are capitalized. When defined words are used in this Vision EOC, they have the meaning set forth in this section.

1. **Actively at Work** – The performance of all of an Employee's regular duties for the Employer on a regularly scheduled workday at the location where such duties are normally performed. Eligible Employees will be considered to be Actively At Work on a non-scheduled work day (which would include a scheduled vacation day) only if the Employee was Actively At Work on the last regularly scheduled work day
2. **Administrative Services Agreement or ASA** – The arrangements between the administrator and the Employer, including any amendments, and any attachments to the ASA or this Vision EOC.
3. **Allowance** – 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.
4. **Billed Charges** – The amount that a Provider charges for services rendered.
5. **Coated Lenses** – A substance added to a finished lens on one or both surfaces.
6. **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).
        - Anisometrophia of 4.0 diopters or more, provided visual acuity improves to 20/60 or better in the weaker eye.
        - Keratoconus.
7. **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.
8. **Covered Dependent** – A Subscriber's family member who: (1) meets the eligibility requirements of this Vision EOC; (2) has been enrolled for Coverage; and (3) for whom the Plan has received the applicable Payment for Coverage.
9. **Covered Family Members** – A Subscriber and his or her Covered Dependents.
10. **Covered Services, Coverage or Covered** – Those Medically Necessary and Appropriate vision services and supplies that are set forth in Attachment A of this EOC, (which is incorporated by reference). Covered Services are subject to all the terms, conditions, exclusions and limitations of the Plan and this Vision EOC.
11. **Employee** – A person who fulfills all eligibility requirements established by the Employer and the administrator.
12. **Employer** – A corporation, partnership, union or other entity that is eligible for group coverage under State and Federal laws; and that enters into an Agreement with the administrator to provide Coverage to its Employees and their Eligible Dependents.
13. **Enrollment Form** – A form or application that must be completed in full by the eligible Employee before he or she will be considered for Coverage under the Plan. The form or application may be in paper form, or electronic, as determined by the Plan Sponsor.

14. **ERISA** – The Employee Retirement Income Security Act of 1974, as amended.

15. **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; 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.

16. **Late Enrollee** – An Employee or eligible Dependent who fails to apply for Coverage within 31 days after such person first became eligible for Coverage under this Vision EOC.

17. **Medicare** – Title XVIII of the Social Security Act, as amended.

18. **Member, You, Your** – Any person enrolled as a Subscriber or Covered Dependent under the Plan.

19. **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 administrator may require proof that You have made any required Member Payment.

20. **Network Benefit –** The Plan's payment level that applies to Covered Services received from a Network Provider. See Attachment C: Schedule of Benefits.

21. **Network Provider** - An ophthalmologist, optometrist or optician who has contracted with BlueCross to provide access to benefits to Members at specified rates.

22. **Open Enrollment Period** – Those periods of time established by the Plan during which eligible Employees and their dependents may enroll as Members.

23. **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.

24. **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.

25. **Optometrist** – A doctor of optometry (O.D.) who is trained to detect and correct vision problems primarily by prescribing eyeglasses or contact lenses.

26. **Oversized Lens** – Any lens with an eyesize of 61mm or greater.

27. **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.

28. **Out-of-Network Provider** – Any Provider who is an Eligible Provider type but who does not have a contract with BlueCross to provide Covered Services.

29. **Payor(s)** – An insurer, health maintenance organization, no-fault liability insurer, self-insurer or other entity that provides or pays for a Member's health care benefits.

30. **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.

31. **Qualified Medical Child Support Order** – A medical child support order, issued by a court of competent jurisdiction or state administrative agency, that creates or recognizes the existence of a child's right to receive benefits for which a Subscriber is eligible under the Plan. 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.

32. **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.
33. **Standard Frame** – Any frame that has a retail value of $100.00 or less.
34. **Subscriber** – An Employee who meets all applicable eligibility requirements, has enrolled for Coverage and who has submitted the applicable Payment for Coverage.
35. **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 singe 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 cyclopedia 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 Vision EOC's Attachment C: Schedule of Benefits.

Please also read Attachment B: Other Exclusions.

Your benefits are greater when You use Network Providers. BlueCross contracts with Network Providers. Network Providers have agreed to accept the contracted 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 contracted 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 contracted amounts stated in Attachment C: Schedule of Benefits.

Out-of-Network Providers do not have a contract with BlueCross**.** This means they may be able to charge You more than the Maximum Allowable Charge (the amount set by the administrator 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.**

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

A. <u>Vision Care</u>

1. Covered Services

   a. One (1) Vision Examination(s) per Benefit Period.
   b. One (1) pair of eyeglass frames per 24 months.
   c. One (1) set of eyeglass lenses, prescription sunglasses, or contact lenses per Benefit Period.

ATTACHMENT B:
EXCLUSIONS

This Vision 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 administrator 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. Self treatment or training.
16. Services that are free.
17. Services or supplies for the treatment of work related illness or injury, regardless of the presence or absence of workers' compensation coverage.
18. Services or supplies received before Your effective date for Coverage with this Plan.
19. 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.
20. 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.
21. Charges for failure to keep a scheduled appointment.
22. Charges for telephone consultations, e-mail or web based consultations, or telemedicine services.
23. Court ordered examinations and treatment, unless Medically Necessary.
24. Charges for services performed by You or Your spouse, or Your or Your spouse's parent, sister, brother or child.
25. Any charges for handling fees.
26. Safety items or items to affect performance primarily in sports-related activities.

27. Charges for replacement of broken, lost, or stolen lenses, contact lenses, or frames.
28. Charges for services or materials from an Ophthalmologist, Optometrist or Optician not acting within the scope of his or her license.
29. Charges for any additional service required outside basic vision analyses for contact lenses, except fitting fees.

EVIDENCE OF COVERAGE

ATTACHMENT C: SCHEDULE OF BENEFITS – OPTION 1

Group Name: Sumner County Government
Group Number: 88230
Effective Date: July 1, 2022

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:

Benefit	In-Network Member Cost	Out-of-Network Reimbursement	Benefit Frequency
VISION EXAMINATION			
Comprehensive Eye Examination	$10 Copayment	up to $35	Once every 12 months
Retinal Imaging	up to $39 Copayment	N/A	
Contact Lenses Fit And Follow-Up			Once every 12 months
Standard	$55 Copayment	N/A	
Premium	10% off retail	N/A	
VISION MATERIALS			
Standard Plastic Lenses			Once every 12 months
Single Vision	$10 Copayment	up to $30	
Bifocal	$10 Copayment	up to $45	
Trifocal	$10 Copayment	up to $60	
Frames	$0 Copayment, up to $180 allowance, 20% off balance over allowance	up to $75	Once every 24 months
Contacts In lieu of eyeglasses[3]			Once every 12 months
Conventional	$0 Copayment, up to $180 allowance, 15% off balance over allowance	up to $120	
Disposable	$0 Copayment, up to $180 allowance	up to $120	
Medically Necessary	Paid in full	up to $200	
Lens Options			Once every 12 months
Standard Polycarbonate	$40 Copayment	N/A	
Standard Polycarbonate (For covered Dependent children under 19 years of age.)	$0 Copayment	up to $5	
UV Treatment	$15 Copayment	N/A	
Tint (Solid or Gradient)	$15 Copayment	N/A	
Standard Plastic Scratch Coating	$15 Copayment	N/A	
Standard Progressive Lenses (add on to Bifocal)	$65 additional Copayment	up to $45	
Premium Progressive Lenses (add on to Bifocal)	$65 additional Copayment, 20% off retail price less $120	up to $45	
Standard Anti-Reflective Coating	$45 Copayment	N/A	
Other lens options	20% off retail price	N/A	

1. This document serves as a summary of the benefits that are detailed in the Evidence of Coverage. These benefits are subject to the Covered Services and Limitations on Covered Services, Exclusions from Covered Services, and Schedule of Benefits sections of the Evidence of Coverage.
2. When applicable benefits are paid after the Copayment listed above and to the allowance listed. Members are responsible for amounts above the allowance.
3. Members may see any vision care provider. However, contracted providers in Our network have agreed to limit certain charges and provide additional discounts once the allowance has been reached. Because We have no contract with non-network providers, Members are responsible for all charges that exceed the out-of-network reimbursement.

ATTACHMENT C: SCHEDULE OF BENEFITS – OPTION 2

Group Name: Sumner County Government
Group Number: 88230
Effective Date: July 1, 2022

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:

Benefit	In-Network Member Cost	Out-of-Network Reimbursement	Benefit Frequency
VISION EXAMINATION			
Comprehensive Eye Examination	$10 Copayment	up to $35	Once every 12 months
Retinal Imaging	up to $39 Copayment	N/A	
Contact Lenses Fit And Follow-Up			Once every 12 months
Standard	$55 Copayment	N/A	
Premium	10% off retail	N/A	
VISION MATERIALS			
Standard Plastic Lenses			Once every 12 months
Single Vision	$10 Copayment	up to $30	
Bifocal	$10 Copayment	up to $45	
Trifocal	$10 Copayment	up to $60	
Frames	$0 Copayment, up to $135 allowance, 20% off balance over allowance	up to $67.50	Once every 24 months
Contacts In lieu of eyeglasses[3]			Once every 12 months
Conventional	$0 Copayment, up to $135 allowance, 15% off balance over allowance	up to $108	
Disposable	$0 Copayment, up to $135 allowance	up to $108	
Medically Necessary	Paid in full	up to $200	
Lens Options			Once every 12 months
Standard Polycarbonate	$40 Copayment	N/A	
Standard Polycarbonate (For covered Dependent children under 19 years of age.)	$0 Copayment	up to $5	
UV Treatment	$15 Copayment	N/A	
Tint (Solid or Gradient)	$15 Copayment	N/A	
Standard Plastic Scratch Coating	$15 Copayment	N/A	
Standard Progressive Lenses (add on to Bifocal)	$65 additional Copayment	up to $45	
Premium Progressive Lenses (add on to Bifocal)	$65 additional Copayment, 20% off retail price less $120	up to $45	
Standard Anti-Reflective Coating	$45 Copayment	N/A	
Other lens options	20% off retail price	N/A	

1. This document serves as a summary of the benefits that are detailed in the Evidence of Coverage. These benefits are subject to the Covered Services and Limitations on Covered Services, Exclusions from Covered Services, and Schedule of Benefits sections of the Evidence of Coverage.

2. When applicable benefits are paid after the Copayment listed above and to the allowance listed. Members are responsible for amounts above the allowance.
3. Members may see any vision care provider. However, contracted providers in Our network have agreed to limit certain charges and provide additional discounts once the allowance has been reached. Because We have no contract with non-network providers, Members are responsible for all charges that exceed the out-of-network reimbursement.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

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.

Privacy Practices

Important Privacy Practices Notice

Effective Date: July 1, 2021

Important Privacy Information

This notice describes how information we have about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Legal obligations

The law requires Sumner County Government Self Insurance Board ("we," "us," "our") to give this notice of privacy practices to all our members. This notice lets you know about our legal duties and your rights when it comes to your information and privacy.

The law requires us to keep private all of the information we have about you, including your name, address, claims information, and other information that can identify you. The law requires us to follow all the privacy practices in this notice from the date on the cover until we change or replace it.

We have the right to make changes to our privacy practices and this notice at any time, but we will send you a new notice any time we do. Any changes we make to this notice will apply to all information we keep, including information created or received before we made changes.

Please review this notice carefully and keep it on file for reference. You may ask us for a copy of this notice at any time. To get one, please contact us at:

Sumner County Government Self Insurance Board
355 N Belvedere Drive
Room 302
Gallatin, TN 37066
615-452-2632
Fax: 615-452-7335
drobertson@sumnercountytn.gov

You may reach out to us at this address or phone number to ask questions or make a complaint about this notice or how we've handled your privacy rights. You may also submit a written complaint to the U.S. Department of Health and Human Services (HHS). Just ask us for their address, and we will give it to you.

We support your right to protect the privacy of the information we have about you. We won't retaliate against you if you file a complaint with HHS or us.

Organizations This Notice Covers

This notice applies to Sumner County Government Self Insurance Board. We may share our members' information with BlueCross BlueShield of Tennessee, Inc. and certain subsidiaries and affiliates of BlueCross BlueShield of Tennessee, Inc. as outlined in this notice. If BlueCross BlueShield of Tennessee, Inc. buys or creates new subsidiaries, they may also be required to follow the privacy practices outlined in this notice.

For additional information, including TTY/TDD users, please call (615)451-6033. Para obtener ayuda en español, llame al (615)451-6033**.**

How We May Use and Share Your Information

We typically use your information for treatment, payment or health care operations. Sometimes we are allowed, and sometimes we are required, to use or disclose your information in other ways. This is usually to contribute to the public good, such as public health and research.

Some states may have more stringent laws. When those laws apply to your information, we follow the more stringent law. Specifically, Tennessee law and other state and federal laws require us to obtain your consent for most uses and disclosures of behavioral health information, alcohol and other substance use disorder information, and genetic information.

Ways We May Use and Share Your Information

The following are examples of how we may use or disclose your information in accordance with federal and state laws.

For your treatment: We may use or share your information with health care professionals who are treating you. For example, a doctor may send us information about your diagnosis and treatment plan so we can arrange additional care for you from other health care providers.

To make payments: We may use or share your information to pay claims for your care or to coordinate benefits covered under your health care coverage. For example, we may share your information with your dental provider to coordinate payment for dental services.

For health care operations: We may use or share your information to run our organization. For example, we may use or share it to measure quality, provide you with care management or wellness programs, and to conduct audit and other oversight activities.

To work with plan sponsors: We may share your information with your employer-sponsored group health plan (if applicable) for plan administration. Please see your plan documents for all ways a plan sponsor may use this information.

For underwriting: We may use or share your health plan information for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a health plan contract. We're not allowed to use or disclose genetic information for underwriting purposes.

Research: We may use or share your information in connection with lawful research purposes.

In the event of your death: If you die, we may share your health plan information with a coroner, medical examiner, funeral director or organ procurement organization.

To help with public health and safety issues: We can share information about you in certain situations, such as:

- Preventing disease
- Assisting public health authorities in controlling the spread of disease such as during pandemics
- Helping with product recalls
- Reporting negative reactions to medications
- Reporting suspected abuse, neglect or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

As required by law: We may use or share your information as required by state or federal law.

To comply with a court or administrative order: Under certain circumstances, we may share your information in response to a court or administrative order, subpoena, discovery request or other lawful process.

To address workers' compensation, law enforcement and other government requests: We can use or share information about you:

- For workers' compensation claims
- For law enforcement purposes, or with a law enforcement official
- With health oversight agencies for legal activities
- To comply with requests from the military or other authorized federal officials

With your permission: Some uses and disclosures of information require your written authorization, including certain instances if you want us to share your information with anyone. You may cancel your authorization in writing at any time, but doing so won't affect use or disclosure that happened while your authorization was valid.

For example, we would need your written authorization for:

- Most uses and disclosures of psychotherapy notes
- Uses and disclosures of your health plan information for marketing
- Sale of your health plan information
- Other uses and disclosures not described in this notice

We will let you know if any of these circumstances arise.

Your Individual Rights

To access your records: You have the right to view and get copies of your information that we maintain, with some exceptions. You must make a written request, using a form available from the Privacy Office, to get access to your information.

If you ask for copies of your information, we may charge you a reasonable, cost-based fee for staff time, and postage if you want us to mail the copies to you. If you ask for this information in another format, this charge will reflect the cost of giving you the information in that format. If you prefer, you may request a summary or explanation of your information, which may also result in a fee. For details about fees we may charge, please contact the Privacy Office.

To see who we've disclosed your information to: You have the right to receive a list of most disclosures we (or a business associate on our behalf) made of your information, other than for the purpose of treatment, payment or health care operations, within the past six years. This list will include the date of the disclosure, what information was disclosed, the name of the person or entity it was disclosed to, the reason for the disclosure and some other information.

If you ask for this list of disclosures more than once in a 12-month period, we may charge you based on the cost of responding to those additional requests. Please contact the Privacy Office for a more detailed explanation of these charges.

To ask for restrictions: You have the right to ask for restrictions on how we use or disclose your health plan information. We're not required to agree to these requests except in limited circumstances. If we agree to a restriction, you and we will agree to the restriction in writing. Please contact the Privacy Office for more information.

To get notified of a breach: The law requires us to notify you after the unauthorized acquisition, access, use, or disclosure of your unsecured information that compromises the security or privacy of the information. This notice must include various data points, such as:

- The date of the breach
- The type of data disclosed
- Who accessed, used or disclosed the information without permission
- Who received your information, if known
- What we did or will do to prevent future breaches

To ask for confidential communications: You have the right to ask us in writing to send your information to you at a different address or by a different method if you believe that sending information to you in the normal manner will put you in danger. We have to grant your request if it's reasonable. We will also need information from you, including how and where to communicate with you. Your request must not interfere with payment of your premiums.

If there's an immediate threat, you may make your request by calling the Member Service number on the back of your Member ID card or the Privacy Office. Please follow up your call with a written request as soon as possible.

To ask for changes to your personal information: You have the right to request in writing that we revise your information. Your request must be in writing and explain why the information should be revised. We may deny your request, for example, if we received (but didn't create) the information you want to amend. If we deny your request, we will write to let you know why. If you disagree with our denial, you may send us a written statement that we will include with your information.

If we grant your request, we will make reasonable efforts to notify people you name about this change. Any future disclosures of that information will be revised.

To request another copy of this notice: You can ask for a paper copy of this notice at any time, even if you got this notice by email or from our website. Please contact the Privacy Office at the address above.

To choose a personal representative: You may choose someone to exercise your rights on your behalf, such as a power of attorney. You may also have a legal guardian exercise your rights. We will work with you if you'd like to make this effective.

1 Cameron Hill Circle
Chattanooga, Tennessee
37402

www.bcbst.com

BENEFIT QUESTIONS?

Call the Customer Service
Number on the membership I.D. Card

SELF-FUNDED VISION EOC (1/15)