

NATIONAL SEATING & MOBILITY, INC.

OPTIONS 1, 2, & 3

Health Benefit Plan Summary of Material Modification



NOTICE

Please read this Summary of Material Modification (SMM) carefully and keep it in a safe place for future reference. It explains Your benefits as administered by BlueCross BlueShield of Tennessee, Inc. This SMM is effective January 1, 2025.

The EOC You received is hereby modified in the following sections:

1. Under the heading, **ATTACHMENT A: COVERED SERVICES AND EXCLUSIONS**, the following is hereby modified to read as follows:

K. Therapeutic/Rehabilitative Services

Medically Necessary and Medically Appropriate therapeutic and rehabilitative services performed in a Practitioner's office, outpatient facility or home health setting and intended to restore or improve bodily function lost as the result of Acute illness, Acute injury, autism spectrum disorder, or congenital anomaly.

Therapeutic/Rehabilitative services may require Prior Authorization. For Therapeutic/Rehabilitative services received in the home health setting, Home Health Care benefits will apply.

1. Covered Services

- a) Outpatient, home health or office therapeutic and rehabilitative services that are expected to result in significant and measurable improvement in Your condition resulting from an Acute illness, Acute injury, autism spectrum disorder, or congenital anomaly. The services must be performed by, or under the direct supervision of a licensed therapist.
- b) Therapeutic/rehabilitative services include: (1) physical therapy; (2) speech therapy for restoration of speech; (3) occupational therapy; (4) spinal manipulation therapy; and (5) cardiac and pulmonary rehabilitative services.
 - 1) Speech therapy is Covered regardless of Your condition.
- c) Telehealth.
- d) Coverage is limited as indicated in "Attachment C: Schedule of Benefits".
 - 1) The limit on the number of visits for therapy applies to all visits for that therapy, whether received in a Practitioner's office, outpatient facility or home health setting.
 - 2) Services received during an inpatient hospital, skilled nursing or rehabilitative facility stay are Covered as shown in the Inpatient Acute Care Hospital Services and Skilled Nursing/Rehabilitative Facility Services sections, and are not subject to the therapy visit limits.

2. Exclusions

- a) Enhancement therapy that is designed to improve Your physical status beyond Your pre-injury or pre-illness state.
- b) Complementary and alternative therapeutic services, including, but not limited to: (1) massage therapy; (2) craniosacral therapy; and (3) vision exercise therapy.
- c) Modalities that do not require the attendance or supervision of a licensed therapist. These include, but are not limited to: (1) activities that are primarily social or recreational in nature; (2) simple exercise programs; (3) hot and cold packs applied in the absence of associated therapy modalities; (4) repetitive exercises or tasks that You can perform without a therapist, in a home setting; (5) routine dressing changes; and (6) Custodial Care services that can ordinarily be taught to You or a caregiver.
- d) Duplicate therapy. For example, when You receive both occupational and speech therapy, the therapies should provide different treatments and not duplicate the same treatment.

If You have any questions about this SMM 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**



**BlueCross BlueShield
of Tennessee***

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 EOC

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association
® Registered marks of the BlueCross BlueShield Association, an Association of Independent BlueCross BlueShield Plans