Addendum #1
East Tennessee State University
Broker Services for Medical Resident Insurance(s)
RFP 6883

TO: All Proposers

FROM: Katherine Little Zink

RE: Request for Proposal #6883

Broker Services for Medical Resident Insurances(s)

DATE: January 25, 2024

This Addendum #1, dated January 25, 2024 is issued as supplemental information and is hereby made part of the final RFP documents. Proposers shall acknowledge receipt of this addendum in their proposal response. The attachments provided are and shall remain a part of the Request for Proposal. Proposals shall acknowledge receipt of this Addendum within their proposal response.

Institution's response to RFP #6883 Broker Services for Medical Resident Insurance(s) questions:

1. Please provide a census in Excel format indicating date of birth, gender, salary, coverage level, and zip code.
   See attached.

2. 1.0 TECHNICAL PROPOSAL REQUIREMENTS Part M on page 41 of the RFP document indicates "A letter of authorization must be included in the proposal from the insurance carrier appointing the servicing agency as the insurance carrier's exclusive agent for purposes of proposing the policy/plan."

   Here is ETSU's response to a previous clarifying question: "ETSU will consider a proposal from the same carrier submitted by different brokers. We realize it is possible one broker may have the opportunity to negotiate a better price than another ultimately."

   Since the letter and response above appear to contradict one another, will ETSU allow the removal of the "exclusive agent" language from the requested letter of authorization?
   Yes, that is acceptable.

3. Could we obtain a copy of each policy booklet including policy plan design, current rates and renewal rates?
   All we have available is the summary of benefits that were previously provided. Attached is a document of current rates and renewal rates.

4. Please provide incomes for each program year.

	2023-2024	2024-2025
PGY I	58,084	59,827
PGY II	59,820	61,615
PGY III	61,961	63,820

PGY IV	64,330	66,260
PGY V	66,687	68,688
PGY VI	69,217	71,294

5. The medical package is missing the month by month claims and enrollment reports. We will need it for the time period 1/1/22 – 12/31/23. We need a claim detail report for 2023.
   See attached.

6. Attachment 6.11- The RFP requests we provide written documentation on how the product/service meets the THEC/ETSU accessibility standards. In order to provide a response, please provide THEC/ETSU's accessibility standards.
   Attachment 6.11 is an informative attachment per the RFP. This only needs a response from the selected winning party at the conclusion of this RFP process. We do not need a response for this at this time.

7. Accessibility Conformance and Remediation Form instructions were provided; however, the Conformance and Remediation Form was not included in the RFP documents. Please provide the referenced form.
   See Attachment 6.12; however, this form is only needed from the selected winning party at the conclusion of this RFP process. We do not need a response for this at this time.

8. Attachment 6.7 – Score Summary Matrix – is this for informational purposes only or are bidders required to address in any way?
   Informational

9. Provide 24 months of monthly BCBS dental claims/enrollment.
   See attached.

10. Confirm if the BCBS OON reimbursement is based on MAC or a percentage of UCR.
    MAC

End of Addendum #1.

Network: S

Benefit Summary

Option: 1

Benefit Plan Features:	Your Cost In-Network	Your Cost Out-of-Network [1]
Annual Deductible		
Individual/Family	$500 / $1,500	$500 / $1,500
Annual Out-of-Pocket Maximum		
(includes copay, coinsurance and deductibles)		
Individual/Family	$1,500 / $4,500	$3,000 / $9,000
4th Quarter Carry-over	Included	
Covered Services		
Preventive Care Services (see page 3 for a list)	Covered at 100%	30% after deductible
Practitioner Office Services		
Primary Care Office Visits	20% after deductible	30% after deductible
Specialist Office Visits	20% after deductible	30% after deductible
Office Surgery [3, 4, 6]	20% after deductible	30% after deductible
Routine Diagnostic Lab, X-Ray & Injections	20% after deductible	30% after deductible
Advanced Radiological Imaging [2, 4, 7]	20% after deductible	30% after deductible
PhysicianNow® [17]	20% after deductible	Not Covered
Services Received at a Facility		
(includes professional and facility charges)		
Inpatient Services [2, 4]	20% after deductible	30% after deductible
Outpatient Surgery [3, 4, 6]	20% after deductible	30% after deductible
Routine Diagnostic Services - Outpatient	20% after deductible	30% after deductible
Advanced Radiological Imaging - Outpatient [2, 4, 7]	20% after deductible	30% after deductible
Other Outpatient Services [8]	20% after deductible	30% after deductible
Urgent Care Center Services	20% after deductible	30% after deductible
Emergency Care Services [9]	$300 copay	$300 copay
Emergency Care Advanced Radiological Imaging [7]	20% after deductible	20% after deductible
Medical Equipment Services [3, 4]		
Durable Medical Equipment	20% after deductible	30% after deductible
Prosthetic or Orthotics	20% after deductible	30% after deductible
Hearing Aids (under age 18)	20% after deductible	30% after deductible
Behavioral Health Services		
Inpatient: Unlimited days per annual benefit period [2, 4]	20% after deductible	30% after deductible
Outpatient: Unlimited visits per annual benefit period [5]	20% after deductible	30% after deductible
Therapeutic Services [10] **(limits apply; see footnote)**	$25 copay	30% after deductible
Skilled Nursing & Rehabilitation Facility Services [2, 4]		
Limited to 100 days combined per annual benefit period	20% after deductible	30% after deductible
Home Health Care Services [3, 4, 10]	20% after deductible	30% after deductible
Hospice Services		
Inpatient [2, 4]	Covered at 100%	30% after deductible
Outpatient	Covered at 100%	30% after deductible
Ambulance Services [3, 4]	20% after deductible	20% after deductible

Prescription Drugs [3]		
Prescription Contraceptives [16]	Covered at 100%	30% after deductible
Retail RX03 Network up to 30 day supply [13]		
Preferred Generic	$10 copay	30% after deductible
Non-Preferred Generic	$10 copay	30% after deductible
Preferred Brand [15]	$45 copay	30% after deductible
Non-Preferred Brand [15]	$90 copay	30% after deductible
Plus90 or Home Delivery Network up to 90 day supply [14]		
Preferred Generic	$30 copay	30% after deductible
Non-Preferred Generic	$30 copay	30% after deductible
Preferred Brand [15]	$135 copay	30% after deductible
Non-Preferred Brand [15]	$270 copay	30% after deductible
Self-Administered Specialty Drugs [3, 11, 12]		
Preferred Specialty Drugs	$180 copay	Not Covered
Non-Preferred Specialty Drugs	$180 copay	Not Covered
Provider-Administered Specialty Drugs [3, 21]	$180 copay	Not Covered

1. Out-of-network benefits may be based on BlueCross BlueShield of Tennessee maximum allowable charge. You may be responsible for any unpaid billed charges for certain services received from out-of-network providers. For true emergency services received at an out-of-network hospital, items and services received from an out-of-network provider at an in-network hospital (unless you give certain providers written consent), or emergent and authorized air ambulance services, in-network benefits including deductible will apply up to the qualified payment amount, and the provider may not bill you for more than your in-network cost share.
2. Prior authorization is required.
3. Certain procedures, services, medication and equipment may require prior authorization.
4. If prior authorization is required but not obtained and services are medically necessary, when using network providers outside Tennessee for physician and outpatient services and all services from out-of-network providers, your liability will be increased to 50% based on out-of-network coinsurance. If services are not medically necessary, no benefits will be provided.
5. Outpatient behavioral health benefits are determined by place of service. Benefits displayed are for services received in an office setting; separate benefits may apply for outpatient services received in an alternate setting.
6. Surgeries include incisions, excisions, biopsies, injection treatments, fracture treatments, applications of casts and splints, sutures and invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy and endoscopy for non-preventive purposes).
7. Includes CT scans, PET scans, MRIs, nuclear medicine and other similar technologies.
8. Includes services such as chemotherapy, infusions, injections, radiation therapy and renal dialysis.
9. Copay, if applicable, waived if admitted to hospital.
10. Physical, speech, acupuncture, spinal manipulative and occupational therapies are limited to 60 visits combined per annual benefit period. Cardiac and pulmonary rehabilitative therapies are limited to 36 visits per therapy type per annual benefit period.
11. Visit www.bcbst.com/rx for the Preferred Formulary which includes specialty drugs.
12. To receive benefits for self-administered specialty drugs, you must use a Specialty Pharmacy Network provider. Visit www.bcbst.com/rx for a list of providers in the Specialty Pharmacy Network. These drugs are limited to a 30-day supply.
13. Copay, if applicable, applied per prescription, up to a 30 day supply.
14. Your plan requires you to receive long-term medications in a 90-day supply from home delivery or at a retail pharmacy in the Plus90 Network. If you choose to use a retail pharmacy that is not part of the Plus90 Network, you are limited to a 30-day supply. Visit www.bcbst.com/rx to find a list of pharmacies in the Plus90 Network.
15. A financial penalty may be applied if you choose a brand name drug when a generic equivalent is available. Please refer to your Evidence of Coverage (EOC) for specific information.
16. Certain prescription drugs are covered at 100% at network pharmacies, in accordance with the Preventive Services provision of the Affordable Care Act, and are identified with an "ACA" indicator on the Preferred Formulary located at www.bcbst.com/rx.
17. Speak to a board-certified doctor for certain non-emergency conditions day or night over the phone or using secure online video. Or schedule a visit for counseling services in advance. Visit www.bcbst.com/physiciannow or call 1-888-283-6691 to register.
21. To receive benefits for provider-administered specialty drugs as identified on the provider-administered specialty drug list, you must use a Specialty Pharmacy Network provider. Visit www.bcbst.com/rx for the drug list and a list of providers in this network. Cost share listed is for the medication only; providers may bill additional charges for the administering of the drug under your medical benefit.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your Evidence of Coverage (EOC) and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the EOC will govern. For a complete list of limitations and exclusions, please refer to your EOC.

Summary of Preventive Care Services
Covered at 100% In-Network

In-network preventive care services that are covered with no member cost share include, but are not limited to:

- Primary care services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF)
- Immunizations recommended by the Advisory Committee on Immunization Practices that have been adopted by the Centers for Disease Control and Prevention (CDC)
- Bright Futures recommendations for infants, children and adolescents that are supported by the Health Resources and Services Administration (HRSA)
- Preventive care and screening for women as provided in the guidelines supported by HRSA

The following preventive care services are covered (not an all-inclusive list). Coverage of some services may depend on age and/or risk exposure.

All Members:

- One preventive health exam per annual benefit period. More frequent preventive exams are covered for children up to age 3.
- All standard immunizations adopted by the CDC
- Screening for colorectal cancer (age 45 – 75), high cholesterol and lipids (45 and older for women; 35 and older for men), high blood pressure, obesity, diabetes, and depression (12 and older)
- Screening for lung cancer for adults (50 to 80) who have a 20 pack-year smoking history and either currently smoke or have quit within the past 15 years, per annual benefit period
- Screening for HIV and certain sexually transmitted diseases, and counseling for the prevention of sexually transmitted diseases
- Screening and counseling in a primary care setting for alcohol misuse and tobacco use; alcohol misuse and tobacco use limited to 8 visits per annual benefit period
- Dietary counseling for adults with hyperlipidemia, hypertension, type 2 diabetes, obesity, coronary artery disease and congestive heart failure; limited to 12 visits per annual benefit period
- One retinopathy screening for diabetics per annual benefit period
- Hemoglobin A1C testing

Women:

- Well-woman visit, including annual sexually transmitted infection (STI) counseling and annual domestic violence screening & counseling per annual benefit period
- Cervical Cancer Screening per annual benefit period
- Screening of pregnant women for anemia, iron deficiency, bacteriuria, hepatitis B virus, Rh factor incompatibility, gestational diabetes
- Breastfeeding support/counseling & supplies, including lactation support and counseling by a trained provider and one manual breast pump per pregnancy
- Counseling for women at high risk of breast cancer for chemoprevention, including risks and benefits
- Mammography screening at age 40 and over, and genetic counseling and, if indicated after counseling, BRCA testing for BRCA breast cancer gene
- Osteoporosis screening (age 60 or older)
- HPV testing once every 3 years, beginning at age 30
- FDA-approved contraceptive methods and counseling

Medical plan: Injectable or implantable hormonal contraceptives and barrier methods, sterilization for women

Rx plan: Generic oral & injectable contraceptives, vaginal contraceptive, patch, prescription emergency contraception

Men:

- Prostate cancer screening at age 50 and older
- One-time abdominal aortic aneurysm screening at age 65 – 75 (for men who have ever smoked)

Children:

- Newborn screening for hearing, phenylketonuria (PKU), thyroid disease, sickle cell anemia, and cystic fibrosis
- Development delays and autism screening
- Iron deficiency screening
- Vision screening

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 or call 1-800-565-9140 (TTY: 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.

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

BlueCross BlueShield of Tennessee is a Qualified Health Plan Issuer in the Health Insurance Marketplace.

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 لذكر 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: ຖ້າ ວ່າ ທ່ ານ ເວ ົ້ າ ພາ ສາ ລາ ວ, ການ ບ ໍ ລ ິ ການ ຊ ່ ວ ຍ ເຫ ລ ື ອ ດ ້ ານ ພ າ ສາ, ໂດ ຍ ບ ໍ ເ ສ ັ ຽ ຄ ່ າ, ແ ມ ນ ມ ີ ພ ້ ອ ມ ໃ ຫ ້ ທ ່ ານ. ໂທ ຣ 1-800-565-9140 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሎት ተዘጋጅተዋል፡ 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).

ધ્યાન: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક 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).

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-565-9140 (TTY: 1-800-848-0299) or visit us at www.bcbst.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-565-9140 to request a copy. Coverage documents are not available until after the effective date of your coverage, but you may obtain a sample at **http://www.bcbst.com/samplepolicy/2023/LG.pdf** .This sample may not match your benefits exactly, so you should review your coverage document once it is available.

Contributions made by you and/or your employer to health savings accounts (HSAs), flexible spending accounts (FSAs), or health reimbursement arrangements (HRAs) may help pay your deductible or other out-of-pocket expenses.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $500 person/$1,500 family Out-of-network: $500 person/$1,500 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive services, Prescriptions drugs, and Emergency room visits are covered before you meet your deductible (unless specified).	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $1,500 person/$4,500 family Out-of-network: $3,000 person/$9,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billing charges, penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. This plan uses Network S. See http://www.bcbst.com/Network-S or call 1-800-565-9140 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

⚠ All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	30% coinsurance	PhysicianNow - Powered by MDLIVE: 20% coinsurance
	Specialist visit	20% coinsurance	30% coinsurance	None
	Preventive care/screening/ immunization	No Charge	30% coinsurance	A1c testing will be covered at 100%. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Travel immunization not covered in office or clinic setting.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbst.com/rxp	Preferred Generic drugs / Non-Preferred Generic drugs	$10 copay/prescription deductible does not apply.	30% coinsurance	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network Copayment per 30 day supply.
	Preferred brand drugs	$45 copay/prescription deductible does not apply.	30% coinsurance	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network Copayment per 30 day supply. When a brand drug is chosen and a generic drug equivalent is available, you will pay a penalty for the difference between the cost of the brand drug and the generic drug, plus the non-preferred brand drug copayment or
	Non-preferred brand drugs	$90 copay/prescription deductible does not apply.	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				coinsurance.
	Preferred Specialty drugs / Non-Preferred Specialty drugs	$180 copay/prescription deductible does not apply.	Not Covered	Up to a 30 day supply. Must use a pharmacy in the Preferred Specialty Pharmacy Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained.
If you need immediate medical attention	Emergency room care	$300 copay/visit deductible does not apply..	$300 copay/visit deductible does not apply..	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	30% coinsurance	Prior Authorization required for electro-convulsive therapy (ECT). Your cost share may increase to 50% if not obtained.
	Inpatient services	20% coinsurance	30% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you are pregnant	Office visits	20% coinsurance	30% coinsurance	PhysicianNow - Powered by MDLIVE: 20% coinsurance
	Childbirth/delivery professional services	$200 copay	30% coinsurance	Global Maternity Care - $200 copay per pregnancy
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	Unlimited
	Rehabilitation services	$25 copay	30% coinsurance	Therapy limited to 60 visits combined per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	Habilitation services	$25 copay	30% coinsurance	Therapy limited to 60 visits combined per

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	Skilled nursing care	20% coinsurance	30% coinsurance	Skilled nursing and rehabilitation facility limited to 100 days combined per year.
	Durable medical equipment	20% coinsurance	30% coinsurance	Prior Authorization may be required for certain durable medical equipment. Your cost share may increase to 50% if not obtained.
	Hospice services	No Charge	30% coinsurance	Prior Authorization required for inpatient hospice. Your cost share may increase to 50% if not obtained.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Bariatric surgery	• Infertility treatment	• Routine eye care (Adult)
• Cosmetic surgery	• Long-term care	• Routine eye care (Children)
• Dental care (Adult)	• Non-emergency care when traveling outside the U.S.	• Routine foot care for non-diabetics
• Dental care (Children)	• Private-duty nursing	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Hearing aids for adults	• Hearing aids for children under 18
• Chiropractic care		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For plans subject to ERISA, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental plans, the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- For church plans, the State Division of Benefits Administration at 1-866-576-0029.
- BlueCross at 1-800-565-9140 or www.bcbst.com, or contact your plan administrator.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- BlueCross at 1-800-565-9140 or www.bcbst.com, or your plan administrator.
- For plans subject to ERISA, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- The State Division of Benefits Administration at 1-866-576-0029.

Additionally, a consumer assistance program can help you file your appeal. Contact the Tennessee Department of Commerce and Insurance (TDCI) at 1-800-342-4029, https://sbs-tn.naic.org/Lion-Web/servlet/org.naic.sbs.ext.onlineComplaint.OnlineComplaintCtrl?spanishVersion=N, or email them at CIS.Complaints@state.tn.us. You may also write them at 500 James Robertson Pkwy, Davy Crockett Tower, 6th Floor, Nashville, TN 37243.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ **The plan's overall deductible**	**$500**
■ **Specialist coinsurance**	**20%**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$40
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$1,520**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ **The plan's overall deductible**	**$500**
■ **Specialist coinsurance**	**20%**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$900
Coinsurance	$50
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$1,480**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ **The plan's overall deductible**	**$500**
■ **Specialist coinsurance**	**20%**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$700
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

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 or call 1-800-565-9140 (TTY: 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*.

Language Access Services:

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: 800-848-0298-1

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, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-565-9140 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ 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, koji' hódíílnih 1-800-565-9140 (TTY: 1-800-848-0298).

BlueCross BlueShield of Tennessee

East Tennessee State University Residents

Summary of Benefits | BCBST Dental | Standard Plan

Dental Option: 1 Effective Date: July 1, 2023

Deductible Calendar Year Applies to Coverage B and C only	**Individual** $0	**Family** $0
Benefit Maximums		
Applies to Coverage B and C (per Calendar Year)	$1,000	
Coverage D (per Lifetime)	$1,000	
Benefit Percentages apply to	Any Dentist*	

Covered Services	**Benefit Percentages**
Coverage A Exams, X-rays Cleanings, Fluoride Sealants, Space Maintainers	100%
Coverage B Basic Restorative Services Basic Endodontics Basic Oral Surgery	80%
Coverage C Major Restorative and Prosthodontics Basic and Major Periodontics Major Endodontics Major Oral Surgery Implants	12 month Waiting Period 50%
Coverage D Orthodontics-Child to age 18	12 month Waiting Period 50%
Preferred Option	Network Dentists paid at PPO fee schedule; non-network dentists paid 30% less than PPO fee schedule
National Network	Included
Blue365	Discounts on health and wellness services including routine vision care, Lasik surgery, weight loss and fitness centers, and more

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 Coverage, and Schedule of Benefits sections of the Evidence of Coverage.

When applicable, benefits will be paid based on the Benefit Percentages listed above. Members will be responsible for co-insurance (when benefit percentages are less than 100%), deductible(s), and all other charges when benefit maximums have been met.

*Members may see any dentist. We have contracted dentists in our network that have agreed to limit their charges to our fee schedule. Because we have no contract with non-network dentists, members may be responsible for any billed charges that exceed our Maximum Allowable Charge.

COVERED SERVICES AND EXCLUSIONS

EXAMS

Covered: One periodic exam in any 6-month period. One limited oral evaluation in any 12-month period. One comprehensive, detailed/extensive, or periodontal exam in any 36- month period.

X-RAYS

Covered: One full mouth set of x-rays in any 36- month period. A full mouth set of x-rays is defined as either an intraoral complete series or panoramic x-ray. Benefits provided for either include benefits for all necessary intraoral and bitewing films taken on the same day. Up to four bitewing films in any 12-month period. All bitewing films must be taken on the same date of service.

Exclusions: Extraoral, skull and bone survey, sialography, temporomandibular joint dysfunction (TMJ), and tomographic survey x-ray films, cephalometric films and diagnostic photographs, unless otherwise stated in this Dental EOC.

CLEANINGS, FLUORIDE TREATMENT

Covered: One prophylaxis in any 6-month period, except when replaced as described below in Basic Periodontics. One fluoride treatment in any 12-month period for Members age 18 and under.

SEALANTS, SPACE MAINTAINERS

Covered: One sealant or preventive resin restoration per lifetime on first and second permanent molars for Members age 15 and under. Space maintainers for Members age 13 and under. One recementation per space maintainer in any 12-month period.

BASIC RESTORATIVE SERVICES

Covered: One amalgam or resin restoration per tooth surface in any 12-month period. Replacement of existing amalgam and resin composite restorations Covered only after 12-months from the date of initial restoration. Stainless steel crowns. Replacement of stainless steel crowns Covered after 36-months from the date of initial restoration. One sealant, preventive resin restoration, or resin infiltration per first or second permanent molar tooth per lifetime, for Members age 15 and under. Sealant/Preventive resins are subject to additional limitations listed under Preventive Services, and may be subject to a different Coverage level under Attachment C: Schedule of Benefits. Palliative (emergency) treatment for the relief of pain. One repair per denture in any 24-month period. General anesthesia or intravenous (IV) sedation in connection with major oral surgery procedures and implants when provided by a Dentist licensed to administer such agents.

Exclusions: Gold foil restorations.

MAJOR RESTORATIVE SERVICES – SINGLE TOOTH RESTORATIONS

Covered: Crowns, inlays and onlays only for the treatment of severe carious lesions or severe fracture on permanent teeth, and only when teeth cannot be adequately restored with an amalgam or resin composite restoration (filling).Replacement of single tooth restorations or fixed partial dentures (bridges) after 60-months from the date of initial placement. Veneers for anterior permanent teeth.

Exclusions: Provisional restorations and crowns. Cast crowns or laminate veneers for Members age 11 and under.

PROSTHODONTIC SERVICES – FIXED BRIDGES

Covered: Fixed partial dentures (bridges), including pontics, retainers, and abutment crowns, inlays, and onlays (resin, porcelain, ¾ and full cast) for permanent teeth only. Replacement of fixed partial dentures or single tooth restorations after 60-months from the date of initial placement.

Exclusions: Provisional or interim restorations. Bridges for Members age 15 and under.

PROSTHODONTIC SERVICES – REMOVABLE DENTURES

Covered: Complete, immediate and partial dentures utilizing standard techniques and materials as determined by the Plan. Personalized restorations, special techniques or materials shall be covered up to the amount allowed for standard techniques and materials. Replacement of removable dentures after 60-months from the date of initial placement.

Exclusions: Interim (temporary) dentures. Dentures for members age 15 and under.

OTHER MAJOR RESTORATIVE & PROSTHODONTIC SERVICES

Covered Services: Core build-up covered separately from restoration only in those circumstances where benefits are provided because severe carious lesions or fractures are so extensive that retention of the restoration would not be possible. Crown inlay, onlay, veneer and bridge repair and re-cementation after 12-months from the date of initial placement. One denture adjustment in any 6-month period and only after 6-months from the date of initial placement. One denture reline, rebase, or tissue conditioning in any 36-month period. One implant per tooth per lifetime. One bone graft for implant per tooth per lifetime. One implant debridement per tooth per lifetime. Initial placement or replacement of implant supported prosthesis after 60-months from the date of any corresponding major restoration.

Exclusions: Provisional and interim restorations. Other major restorative services including protective restoration and coping. Other prosthodontic services including overdenture, precision attachments, connector bars, stress breakers and coping metal. Crown preparation, temporary or prefabricated crowns, impressions and cementation. Post and core services not performed in conjunction with a Covered crown or bridge.

BASIC ENDODONTICS

Covered: Pulpotomy, pulpal therapy for primary teeth but not when performed in conjunction with major endodontic treatment.

Exclusions: Pulpal debridement. Pulp vitality tests. Protective restorations.

MAJOR ENDODONTICS

Covered: One root canal treatment (root canal, re-treatment, apexification, pulpal regeneration, hemisection, pulp cap or root amputation) per tooth in any 60-month period. One apicoectomy per root per lifetime. Retrograde filling if done on same date of service as apicoectomy.

Exclusions: Guided tissue regeneration. Intentional re-implantation (including necessary splinting). Canal preparation. Incomplete endodontic therapy. Pulp vitality test. Protective restorations.

BASIC PERIODONTICS

Covered: One periodontal scaling and root planing per quadrant in any 24- month period. One full mouth debridement per lifetime. Periodontal maintenance no sooner than 90 days after completion of any one of the Basic Periodontic Covered Services above. Periodontal maintenance will replace a prophylaxis or scaling. Scaling in the presence of generalized moderate or severe gingival inflammation – full mouth, once per lifetime. Scaling will replace a prophylaxis or periodontal maintenance procedure.

Exclusions: Provisional splinting, and antimicrobial medication and dressing changes. Periodontal scaling and root planing, full mouth debridement, periodontal maintenance and prophylaxis when more than one of these procedures is performed on the same date of service.

MAJOR PERIODONTICS

Covered: One major surgical periodontal procedure, including gingivectomy, gingivoplasty, gingival flap procedure, osseous surgery, per quadrant in any 36-month period. One crown lengthening per tooth in any 36-month period. One bone and tissue grafting per site in any 36-month period.

Exclusions: Tissue regeneration and apically positioned flap procedure.

BASIC ORAL SURGERY

Covered: Non-surgical or simple extractions (pulling teeth).

MAJOR ORAL SURGERY

Covered: Surgical extractions (including removal of impacted teeth), coronectomy, and other oral surgical procedures typically not Covered under a medical plan.

Exclusion: Oral surgery typically Covered under a medical plan, including but not limited to, excision of lesions and bone tissue, treatment of fractures, suturing, wound and other repair procedures, TMJ and related procedures. Orthognathic surgery and treatment for congenital malformations. Harvesting of bone for use in autogenous grafting.

ORTHODONTIC SERVICES (MANY PLANS DO NOT PROVIDE ORTODONTIC COVERAGE)

Covered: Exams, photographic images, diagnostic casts, cephalometric x-rays, installation and adjustment of orthodontic appliances and treatment to reduce or eliminate an existing malocclusion.

Exclusions: Replacement or repair of any lost, stolen and damaged appliance. Surgical procedures to aid in orthodontic treatment.

OTHER EXCLUSIONS FROM COVERAGE

1. Dental services received from a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trustee or similar person or group.
2. Services or supplies not listed as Covered Services under Attachment A, Covered Services and Limitations on Covered Services.
3. Charges for services performed by You or Your spouse, or Your or Your spouse's parent, sister, brother or child.
4. Services rendered by a Dentist beyond the scope of his or her license.
5. Dental services which are free, or for which You are not required or legally obligated to pay or for which no charge would be made if You had no dental Coverage.
6. Dental services to the extent that charges for such services exceed the charge that would have been made and collected if no Coverage existed hereunder.
7. Dental services covered by any medical insurance coverage, or by any other non-dental contract or certificate issued by BlueCross BlueShield of Tennessee or any other insurance company, carrier, or plan. For example, removal of impacted teeth, tumors of lip and gum, accidental injuries to the teeth, etc.
8. Any court-ordered treatment of a Member unless benefits are otherwise payable.
9. Courses of treatment undertaken before You become Covered under this program.
10. Any services performed after You cease to be eligible for Coverage, except as shown under the Payment for Services Rendered after Termination of Coverage section.
11. Dental care or treatment not specifically listed in Attachment C: Schedule of Benefits.
12. Any treatment or service that the Plan determines is not Necessary Dental Care that does not offer a favorable prognosis that does not meet generally accepted standards of professional dental care, or that is experimental in nature.
13. 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; (2) a partner of the Group; or (3) a corporate officer of the Group, provided the officer filed an election not to accept Workers' Compensation with the appropriate government department.
14. Charges for any hospital or other surgical or treatment facility and any additional fees charged by a Dentist for treatment in any such facility.
15. Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes. This does not exclude those services provided under Orthodontic benefits (if applicable.)
16. Replacement of tooth structure lost from wear or attrition.
17. Dental services resulting from loss or theft of a denture, crown, bridge or removable orthodontic appliance.
18. Charges for a prosthetic device that replaces one or more lost, extracted or congenitally missing teeth before Your Coverage becomes effective under the Plan unless it also replaces one or more natural teeth extracted or lost after Your Coverage became effective.
19. Diagnosis for, or fabrication of, adjustment or maintenance and cleaning of maxillofacial prosthesis, appliances or restorations necessary to correct bite problems or restore the occlusion or correct temporomandibular joint dysfunction (TMJ) or associated muscles.
20. Diagnostic dental services such as diagnostic tests and oral pathology services.
21. Adjunctive dental services including all local and general anesthesia, sedation, and analgesia (except as stated elsewhere in this EOC).
22. Charges for the treatment of desensitizing medicaments, drugs, occlusal guards and adjustments, mouthguards, microabrasion, behavior management, and bleaching.
23. Charges for the treatment of professional visits outside the dental office or after regularly scheduled hours or for observation.
24. Charges for the inhalation of nitrous oxide/analgesia, anxiolysis.
25. Dental consultations including but not limited to re-evaluations, teledentistry, nutritional and tobacco counseling and oral hygiene instruction.

BlueCross BlueShield of Tennessee

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

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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.

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[illegible] 1-800-565-9140 (TTY: 1-800-848-0298).

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

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(TTY:1-800-848-0298)

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पर कॉल करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните
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توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با
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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.

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- 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 or call 1-800-565-9140 (TTY: 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*.

BlueCross BlueShield of Tennessee

An Independent Licensee of the BlueCross BlueShield Association

Group Name: East Tennessee State University Residents
Group Number: 140394
Effective Date: 07/01/2023

VisionBlue

Benefit	In-Network Member Cost	Out-of-Network Reimbursement	
VISION EXAMINATION			
Comprehensive Eye Examination	$10 Copayment	Up to $35	One exam within a 12 month period for each member covered under the plan.
Retinal Imaging	Up to $39	N/A	
Contact Lenses Fit and Follow-Up			
Standard	$55 Copayment	N/A	
Premium	10% off retail	N/A	
VISION MATERIALS			
Standard Plastic Lenses			One set of lenses within a 12 month period for each member covered under the plan.
Single Vision	$0 Copayment	Up to $30	
Bifocal	$0 Copayment	Up to $45	
Trifocal	$0 Copayment	Up to $60	
Frames	$0 Copayment up to $150 allowance, 20% off balance over allowance	Up to $75	One pair of frames within a 24 month period for each member covered under the plan.
Contacts			One set of lenses within a 12 month period for each member covered under the plan (In lieu of lenses + frames).
Conventional	$0 copay up to $150 allowance, 15% off balance over allowance	Out-of-network up to $120	
Disposable	$0 copay up to $150 allowance	Out-of-network up to $120	
Medically Necessary	Paid in Full	Up to $200	
Lens Options			One set of lenses within a 12 month period for each member covered under the plan.
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 Additional Copayment	$0 Additional *	
Premium Progressive Lenses (add on to Bifocal)	$65 Additional Copayment, 20% off retail price less $120 allowance	$0 Additional *	
Standard Anti-Reflective Coating	$45 Copayment	Up to $0	
Other Lens Options	20% off retail	N/A	

* $45 maximum reimbursement

Diabetic Eye Care *(Care and testing for diabetic members)*			Up to 2 services per year for each listed service.**
Exam	$0	Up to $77	
Retinal Imaging	$0	Up to $50	
Extended Ophthalmoscopy	$0	Up to $15	
Gonioscopy	$0	Up to $15	
Scanning Laser	$0	Up to $33	

**Some or all of the diagnostic services described above will be provided as deemed appropriate, subject to provider determination of service necessity and the benefit frequency limitations referenced above.

- 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.
- When applicable benefits are paid after the Copayment listed above and to the allowance listed, members are responsible for amounts above the allowance.
- 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.

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

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of Tennessee

Date: 01-19-2024

Dental Benefits & Paid Claims per Employee

East Tennessee State University Residents

Current Paid Period: 12/01/2021 through 12/31/2023

Prior Paid Period: 12/01/2020 through 12/31/2022

	Prior	Current	Change	% Change
Total Average Number Employees	242	244	2	0.8%
Net Benefits per Employee	$696	$649	($47)	-6.7%
Employee Cost Share per Employee	$119	$110	($10)	-8.0%
Plan Paid Amount per Employee	$577	$539	($37)	-6.5%
Total Average Number Members	474	466	-8	-1.7%
Net Benefits per Member	$355	$340	($15)	-4.4%
Member Cost Share per Member	$61	$58	($3)	-5.6%
Plan Paid Amount per Member	$294	$282	($12)	-4.1%
Average Number of Treated Members	371	363	-8	-2.2%
Net Benefits per Treated Member	$454	$436	($18)	-3.9%
Member Cost Share per Treated Member	$78	$74	($4)	-5.2%
Plan Paid Amount per Treated Member	$376	$362	($14)	-3.6%

Paid date reports are based on the paid date, rather than the date of service.

of Tennessee

Date: 01-19-2024

Report Parameters

Parameter	Parameter Selected Value
Dental Group(s):	140394 - East Tennessee State University Residents
Dental Subgroup(s):	No Filter Selected
Dental Plan ID(s):	No Filter Selected
Dental Department(s):	No Filter Selected
Claim Date Type:	Paid Dates Only
Claims Lag:	N/A
Begin Date:	12/01/2021
End Date:	12/31/2023
Prior Period:	Yes
Parent:	612620

Paid date reports are based on the paid date, rather than the date of service.

of Tennessee
plans for better health. plans for a better life.®
1 Cameron Hill Circle
Chattanooga, TN 37402
bcbst.com

Single Option - Renewal Rate Sheet

Fully Insured

Dental

Group Information

Group Name: **East Tennessee State University Residents - Dental**

Marketing Rep: **Diana McClurg**

Group Number: **140394**

Region: **Knoxville**

Effective Date: **7/1/23 - 6/30/24**

Broker: **Torbett, Hanes Lancaster**

Contract Year: **5th**

Current Rates

	Individual	-	-	Family	Total
Current Contracts:	123	-	-	110	233
Current Rates:	$ 13.32	$ -	$ -	$ 47.15	

Total Current Monthly Premium: $6,825

Renewal Rates - Dental

		Individual	-	-	Family
Dental:	Dental	$ 13.32	$ -	$ -	$ 47.15
COBRA Admin:	Combined w/ Medical	-	-	-	-
	Total:	$ 13.32	$ -	$ -	$ 47.15

Total Renewal Monthly Premium: $6,825

Total Increase: 0.00%

* IER Retention = 22.07%
* The rates presented in this renewal include 10.00% commissions and may include additional compensation. If you have questions, please contact your broker.
* 50% of net eligible employees must be enrolled (employees w/ other coverage are excluded from the calculation). Employer required to contribute a minimum of 50% of the individual rate for each employee.

of Tennessee

East Tennessee State University
Medical Residents
Benefit Summary

Effective Date: 6/20/2019
Network: S
Quote: #16

Benefit Plan Features:	Your Cost In-Network	Your Cost Out-Of-Network [1]
Annual Deductible		
Individual/Family	$100/$300	$100/$300
Annual Out-of-Pocket Maximum (includes copays, coinsurance and deductibles)		
Individual/Family	$1100/$3300	$2200/$6600
4th Quarter Carry-over	Included	
Covered Services		
Preventive Care Services (see page 3 for a list)	Covered at 100%	30% after Deductible
Practitioner Office Services		
Primary Care Office Visits	20% after Deductible	30% after Deductible
Specialist Office Visits	20% after Deductible	30% after Deductible
Office Surgery [3, 4, 6]	20% after Deductible	30% after Deductible
Routine Diagnostic Lab, X-Ray & Injections	20% after Deductible	30% after Deductible
Advanced Radiological Imaging [2, 4, 7]	20% after Deductible	30% after Deductible
Provider-Administered Specialty Drugs [3]	$60 Copay	30% after Deductible
Services Received at a Facility (includes professional and facility charges)		
Inpatient Services [2, 4]	20% after Deductible	30% after Deductible
Outpatient Surgery [3, 4, 6]	20% after Deductible	30% after Deductible
Routine Diagnostic Services - Outpatient	20% after Deductible	30% after Deductible
Advanced Radiological Imaging - Outpatient [2, 4, 7]	20% after Deductible	30% after Deductible
Other Outpatient Services [8]	20% after Deductible	30% after Deductible
Urgent Care Center Services	20% after Deductible	30% after Deductible
Emergency Care Services [9, 10]	$300 Copay	$300 Copay
Emergency Care Advanced Radiological Imaging [7, 10]	20% after Deductible	20% after Deductible
Medical Equipment Services [3, 4]		
Durable Medical Equipment	20% after Deductible	30% after Deductible
Prosthetics or Orthotics	20% after Deductible	30% after Deductible
Hearing Aids (limit 1 per ear every 3 years)	20% after Deductible	30% after Deductible
Behavioral Health Services		
Inpatient: Unlimited days per annual benefit period [2, 4]	20% after Deductible	30% after Deductible
Outpatient: Unlimited visits per annual benefit period [5]	20% after Deductible	30% after Deductible
Therapeutic Services [11] (limits apply; see footnote)	$25 Copay	30% after Deductible
Skilled Nursing & Rehabilitation Facility Services [2, 4]		
Limited to 100 days combined per annual benefit period	20% after Deductible	30% after Deductible
Home Health Care Services [3, 4]		
Limited to 60 visits per annual benefit period	20% after Deductible	30% after Deductible

Benefit Plan Features:	Your Cost In-Network	Your Cost Out-Of-Network [1]
Hospice Services		
Inpatient [2]	Covered at 100%	30% after Deductible
Outpatient	Covered at 100%	30% after Deductible
Ambulance Services [3, 4]	20% after Deductible	20% after Deductible
Prescription Drugs [3]		
Prescription Contraceptives [17]	Covered at 100%	30% after Deductible
Retail RX04 Network up to 30 day supply		
Generic [14]	$10.00	30% after Deductible
Preferred [14, 16]	$20.00	30% after Deductible
Non-Preferred [14, 16]	$30.00	30% after Deductible
Plus90 or Home Delivery Network up to 90 day supply		
Generic [15]	$20.00	30% after Deductible
Preferred [15, 16]	$40.00	30% after Deductible
Non-Preferred [15, 16]	$60.00	30% after Deductible
Self-Administered Specialty Drugs [3, 12, 13]		
Specialty Pharmacy Network - up to 30 day supply	$60.00	Not Covered

Notes:

1. Out-of-network benefit payment based on BlueCross BlueShield of Tennessee maximum allowable charge. You are responsible for any unpaid billed charges.
2. Prior authorization is required.
3. Certain procedures, services, medication and equipment may require prior authorization.
4. If prior authorization is required but not obtained and services are medically necessary, when using network providers outside Tennessee for physician and outpatient services and all services from out-of-network providers, your liability will be increased to 50% based on out-of-network coinsurance. If services are not medically necessary, no benefits will be provided.
5. Outpatient behavioral health benefits are determined by place of service. Benefits displayed are for services received in an office setting; separate benefits may apply for outpatient services received in an alternate setting.
6. Surgeries include incisions, excisions, biopsies, injection treatments, fracture treatments, applications of casts and splints, sutures and invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy and endoscopy for non-preventive purposes).
7. Includes CT scans, PET scans, MRIs, nuclear medicine and other similar technologies.
8. Includes services such as chemotherapy, infusions, injections, radiation therapy and renal dialysis.
9. Copay, if applicable, waived if admitted to hospital.
10. In true emergency situations, out-of-network emergency services apply to the in-network deductible and/or out-of-pocket maximum.
11. Physical, speech, acupuncture, spinal manipulative and occupational therapies are limited to 60 visits combined per annual benefit period. Cardiac and pulmonary rehabilitative therapies are limited to 36 visits per therapy type per annual benefit period.
12. Visit www.bcbst.com for the Preferred Formulary which includes specialty drugs.
13. You have a distinct arrangement for self-administered specialty drugs. To receive benefits, you must use a Specialty Pharmacy Network provider. Visit www.bcbst.com for a list of providers in the Specialty Pharmacy Network. Specialty drugs are limited to a 30-day supply.
14. Copay, if applicable, applied per prescription, up to a 30 day supply.
15. Your plan requires you to receive long-term medications in a 90-day supply from home delivery or at a retail pharmacy in the Plus90 Network. If you choose to use a retail pharmacy that is not part of the Plus90 Network, you are limited to a 30-day supply. Visit www.bcbst.com to find a list of pharmacies in the Plus90 Network.
16. A financial penalty may be applied if you choose a brand name drug when a generic equivalent is available. Please refer to your Evidence of Coverage (EOC) for specific information.
17. Certain prescription drugs are covered at 100% at network pharmacies, in accordance with the Preventive Services provision of the Affordable Care Act, and are identified on the drug formulary with an "ACA" indicator. Visit www.bcbst.com for the Preferred Formulary.

Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your Evidence of Coverage (EOC) and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the EOC will govern. For a complete list of limitations and exclusions, please refer to your EOC.

Summary of Preventive Care Services
Covered at 100% In-Network

In-network preventive care services that are covered with no member cost share include, but are not limited to:

- Primary care services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF)
- Immunizations recommended by the Advisory Committee on Immunization Practices that have been adopted by the Centers for Disease Control and Prevention (CDC)
- Bright Futures recommendations for infants, children and adolescents that are supported by the Health Resources and Services Administration (HRSA)
- Preventive care and screening for women as provided in the guidelines supported by HRSA

The following preventive care services are covered (not an all-inclusive list). Coverage of some services may depend on age and/or risk exposure.

All Members:

- One preventive health exam per annual benefit period. More frequent preventive exams are covered for children up to age 3.
- All standard immunizations adopted by the CDC
- Screening for colorectal cancer (age 50 – 75), high cholesterol and lipids (45 and older for women; 35 and older for men), high blood pressure, obesity, diabetes, and depression (12 and older)
- Screening for lung cancer for adults (55 to 80) who have a 30 pack-year smoking history and either currently smoke or have quit within the past 15 years, per annual benefit period
- Screening for HIV and certain sexually transmitted diseases, and counseling for the prevention of sexually transmitted diseases
- Screening and counseling in a primary care setting for alcohol misuse and tobacco use; alcohol misuse and tobacco use limited to 8 visits per annual benefit period
- Dietary counseling for adults with hyperlipidemia, hypertension, type 2 diabetes, obesity, coronary artery disease and congestive heart failure; limited to 12 visits per annual benefit period
- One retinopathy screening for diabetics per annual benefit period

Women:

- Well-woman visit, including annual sexually transmitted infection (STI) counseling and annual domestic violence screening & counseling per annual benefit period
- Cervical Cancer Screening per annual benefit period
- Screening of pregnant women for anemia, iron deficiency, bacteriuria, hepatitis B virus, Rh factor incompatibility, gestational diabetes
- Breastfeeding support/counseling & supplies, including lactation support and counseling by a trained provider and one manual breast pump per pregnancy
- Counseling for women at high risk of breast cancer for chemoprevention, including risks and benefits
- Mammography screening at age 40 and over, and genetic counseling and, if indicated after counseling, BRCA testing for BRCA breast cancer gene
- Osteoporosis screening (age 60 or older)
- HPV testing once every 3 years, beginning at age 30
- FDA-approved contraceptive methods and counseling
  Medical plan: Injectable or implantable hormonal contraceptives and barrier methods, sterilization for women
  Rx plan: Generic oral & injectable contraceptives, vaginal contraceptive, patch, prescription emergency contraception

Men:

- Prostate cancer screening at age 50 and older
- One-time abdominal aortic aneurysm screening at age 65 – 75 (for men who have ever smoked)

Children:

- Newborn screening for hearing, phenylketonuria (PKU), thyroid disease, sickle cell anemia, and cystic fibrosis
- Development delays and autism screening
- Iron deficiency screening
- Vision screening

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.

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- 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 or call 1-800-565-9140 (TTY: 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.

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

BlueCross BlueShield of Tennessee is a Qualified Health Plan Issuer in the Health Insurance Marketplace.

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 تحدث اذكر اللغة فإن خدمات المساعدة اللغوية متوافر 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: ຖ້າ ວ່າ ທ່ ານ ເວ ົ້ າ ພາ ສາ ລາ ວ, ການ ບ ໍ ລ ິ ການ ຊ ່ ວ ຍ ເຫ ລ ື ອ ດ ້ ານ ພ າ ສາ, ໂດ ຍ ບ ໍ ເ ສ ັ ຽ ຄ ່ າ, ແ ມ ່ ນ ມ ີ ພ ້ ອ ມ ໃ ຫ ້ ທ ່ ານ. ໂທ ຣ 1-800-565-9140 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሎት 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).

મુચના: 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 تماس بگیرید. 1-800-565-9140 (TTY:1-800-848-0298)

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'dęę́', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-800-565-9140 (TTY: 1-800-848-0298).

BlueCross BlueShield of Tennessee

East Tennessee State University Medical Residents

Summary of Benefits (SL# 20) — DentalBlue — Standard Plan

Dental Option: 1
Effective Date: June 20, 2019

Deductible Calendar Year Applies to Coverage B and C only	**Individual** $0 / In-Network $50 / Out-of-Network	**Family** $0 / In-Network $150 / Out-of-Network
Benefit Maximums		
Applies to Coverage B and C (per Calendar Year)	$1,000	
Coverage D (per Lifetime)	$1,000	
Benefit Percentages apply to	Any Dentist*	

Covered Services	**Benefit Percentages**
Coverage A Exams, X-rays Cleanings, Fluoride Sealants, Space Maintainers	100%
Coverage B Basic Restorative Services Basic Endodontics Basic Oral Surgery	80%
***Coverage C** Major Endodontics Basic and Major Periodontics Major Oral Surgery Major Restorative and Prosthodontics Implants	50% *12-month waiting period to apply to all not currently enrolled
***Coverage D** Orthodontics-Child to age 18	50% *12-month waiting period to apply to all not currently enrolled
Preferred Option	Network Dentists paid at PPO fee schedule; non-network dentists paid 30% less than PPO fee schedule
National Network	Included
Blue365	Discounts on health and wellness services including routine vision care, Lasik surgery, weight loss and fitness centers, and more

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 Coverage, and Schedule of Benefits sections of the Evidence of Coverage.

When applicable, benefits will be paid based on the Benefit Percentages listed above. Members will be responsible for co-insurance (when benefit percentages are less than 100%), deductible(s), and all other charges when benefit maximums have been met.

*Members may see any dentist. We have contracted dentists in our network that have agreed to limit their charges to our fee schedule. Because we have no contract with non-network dentists, members may be responsible for any billed charges that exceed our Maximum Allowable Charge.

COVERED SERVICES, LIMITATIONS, & EXCLUSIONS

Exams
Covered: Standard exams including comprehensive, periodic, detailed/extensive and periodontal oral evaluations (exams). Emergency exams, including limited oral evaluations (exams).
Limitations: No more than one standard exam in any 6-month period. No more than one emergency exam in any 12-month period. No more than one comprehensive, detailed/extensive, or periodontal exam in any 36-month period.
Exclusions: Re-evaluations and consultations.
X-rays
Covered: Full mouth series, intraoral and bitewing radiographs (x-rays).
Limitations: No more than one full mouth set of x-rays in any 36-month period. A full mouth set of x-rays is defined as either an intraoral complete series or panoramic x-ray. Benefits provided for either include benefits for all necessary intraoral and bitewing films taken on the same day. No more than four bitewing films in any 12-month period. Bitewing films must be taken on the same date of service.
Exclusions: Extraoral, skull and bone survey, sialography, TMJ, and tomographic survey x-ray films, cephalometric films and diagnostic photographs. Cephalometric films and diagnostic photographs may be covered as orthodontic benefits under Coverage D.
Cleanings, Fluoride Treatment
Covered: Adult and child prophylaxis (cleaning). Child and adult (subject to age limitations) fluoride treatments, performed with or without a prophylaxis.
Limitations: No more than one of any prophylaxis or periodontal maintenance procedure in any 6month period. Periodontal maintenance procedures are subject to additional limitations listed below under Basic Periodontics in Section VI, and may be subject to a different Coverage level under Attachment C: Schedule of Benefits. No more than one fluoride treatment in any 12-month period, for Members under age 19. Fluoride must be applied separately from prophylaxis paste.
Sealants, Space Maintainers
Covered: Other Preventive Services, including sealants, space maintainers.
Limitations: No more than one sealant per first or second molar tooth per lifetime, for Dependents under age 16. Space maintainers for Dependents under age 14. No more than one recementation in any 12month period.
Exclusions: Nutritional and tobacco counseling, oral hygiene instructions.
Basic Restorative Services
Covered: Basic restorative services, including amalgam restorations (silver fillings), resin composite restorations (tooth colored fillings), stainless steel crowns. Palliative (emergency) treatment for the relief of pain. Other restorative services, including repair of full and partial dentures.
Limitations: No more than one amalgam or resin restoration per tooth surface in any 12-month period. Replacement of existing amalgam and resin composite restorations Covered only after 12 months from the date of initial restoration. Replacement of stainless steel crowns Covered only after 36 months from the date of initial restoration. No more than one repair per denture per 24 months.
Exclusions: Gold foil restorations.
Major Restorative Services
Covered: Single tooth restorations, including crowns (resin, porcelain, ¾ cast, and full cast), inlays and onlays (metallic, resin and porcelain), and veneers.
Limitations: Only for the treatment of severe carious lesions or severe fracture on permanent teeth, and only when teeth cannot be adequately restored with an amalgam or resin composite restoration (filling). For permanent teeth only. For Dependents under age 12, benefits will not be provided for cast crowns or laminate veneers. Replacement of single tooth restorations Covered only after 60 months from the date of initial placement.
Exclusions: Temporary and provisional crowns.
Prosthodontic Services - Fixed Bridges
Covered: Fixed partial dentures (bridges), including pontics, retainers, and abutment crowns, inlays, and onlays (resin, porcelain, ¾ and full cast).
Limitations: Only for treatment where a missing tooth or teeth cannot be adequately restored with a removable partial denture. For permanent teeth only, no benefits for Dependents under age 16. Replacement of fixed partial dentures Covered only after 60 months from the date of initial placement.
Prosthodontic Services - Removable Dentures
Covered: Complete, immediate and partial dentures.
Limitations: If, in the construction of a denture, the Member and the Dentist decide on a personalized restoration or to employ special rather than standard techniques or materials, benefits provided shall be limited to those which would otherwise be provided for the standard procedures or materials (as determined by the Plan). Benefits are not provided for Dependents under age 16. Replacement of removable dentures Covered only after 60 months from the date of initial placement.
Exclusions: Interim (temporary) dentures.
Other Major Restorative & Prosthodontic Services
Covered: Crown and bridge services including core buildups, post and core, recementation, and repair. Denture services including adjustment, relining, rebasing and tissue conditioning. Implants and supported prosthetics including local anesthetic.
Limitations: The benefits provided for crown and bridge restorations include benefits for the services of crown preparation, temporary or prefabricated crowns, impressions and cementation. Benefits will not be provided for a core build-up separate from those provided for crown construction, except in those circumstances where benefits are provided for a crown because of severe carious lesions or fracture is so extensive that retention of the crown would not be possible. Post and core services are Covered only when performed in conjunction with a Covered crown or bridge. Crown and bridge repair and re-cementation are Covered separately only after 12 months from the date of initial placement. Denture adjustments are Covered separately from the denture only after 6 months from the date of initial placement. No more than one denture reline or rebase in any 36 month period.
Exclusions: Other major restorative services including sedative fillings and coping. Other prosthodontic services including overdenture, precision attachments, connector bars, stress breakers and coping metal.
Basic Endodontics
Covered: Pulpotomy, pulpal therapy.
Limitations: For primary teeth only. Not Covered when performed in conjunction with major endodontic treatment. The benefits for basic endodontic treatment include benefits for x-rays, pulp vitality tests, and sedative fillings provided in conjunction with basic endodontic treatment.
Exclusions: Pulpal debridement.
Major Endodontics
Covered: Root canal treatment and re-treatment, apexification, apicoectomy services, root amputation, retrograde filling, hemisection, pulp cap.
Limitations: No more than one root canal treatment, re-treatment or apexification per tooth in 60month period. No more than one apicoectomy per root per lifetime. The benefits for major endodontic treatment include benefits for x-rays, pulp vitality tests, pulpotomy, pulpectomy and sedative fillings and temporary filling material provided in conjunction with major endodontic treatment.
Exclusions: Implantation, canal preparation, and incomplete endodontic therapy.
Basic Periodontics
Covered: Non-surgical periodontics, including periodontal scaling and root planing, full mouth debridement and periodontal maintenance procedure.
Limitations: No more that one periodontal scaling and root planing per quadrant in any 24month period. No more than one full mouth debridement per lifetime. No more than one of any prophylaxis (cleanings) or periodontal maintenance procedure in any 6month period. Cleanings are subject to additional limitations listed under Preventive Services, and may be subject to a different Coverage level under Attachment C: Schedule of Benefits. Benefits for periodontal maintenance are provided only after active periodontal treatment (surgical or non-surgical), and no sooner than 90 days after completion of such treatment. Benefits for periodontal scaling and root planing, full mouth debridement, periodontal maintenance and prophylaxis are not provided when more than one of these procedures is performed on the same day.
Exclusions: Provisional splinting, scaling in the presence of gingival inflammation, antimicrobial medication and dressing changes.
Major Periodontics
Covered: Surgical periodontics including gingivectomy, gingivoplasty, gingival flap procedure, crown lengthening, osseous surgery and bone and tissue grafting.
Limitations: No more than one major periodontal surgical procedure in any 36-month period. Benefits provided for major periodontics include benefits for services related to 90 days of postoperative care.
Exclusions: Tissue regeneration and apically positioned flap procedure.
Basic Oral Surgery
Covered: Non-surgical or simple extractions.
Limitations: Benefits provided for basic oral surgery include benefits for suturing and postoperative care.
Exclusions: Benefits for general anesthesia or intravenous sedation when performed in conjunction with basic oral surgery.
Major Oral Surgery
Covered: Surgical extractions (including removal of impacted teeth and wisdom teeth), and other oral surgical procedures typically not Covered under a medical plan.
Limitations: Benefits provided for major oral surgery include benefits for local anesthesia, suturing and postoperative care. Benefits for general anesthesia or intravenous (IV) sedation are provided only in connection with major oral surgery procedures, and only when provided by a Dentist licensed to administer such agents.
Exclusions: Implants and any related oral surgery typically Covered under a medical plan, including but not limited to, excision of lesions and bone tissue, treatment of fractures, suturing, wound and other repair procedures, TMJ and related procedures. Orthognathic surgery and treatment for congenital malformations.
Orthodontics Services
Covered: Exams, photographic images, diagnostic casts, cephalometric xrays, installation and adjustment of orthodontic appliances and treatment to reduce or eliminate an existing malocclusion.
Limitations: The need for orthodontic services must be diagnosed, identifying a handicapping malocclusion that is both abnormal and correctable, and a Treatment Plan must be submitted to and approved by the Plan. The Plan reserves the right to review the Member's dental records, including necessary x-rays, photographs, and models to determine whether orthodontic treatment is Covered. Orthodontic services may be limited to Dependents under a specified age limit, as defined on Attachment C: Schedule of Benefits. Orthodontic services may be limited by a Maximum Allowable Charge, Calendar Year Deductible and lifetime maximum as defined on Attachment C: Schedule of Benefits. Multiple occurrences of orthodontic treatment may be allowed subject to the lifetime maximum. All orthodontic services shall be deemed to have been concluded on the last date treatment performed during Member's Coverage, even if a prior approved Treatment Plan has not been completed.
Exclusions: Replacement or repair of any lost, stolen and damaged appliance furnished under the Treatment Plan. Surgical procedures to aid in orthodontic treatment.

Other Exclusions From Coverage

1) This EOC does not provide benefits for the following services supplies or charges:
2) Dental services received from a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trustee or similar person or group.
3) Charges for services performed by You or Your spouse, or Your or Your spouse's parent, sister, brother or child.
4) Services rendered by a Dentist beyond the scope of his or her license.
5) Dental services which are free, or for which You are not required or legally obligated to pay or for which no charge would be made if You had no dental Coverage.
6) Dental services to the extent that charges for such services exceed the charge that would have been made and collected if no Coverage existed hereunder.
7) Dental services covered by any medical insurance coverage, or by any other non-dental contract or certificate issued by BlueCross BlueShield of Tennessee or any other insurance company, carrier, or plan. For example, removal of impacted teeth, tumors of lip and gum, accidental injuries to the teeth, etc.
8) Any court-ordered treatment of a Member unless benefits are otherwise payable.
9) Courses of treatment undertaken before You become Covered under this program.
10) Any services performed after You cease to be eligible for Coverage.
11) Dental care or treatment not specifically listed in Attachment C: Schedule of Benefits.
12) Any treatment or service that the Plan determines is not Necessary Dental Care, that does not offer a favorable prognosis that does not meet generally accepted standards of professional dental care, or that is experimental in nature.
13) 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; (2) a partner of the Group; or (3) a corporate officer of the Group, provided the officer filed an election not to accept Workers' Compensation with the appropriate government department.
14) Charges for any hospital or other surgical or treatment facility and any additional fees charged by a Dentist for treatment in any such facility.
15) Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes. This does not exclude those services provided under Orthodontic benefits (if applicable.)
16) Replacement of tooth structure lost from wear or attrition.
17) Dental services resulting from loss or theft of a denture, crown, bridge or removable orthodontic appliance.
18) Charges for a prosthetic device that replaces one or more lost, extracted or congenitally missing teeth before Your Coverage becomes effective under the Plan unless it also replaces one or more natural teeth extracted or lost after Your Coverage became effective.
19) Diagnosis for, or fabrication of, appliances or restorations necessary to correct bite problems or restore the occlusion or correct temporomandibular joint dysfunction (TMJ) or associated muscles.
20) Implant supported prosthetics. Alternate benefits may be provided for a standard crown, bridge or denture, at Our sole discretion.
21) Diagnostic dental services such as diagnostic tests and oral pathology services.
22) Adjunctive dental services including all local and general anesthesia, sedation, and analgesia (except as provided under major oral surgery).
23) Charges for the treatment of desensitizing medicaments, drugs, occlusal guards and adjustments, mouthguards, microabrasion, behavior management, and bleaching.
24) Charges for the treatment of professional visits outside the dental office or after regularly scheduled hours or for observation.

BlueCross BlueShield of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402
www.bcbst.com

Nondiscrimination Notice

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

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ለያግዝዎት 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).

ધ્યાન: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક 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 है तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध है। 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, koji' hódíílnih 1-800-565-9140 (TTY: 1-800-848-0298).

BlueCross BlueShield of Tennessee

An Independent Licensee of the BlueCross BlueShield Association

Group Name: East Tennessee State University Residents
Group Number: 140394
Effective Date: 06/20/2019

isionBlue

enefit	In-Network Member Cost	Out-of-Network Reimbursement	
SION EXAMINATION			
omprehensive Eye Examination	$10 Copayment	Up to $35	One exam within a 12 month period for each member covered under the plan.
Retinal Imaging	Up to $39	N/A	
ontact Lenses Fit and Follow-Up			
Standard	$55 Copayment	Up to $0	
Premium	10% off retail	Up to $0	
ISION MATERIALS			
tandard Plastic Lenses			One set of lenses within a 12 month perioc for each member covered under the plan.
Single Vision	$0 Copayment	Up to $30	
Bifocal	$0 Copayment	Up to $45	
Trifocal	$0 Copayment	Up to $60	
rames	$0 Copayment up to $150 allowance, 20% off balance over allowance	Up to $75	One pair of frames within a 24 month period for each member covered under the plan.
ontacts			One set of lenses within a 12 month perioc for each member covered under the plan (In lieu of lenses + frames).
Conventional	$0 copay up to $150 allowance, 15% off balance over allowance	Out-of-network up to $120	
Disposable	$0 copay up to $150 allowance	Out-of-network up to $120	
Medically Necessary	Paid in Full	Up to $200	
ens Options			One set of lenses within a 12 month perioc for each member covered under the plan.
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 Additional Copayment	$0 Additional *	
Premium Progressive Lenses (add on to Bifocal)	$65 Additional Copayment, 20% off retail price less $120 allowance	$0 Additional *	
Standard Anti-Reflective Coating	$45 Copayment	Up to $0	
Other Lens Options	20% off retail	N/A	

* $45 maximum reimbursement

iabetic Eye Care *(Care and testing for diabetic members)*			Up to 2 services per year for each listed service.**
Exam	$0	Up to $77	
Retinal Imaging	$0	Up to $50	
Extended Ophthalmoscopy	$0	Up to $15	
Gonioscopy	$0	Up to $15	
Scanning Laser	$0	Up to $33	

**Some or all of the diagnostic services described above will be provided as deemed appropriate, subject to provider determination of ervice necessity and the benefit frequency limitations referenced above.

- 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.
- When applicable benefits are paid after the Copayment listed above and to the allowance listed, members are responsible for amounts above the allowance.
- 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.

Standard Insurance Company
East Tennessee State University GME
Group Policy #165753
Effective Date June 20, 2019

Group Long Term Disability Insurance

Group Long Term Disability insurance from Standard Insurance Company helps provide financial protection for insured members by promising to pay a monthly benefit in the event of a covered disability.

The cost of this insurance is paid by East Tennessee State University GME.

Eligibility

Definition of a Member	You are a member if you are a regular employee of East Tennessee State University GME, actively working at least 40 hours per week, and a citizen or resident of the United States or Canada. You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
Eligibility Waiting Period	The eligibility waiting period varies; contact your human resources representative for details.

Benefits

Monthly Benefit	40 percent of the first $2,500 of monthly predisability earnings, reduced by deductible income (e.g., work earnings, workers' compensation, state disability, etc.)
Maximum Monthly Benefit	$1,000
Minimum Monthly Benefit	$100
Benefit Waiting Period	90 days

Definition of Disability

For the benefit waiting period and the first 24 months that Long Term Disability benefits are payable, you will be considered disabled if, as a result of physical disease, injury, pregnancy or mental disorder:

- You are unable to perform with reasonable continuity the material duties of your own occupation, and
- You suffer a loss of at least 20 percent of your predisability earnings when working in your own occupation.

You are not considered disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license.

After the own occupation period of disability, you will be considered disabled if, as a result of a physical disease, injury, pregnancy or mental disorder, you are unable to perform with reasonable continuity the material duties of any occupation.

Maximum Benefit Period

If you become disabled before age 62, Long Term Disability benefits may continue during disability until age 65. If you become disabled at age 62 or older, the benefit duration is determined by the age when disability begins:

Age	Maximum Benefit Period
62	3 years 6 months
63	3 years
64	2 years 6 months
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69+	1 year

Other Features and Services

- 24 hour coverage, including coverage for work-related disabilities
- Employee Assistance Program
- Lifetime Security Benefit
- Reasonable Accommodation Expense Benefit
- Rehabilitation Incentive Benefit
- Rehabilitation Plan Provision
- Return to Work Incentive
- Survivors Benefit
- Temporary Recovery Provision
- Waiver of Premium while Long Term Disability benefits are payable

This information is only a brief description of the group Long Term Disability insurance policy sponsored by East Tennessee State University GME. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, reduction in benefits, exclusions and when The Standard and East Tennessee State University GME may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those who become insured according to its terms. For more complete details of coverage, contact your human resources representative.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 13271-D-TN-165753 (3/19)

of Tennessee

Pharmacy - Preferred Formulary

Your pharmacy coverage gives you access to an extensive list of prescription drugs to treat a wide range of conditions. You can get these medications at preferred prices from thousands of pharmacies in Tennessee and across the nation, including many national chains and independent pharmacies.

Understanding Your Benefits

It's important to know which drugs your plan covers. Reviewing your pharmacy plan now can help you later when you need to fill a prescription. Your plan uses the Preferred Formulary Guide, which includes a list of all the generic, brand name and specialty drugs your plan covers. It also lists applicable plan details including quantity limits and prior authorization requirements.

View these details by downloading the Preferred formulary at **bcbst.com/PreferredRX**.

You can also call Member Service at the number listed on your Member ID card for questions about the drugs covered under your plan.

To learn about other aspects of your prescription drug coverage, visit the Pharmacy section of BlueAccess℠. You'll need to know your pharmacy network (for example, RX04). You can find this information on your Member ID card.

How Do I Fill My Prescriptions?

To locate a network pharmacy anywhere in the country, you can use the Find a Doctor tool at **bcbst.com**.

of Tennessee

DentalBlue℠

Your benefits give you convenient access to quality dental services. DentalBlue is one of the largest dental PPO (Preferred Provider Organization) networks in Tennessee. Your network includes:

- 3,000+ dentists in Tennessee and bordering counties
- Over 200,000 dental access points across the United States

Pay Less With DentalBlue

Preventive Screenings Are Good For You

Prevention and early detection lead to better health because they can identify dental problems early before they become more serious. Most of our dental plans cover two exams and two cleanings per year as well as one set of bitewing X-rays.

Networks Stretch Your Benefit Dollar

Even though some dental services cost $1,000 or more, most dental plans still have an annual maximum benefit of $1,000. When network dentists discount their fees, you save money.

Check Your Plan Options And Benefits

Review your schedule of benefits in your Evidence of Coverage (EOC)* to see your specific plan option, limits, deductible and coinsurance levels. Not all dental services are covered by these plans. Benefits are arranged in four levels of coverage, A-D.

Note: Services may vary based on your plan or contract. Some plans don't include coverage for all four levels, move services from coverage B to C or have waiting periods.

Coverage A	Diagnostic and preventive services such as exams, cleanings and X-rays
Coverage B	Basic services such as fillings and extractions
Coverage C**	Major restorative services such as crowns, bridges and dentures
Coverage D**	Orthodontic services such as braces and retainers

*If your employer's plan is self-funded, please check with your employer for your EOC.

**Services not available in some plans

What Services Are Covered?

We ask dentists to bill their services based on the completion date. If you're eligible on the completion date, benefits will be provided. If you have a treatment in progress and had coverage with a different carrier, please check with your dentist to see which carrier should receive the bill. The billing date determines which carrier should provide coverage.

If you started orthodontic treatment before the date your BlueCross coverage started, file that claim with your previous carrier. However, any orthodontic services (e.g., monthly adjustment fees) you have after your DentalBlue coverage starts should be filed with us. We'll apply it to the orthodontic maximum.

Know What We'll Pay

With the exception of emergency care, you and your dentist can determine what your dental plan covers — and the amount we'll — before you have treament. We recommend a prior authorization for any service that may cost more than $200.

BlueAccess℠

See the key details and benefits of your plan in BlueAccess. Log in to your personalized, secure member area at bcbst.com /member.

BlueAccess Sections

Homepage – View a snapshot of your benefit information, recent claims, programs and support.

Benefits & Coverage – Get full details on what's covered, who's covered and what you pay for services.

Claims & Balances – Check your claims status and details. Print benefit and claims information. View your benefit maximums and more.

Managing Your Health – Create a personal health profile and browse information designed to help you reach your health and wellness goals (may not be available to members of some self-funded groups).

Find Care – Find a dentist in your network, get answers about dental care expenses – even compare costs.

Account – Set up your account profile, including contact preferences, communication channels, messaging alerts and BlueVoice participation.

Find A Dentist (Or Other Provider) In Your Network

- Using a dentist in your network helps you save money and avoid balance billing
- Visiting a provider outside your network may cost you more

Look for a new dentist at bcbst.com/findadoctor.

- Find a dental provider by clicking on **Browse by Category** then selecting **Dental Care.**

BlueCross BlueShield of Tennessee | 1 Cameron Hill Circle | Chattanooga, TN 37402 | bcbst.com

of Tennessee

Your Vision Coverage

We offer the flexibility of a national network with thousands of eye doctors in both independent practices and retail chains.

Each covered member gets a routine eye exam every 12 months. Exams by network providers include eye dilation as needed, refraction and evaluation for several conditions. If your plan covers routine vision materials, frames, standard lenses or contact lenses are part of your copayments and allowances. To learn more, log in to BlueAccess℠ at bcbst.com/member or call Member Service at the number on the back of your ID card.

How To Use Your Vision Benefits

1 Find A Provider in Your Network

- Visit bcbst.com and click on **Find a Doctor** to begin your search.
- Choose your vision network from the network dropdown list.
- Search for vision providers through the search bar or explore our preselected options.
- You also have access to the following optical retail locations*:

eye | INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION OPTICAL sears optical JCPenney | optical

2 Make An Appointment And Show Your Member ID Card

Once you've chosen a provider, call to make your appointment and confirm they're in your network. Or, stop by one of the many network providers who offer walk-in appointments. Some also have evening and weekend hours to fit your busy schedule.

Check your plan benefits for details on what services are covered and what share of the cost you may owe.

3 Out-Of-Network Benefits

If you visit a provider who isn't in your network, you'll pay in full at the time of your visit and then send us a claim yourself. If you have out-of-network benefits, we'll send you a check for the amount we cover. Check your plan benefit summary for more information. To get a claim form:

- Visit **bcbst.com/visionclaimform**
- Call the Member Service number on your Member ID card

Submit your claim online or mail your claim and detailed receipts to us at:

EyeMed Vision Care
Attn: Out-of-Network Claims
P.O. Box 8504
Mason, OH 45040

Eyeglasses	If your plan includes benefits for frames and lenses, you can use them at any independent or retail providers in our network, or at Glasses.com. GLASSES.COM After you've used up your eyewear benefit, you can get 40% off retail price when you buy extra complete pairs of glasses.*
Contact Lenses	If your plan includes benefits for contact lenses, you can use them at any independent or retail providers in our network, or at ContactsDirect.com. contactsdirect After you've used up your contacts benefit, you can get 15% off conventional contact lenses.**
Diabetic Eye Care	If you have diabetes, you can get up to two extra eye exams each year. Your plan may also include benefits for retinal imaging and additional diabetic testing at no cost to you.***
Non-Covered Items	You can get up to 20% off retail price of vision care items purchased at participating provider locations including non-prescription sunglasses, cleaning supplies and accessories.
Laser Vision Correction	You can get 15% off the regular price and 5% off the promotional price of laser vision correction performed by U.S. Laser Vision Network Providers. Call 1-877-5LASER or visit EyeMedlasik.com for more details.

* Frames, lenses or lens options purchased separately are 20% off retail price.

** Discount doesn't apply to doctor's services or other types of contact lenses.

*** No cost when deemed necessary and performed by an in-network provider.

COMM-699-F (04/19)

of Tennessee

Talk to Doctors Anytime You Need Them

Use PhysicianNow® Powered by MDLive when it's not an emergency, and you can't get to a doctor's office. **And you'll typically pay less than you would for a visit to the office or urgent care clinic.**

Use PhysicianNow for things like:

- Allergies, cold, fever and flu
- Sinus or respiratory issues
- Skin conditions (rashes or insect bites)
- Certain pediatric conditions
- Urinary tract infections
- Constipation or diarrhea
- Earaches
- Nausea and vomiting
- Pink eye

Have your BlueCross Member ID card with you — your doctor will need information from it.

How do I use PhysicianNow?

You can talk with a doctor using your phone, online video chat, or the mobile app.

It's easy to get started.

Register for PhysicianNow by logging in to your BlueAccess℠ account at **bcbst.com/member** and clicking **Talk With a Doctor Now**. Or call **1-888-283-6691**.

Once you register, you can use it anytime. You can also download the app from the App Store® or Google Play®. Search for PhysicianNow, one word.

of Tennessee

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 or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711).

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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.

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

The PhysicianNow program operates subject to state regulation and may not be available in certain states. PhysicianNow phone consultations are available 24/7 while video consultations are available during the hours of 7 a.m. to 9 p.m. seven days a week or by scheduled availability. MDLive is an independent internet-based service that allows consumers to select and interact with independent physicians and other health care providers. For complete terms of use, visit welcome.mdlive.com/terms-of-use.

The App Store is a registered trademark of Apple, Inc. Android is a trademark of Google, Inc.

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

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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)。

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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, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-565-9140 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ 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).

સુચના: 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.

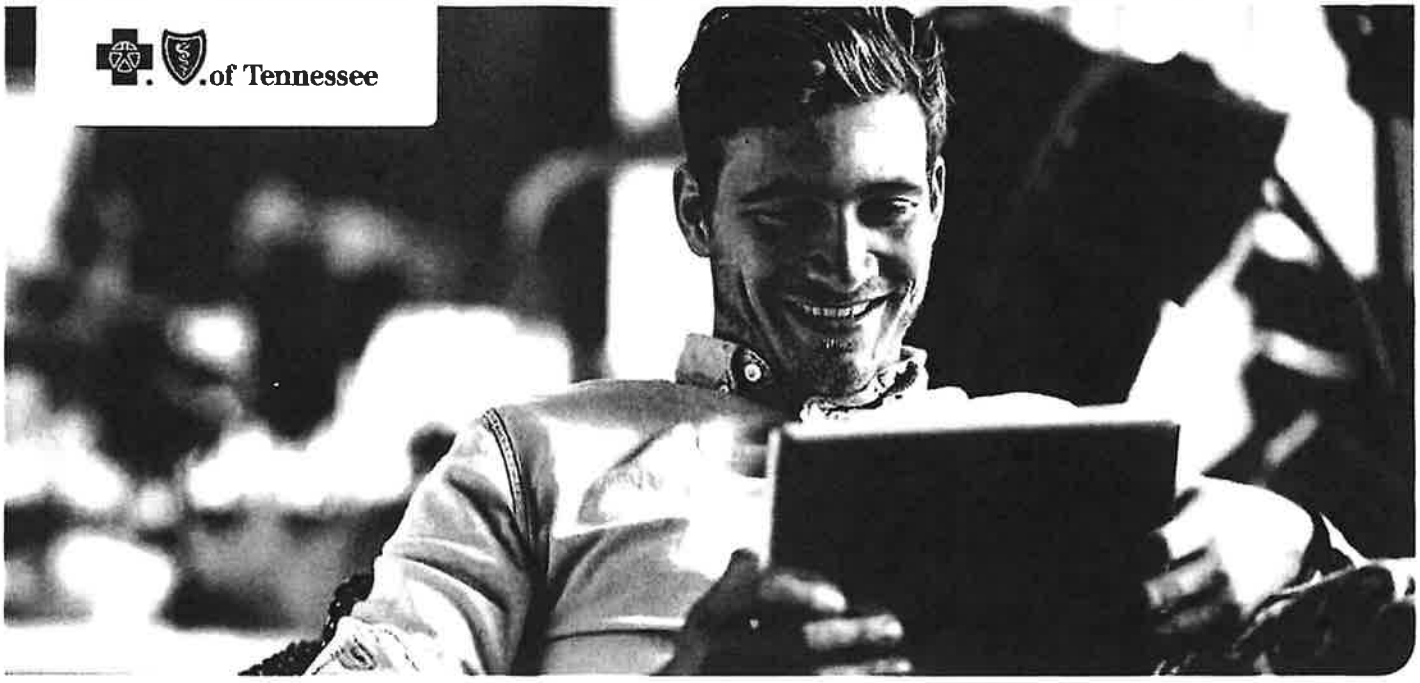
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-565-9140 (TTY: 1-800-848-0298).

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'déé', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-800-565-9140 (TTY: 1-800-848-0298).



See Your Evidence of Coverage at BCBST.com!

If you're new to BlueAccess℠:

Register for BlueAccess (you'll need your Member ID card). If you haven't received your card yet, it should arrive in the next few days. BlueAccess registration will be available the day your coverage starts.

1. **Go to bcbst.com/member**. Select the **Log In or Register** link. Select the Register Now link at the bottom of the **Member Login** box.
2. Enter your subscriber ID, group number, date of birth, and ZIP code. Select Continue.

To complete your registration, verify your identity, and then enter your username, password and credentials. Then agree to the terms of service.

Start here if you have a BlueAccess ID:

View your Evidence of Coverage (EOC).

1. Go to **bcbst.com/member**. Select the **Log In or Register** link. Enter your username and password.
2. Select the **Benefits & Coverage** tab. Select **Benefit Booklets**.

While you're in BlueAccess you can also:

- Find a doctor.
- Look up claims and coverage.
- Take a Personal Health Assessment.
- Check Hospital & Physician Quality.
- Find exclusive Blue365® member discounts.
- Get a temporary Member ID card.
- View current balances.

To request a printed version of your BlueCross BlueShield of Tennessee EOC, please call the phone number on the back of your Member ID card.

of Tennessee

Date: 01-08-2024

Enrollment by Group by Month

East Tennessee State University Residents

Current Period: 01/01/2022 through 12/31/2023

Parent No	Group No	Sub Grp/PlanID/Dept	Year - Month	Contract Description	Sbr Count
612620	140394	Group Level	2022 - 01		
				FAMILY	63
				SUBSCRIBER & SPOUSE	56
				SUBSCRIBER ONLY	118
				SUBSCRIBER & CHILDREN	1
Total for 2022 - 01:					238
612620	140394	Group Level	2022 - 02		
				FAMILY	64
				SUBSCRIBER & SPOUSE	57
				SUBSCRIBER ONLY	116
				SUBSCRIBER & CHILDREN	1
Total for 2022 - 02:					238
612620	140394	Group Level	2022 - 03		
				FAMILY	65
				SUBSCRIBER & SPOUSE	56
				SUBSCRIBER ONLY	116
				SUBSCRIBER & CHILDREN	1
Total for 2022 - 03:					238
612620	140394	Group Level	2022 - 04		
				FAMILY	67
				SUBSCRIBER & SPOUSE	55
				SUBSCRIBER ONLY	115

This report runs using our monthly member summary tables by group. These tables are aggregated at the end of each month for members eligible **as of the end of that month** and grouped by Contract Type.

Parent No	Group No	Sub Grp/PlanID/Dept	Year - Month	Contract Description	Sbr Count
				SUBSCRIBER & CHILDREN	1
Total for 2022 - 04:					238
612620	140394	Group Level	2022 - 05		
				FAMILY	67
				SUBSCRIBER & SPOUSE	55
				SUBSCRIBER ONLY	113
				SUBSCRIBER & CHILDREN	1
Total for 2022 - 05:					236
612620	140394	Group Level	2022 - 06		
				FAMILY	73
				SUBSCRIBER & SPOUSE	68
				SUBSCRIBER ONLY	153
				SUBSCRIBER & CHILDREN	2
Total for 2022 - 06:					296
612620	140394	Group Level	2022 - 07		
				FAMILY	60
				SUBSCRIBER & SPOUSE	60
				SUBSCRIBER ONLY	133
				SUBSCRIBER & CHILDREN	1
Total for 2022 - 07:					254
612620	140394	Group Level	2022 - 08		
				FAMILY	58
				SUBSCRIBER & SPOUSE	61
				SUBSCRIBER ONLY	128
				SUBSCRIBER & CHILDREN	1
Total for 2022 - 08:					248

This report runs using our monthly member summary tables by group. These tables are aggregated at the end of each month for members eligible **as of the end of that month** and grouped by Contract Type.

Parent No	Group No	Sub Grp/PlanID/Dept	Year - Month	Contract Description	Sbr Count
612620	140394	Group Level	2022 - 09		
				FAMILY	55
				SUBSCRIBER & SPOUSE	58
				SUBSCRIBER ONLY	127
				SUBSCRIBER & CHILDREN	1
Total for 2022 - 09:					241
612620	140394	Group Level	2022 - 10		
				FAMILY	56
				SUBSCRIBER & SPOUSE	56
				SUBSCRIBER ONLY	125
				SUBSCRIBER & CHILDREN	1
Total for 2022 - 10:					238
612620	140394	Group Level	2022 - 11		
				FAMILY	56
				SUBSCRIBER & SPOUSE	56
				SUBSCRIBER ONLY	125
				SUBSCRIBER & CHILDREN	1
Total for 2022 - 11:					238
612620	140394	Group Level	2022 - 12		
				FAMILY	55
				SUBSCRIBER & SPOUSE	54
				SUBSCRIBER ONLY	125
				SUBSCRIBER & CHILDREN	1
Total for 2022 - 12:					235
612620	140394	Group Level	2023 - 01		
				FAMILY	57
				SUBSCRIBER & SPOUSE	52

This report runs using our monthly member summary tables by group. These tables are aggregated at the end of each month for members eligible **as of the end of that month** and grouped by Contract Type.

Parent No	Group No	Sub Grp/PlanID/Dept	Year - Month	Contract Description	Sbr Count
				SUBSCRIBER ONLY	123
				SUBSCRIBER & CHILDREN	3
Total for 2023 - 01:					235
612620	140394	Group Level	2023 - 02		
				FAMILY	57
				SUBSCRIBER & SPOUSE	52
				SUBSCRIBER ONLY	123
				SUBSCRIBER & CHILDREN	3
Total for 2023 - 02:					235
612620	140394	Group Level	2023 - 03		
				FAMILY	58
				SUBSCRIBER & SPOUSE	51
				SUBSCRIBER ONLY	123
				SUBSCRIBER & CHILDREN	3
Total for 2023 - 03:					235
612620	140394	Group Level	2023 - 04		
				FAMILY	61
				SUBSCRIBER & SPOUSE	48
				SUBSCRIBER ONLY	123
				SUBSCRIBER & CHILDREN	2
Total for 2023 - 04:					234
612620	140394	Group Level	2023 - 05		
				FAMILY	61
				SUBSCRIBER & SPOUSE	48
				SUBSCRIBER ONLY	123
				SUBSCRIBER & CHILDREN	2
Total for 2023 - 05:					234

This report runs using our monthly member summary tables by group. These tables are aggregated at the end of each month for members eligible **as of the end of that month** and grouped by Contract Type.

of Tennessee

Date: 01-08-2024

Parent No	Group No	Sub Grp/PlanID/Dept	Year - Month	Contract Description	Sbr Count
612620	140394	Group Level	2023 - 06		
				FAMILY	74
				SUBSCRIBER & SPOUSE	57
				SUBSCRIBER ONLY	163
				SUBSCRIBER & CHILDREN	4
Total for 2023 - 06:					298
612620	140394	Group Level	2023 - 07		
				FAMILY	58
				SUBSCRIBER & SPOUSE	45
				SUBSCRIBER ONLY	153
				SUBSCRIBER & CHILDREN	3
Total for 2023 - 07:					259
612620	140394	Group Level	2023 - 08		
				FAMILY	57
				SUBSCRIBER & SPOUSE	45
				SUBSCRIBER ONLY	145
				SUBSCRIBER & CHILDREN	4
Total for 2023 - 08:					251
612620	140394	Group Level	2023 - 09		
				FAMILY	57
				SUBSCRIBER & SPOUSE	44
				SUBSCRIBER ONLY	144
				SUBSCRIBER & CHILDREN	4
Total for 2023 - 09:					249
612620	140394	Group Level	2023 - 10		
				FAMILY	56
				SUBSCRIBER & SPOUSE	44

This report runs using our monthly member summary tables by group. These tables are aggregated at the end of each month for members eligible **as of the end of that month** and grouped by Contract Type.

Parent No	Group No	Sub Grp/PlanID/Dept	Year - Month	Contract Description	Sbr Count
				SUBSCRIBER ONLY	145
				SUBSCRIBER & CHILDREN	4
Total for 2023 - 10:					249
612620	140394	Group Level	2023 - 11		
				FAMILY	56
				SUBSCRIBER & SPOUSE	43
				SUBSCRIBER ONLY	144
				SUBSCRIBER & CHILDREN	4
Total for 2023 - 11:					247
612620	140394	Group Level	2023 - 12		
				FAMILY	59
				SUBSCRIBER & SPOUSE	40
				SUBSCRIBER ONLY	145
				SUBSCRIBER & CHILDREN	4
Total for 2023 - 12:					248

This report runs using our monthly member summary tables by group. These tables are aggregated at the end of each month for members eligible **as of the end of that month** and grouped by Contract Type.

Report Parameters

Parameter	Parameter Selected Value
Medical Group(s):	140394 - East Tennessee State University Residents
Medical Subgroup(s):	No Filter Selected
Medical Plan ID(s):	No Filter Selected
Medical Department(s):	No Filter Selected
Begin Date:	01/01/2022
End Date:	12/31/2023
Parent:	612620
Group By:	Group Level

This report runs using our monthly member summary tables by group. These tables are aggregated at the end of each month for members eligible **as of the end of that month** and grouped by Contract Type.

of Tennessee

Date: 01-19-2024

Dental Claim Payments by Group by Month

East Tennessee State University Residents

Paid Period: 12/01/2021 through 12/31/2023

Department	Paid Month	Paid Claims
No Department		
	Dec 21	$10,491.23
	Jan 22	$5,367.16
	Feb 22	$6,521.60
	Mar 22	$4,755.40
	Apr 22	$5,415.56
	May 22	$5,615.55
	Jun 22	$9,463.01
	Jul 22	$3,981.88
	Aug 22	$4,929.76
	Sep 22	$3,682.44
	Oct 22	$3,652.71
	Nov 22	$4,171.96
	Dec 22	$3,748.18
	Jan 23	$4,269.43
	Feb 23	$8,427.77
	Mar 23	$6,174.81
	Apr 23	$4,418.90
	May 23	$5,998.10
	Jun 23	$5,004.18
	Jul 23	$2,776.63
	Aug 23	$4,792.84
	Sep 23	$2,888.49
	Oct 23	$3,240.83
	Nov 23	$5,953.47
	Dec 23	$5,833.89
Total for No Department:		**$131,575.78**
Totals:		**$131,575.78**

Paid date reports are based on the paid date, rather than the date of service.

Report Parameters

Parameter	Parameter Selected Value
Dental Group(s):	140394 - East Tennessee State University Residents
Dental Subgroup(s):	No Filter Selected
Dental Plan ID(s):	No Filter Selected
Dental Department(s):	No Filter Selected
Claim Date Type:	Paid Dates Only
Claims Lag:	N/A
Begin Date:	12/01/2021
End Date:	12/31/2023
Parent:	612620
Group By:	Plan IDs

Paid date reports are based on the paid date, rather than the date of service.

Claim Payments by Group by Month

East Tennessee State University Residents

Paid Period: 01/01/2022 through 12/31/2023

SubGroup/ PlanID/Dept	Paid Month	Medical	Pharmacy	Total
Group Level				
	Jan 22	$103,535.76	$69,537.18	$173,072.94
	Feb 22	$118,791.54	$63,243.08	$182,034.62
	Mar 22	$123,544.25	$59,116.61	$182,660.86
	Apr 22	$131,323.30	$83,952.19	$215,275.49
	May 22	$73,502.63	$66,950.83	$140,453.46
	Jun 22	$118,448.79	$49,935.59	$168,384.38
	Jul 22	$122,935.19	$54,748.14	$177,683.33
	Aug 22	$53,356.33	$52,853.05	$106,209.38
	Sep 22	$93,886.60	$43,831.60	$137,718.20
	Oct 22	$91,497.20	$44,557.02	$136,054.22
	Nov 22	$111,760.57	$48,682.76	$160,443.33
	Dec 22	$97,186.94	$49,099.09	$146,286.03
	Jan 23	$53,807.69	$29,530.07	$83,337.76
	Feb 23	$99,926.83	$48,443.12	$148,369.95
	Mar 23	$78,072.09	$53,368.94	$131,441.03
	Apr 23	$126,537.95	$82,129.75	$208,667.70
	May 23	$63,458.16	$83,151.71	$146,609.87
	Jun 23	$112,516.95	$91,185.20	$203,702.15
	Jul 23	$61,652.51	$25,682.51	$87,335.02
	Aug 23	$57,640.92	$14,965.88	$72,606.80
	Sep 23	$44,662.78	$52,359.76	$97,022.54
	Oct 23	$71,752.29	$28,538.26	$100,290.55
	Nov 23	$90,678.82	$19,461.65	$110,140.47
	Dec 23	$82,104.17	$14,922.27	$97,026.44
Totals:		**$2,182,580.26**	**$1,230,246.26**	**$3,412,826.52**

Paid date reports are based on the paid date, rather than the date of service.

Report Parameters

Parameter	Parameter Selected Value
Medical Group(s):	140394 - East Tennessee State University Residents
Medical Subgroup(s):	No Filter Selected
Medical Plan ID(s):	No Filter Selected
Medical Department(s):	No Filter Selected
Claim Date Type:	Paid Dates Only
Claims Lag:	N/A
Begin Date:	01/01/2022
End Date:	12/31/2023
Parent:	612620
Group By:	Group Level

Paid date reports are based on the paid date, rather than the date of service.

Fully Insured
SINGLE OPTION – ALTERNATE RATE QUOTE
BLUE NETWORK S

Group Name:	**East Tennessee State University Residents**		**Quote # 54**
Effective Date:	**7/1/2023 - 6/30/2024**		
Mktg. Representative:	**Diana McClurg**	Rep. #	**332**
Broker Name:	**Torbett, Hanes Lancaster**	Region	**2**

PPO CONTRACTS	Individual	Ee-Spouse	Ee-Children	Family	Total
	126	57	1	59	**243**

PPO RATES

2-Tier		Individual	Family
PPO Plan	**Coinsurance**	$304.80	$786.60
Mental Health / SA	**Unltd/Parity – IP only Prior Auth**	6.81	17.57
Prescription Drug Card	**$10/$10/$45/$90**	121.27	312.96
Special Accident	**None**	-	-
Vision Care Rider	**None**	-	-
COBRA Admin.	**Admin w/ Notify**	0.63	0.63
Other	**None**	-	-
Other	**None**	-	-
Total		$433.51	$1,117.76

In Network Benefits	
Deductible	$500
Out-of-Pocket	$1,500
Coinsurance	80%
Office Visit	Ded/Coins
Specialist Office Visit	Ded/Coins
Out-Patient Surgery	Ded/Coins
Emergency Room	$300
Inpatient	Ded/Coins

Comments:
- 50% of net eligible employees must be enrolled (employees w/ other coverage are excluded from the calculation). Employer is required to contribute a minimum of 50% of the individual rate for each employee.
- Benefits are based on standard BlueCross products.

- Commission Disclosure: The rates presented in this proposal include BlueCross' distribution costs. If you use a broker, those costs are paid to the broker as commissions and may include additional compensation. If applicable, your broker can answer any questions you may have regarding commissions.
-

- BlueCross assumes that your plan meets the requirements to be considered Minimum Essential Coverage. If this is not accurate, please inform us immediately. The Minimum Value (MV) statement included on this plan's SBC is based on proposed rules, the MV calculator on the CMS website, and benefits administered by BlueCross. The determination of MV is ultimately an employer or plan sponsor responsibility. You may contact a third party, such as an actuarial consulting firm, for a review if you disagree with our indication.

- BlueCross does not conduct nondiscrimination testing required pursuant to IRS rules.

Essential Health Benefits: No	Minimum Essential Coverage: Yes	Meets Minimim Value: Yes
PPO IER Retention: 16.70%		Monthly Premium: $ 185,400
Underwriter: JoAnne Weddington		Date: 4/7/2023

Rating Proposal Terms & Conditions (IER)

PROPOSAL TERMS AND CONDITIONS for Rating:

I.	**General Terms and Caveats of Rating Offer**
BlueCross may revise or withdraw the Rating Proposal if:	
A.	The policy is not domiciled in TN.
B.	The plan of benefits is different than shown on the rate sheet above.
C.	There is a change in any law, regulation, or required assessment or tax that changes BlueCross costs in offering the plan.
D.	Enrollment increases or decreases by 10% or more, by product or for the total account, from the enrollment assumptions used in establishing the rates, fees, funds and/or fee credits set forth herein.
E.	If additional locations are added or locations are terminated during the rate development phase and/or contract year.
F.	The final enrollment deviates from the quoted enrollment such that it results in a needed change in premium rates. Rates are based on final enrollment factors, including total number of enrollees, their age, sex, demographics, location and the distribution of enrollees by product or by customer tier.
G.	Upon 30 days written notice, if any of the information upon which these rates or benefits were based (including Medical History Information) materially changes or is reasonably determined by the Plan to be inaccurate.
H.	It is not the exclusive provider of Medical / Pharmacy or like products.
I.	The employer changes its level of contribution toward the cost of the coverage.
J.	Federal, State or Local action impacts the benefit levels quoted herein or affects our ability to meet our obligations to you, to your covered employees/our customers or to our contracted providers. By way of illustration, such legislation or executive actions which impose controls or requirements that affect: our ability to determine rates; covered medical expenses or service benefits; providers' delivery of care or the fees they charge; or our contracts with providers, may be deemed to so affect our contractual obligations. Should this happen, BlueCross will make a good faith effort to work to reach a new agreement that equitably reflects the circumstances as altered by government action.
K.	There is a change in reimbursement arrangement ("gap" plan, etc.) that subsidizes or reduces the out-of-pocket obligation of covered persons under the policy.
L.	Client confirmation of employee counts reveal the group to be a Small Employer, as defined under the Patient Protection and Affordable Care Act
M.	Group carves out pharmacy, behavioral health, or any core insurance function.
II.	**Coverage Assumptions**
Unless otherwise noted, the coverage reflected in this Rating Proposal:	
A.	Assumes that any insurance policy, certificate/booklet, or summary plan description material will be made available to the policyholder electronically.
B.	Excludes charges for converting a qualified customer of a group plan to an individual plan.
C.	Requires you notify us within 30 days if any information set forth in this exhibit changes at any time while coverage is provided to you by BlueCross.
D.	Allows caveats and conditions set forth in this document to survive execution of any final contract and/or issuance by BlueCross of any policy and/or Group Service Agreement.
E.	Is a high-level summary of the proposed coverage. It does not identify all the categories of health care expenses that are covered or excluded.
F.	Effective Case Management requires the BlueCross Case Managers have sufficient engagement and contact information for those members identified and/or actively engaged in Case Management programs.

Completed

	A	B	C	D	E
1		Gender	Coverage	Birth Date	Zip Code
2	$ 69,218.04	Male	Single	7/25/1991	37604
3	$ 61,960.80	Male	Family	2/20/1996	37604
4	$ 61,960.80	Male	Family	4/24/1993	37604
5	$ 58,084.32	Male	Single	12/12/1994	37601
6	$ 58,084.32	Male	Family	2/2/1995	37601
7	$ 59,820.00	Male	Single	9/12/1996	37604
8	$ 61,960.80	Male	Single	12/30/1994	37604
9	$ 66,687.12	Male	Single	4/15/1995	37601
10	$ 58,084.32	Male	Family	2/25/1996	37615
11	$ 58,084.32	Male	Single	1/1/1990	37604
12	$ 61,960.80	Male	Single	9/13/1994	37604
13	$ 59,820.00	Male	Single	8/22/1996	37604
14	$ 58,084.32	Male	Single	9/30/1997	37604
15	$ 58,084.32	Male	Family	1/2/1992	37659
16	$ 58,084.32	Male	Family	8/28/1981	37604
17	$ 58,084.32	Female	Single	8/11/1996	37615
18	$ 58,084.32	Female	Single	12/26/1985	37615
19	$ 61,960.80	Female	Single	2/26/1987	37620
20	$ 61,960.80	Male	Single	1/31/1995	37659
21	$ 61,960.80	Female	Single	10/5/1995	37615
22	$ 59,820.00	Male	Family	2/20/1993	24221
23	$ 69,218.04	Female	Single	9/2/1991	37643
24	$ 59,820.00	Male	No Coverage	10/12/1994	24221
25	$ 64,329.84	Male	Family	8/19/1993	37664
26	$ 61,960.80	Female	Family	1/13/1997	37604
27	$ 58,084.32	Female	Family	8/12/1992	37604
28	$ 61,960.80	Female	Family	7/1/1995	37615
29	$ 58,084.32	Female	Single	8/9/1997	37604
30	$ 61,960.80	Male	Single	1/12/1995	37643
31	$ 64,329.84	Female	Single	7/24/1992	37615
32	$ 59,820.00	Female	Single	11/26/1989	37615
33	$ 64,329.84	Male	Single	6/15/1986	37604
34	$ 69,218.04	Male	Family	7/22/1989	67228
35	$ 64,329.84	Female	Family	5/20/1992	37604
36	$ 58,084.32	Female	Single	4/30/1997	37663
37	$ 61,960.80	Female	Single	2/19/1993	37604
38	$ 59,820.00	Male	Single	9/11/1994	37660
39	$ 58,084.32	Male	Single	6/19/1990	37614
40	$ 58,084.32	Female	No Coverage	12/16/1987	37604
41	$ 58,084.32	Female	Family	9/8/1988	37659
42	$ 59,820.00	Male	Single	5/30/1992	37615
43	$ 64,329.84	Male	Family	5/17/1994	37620
44	$ 58,084.32	Female	Single	9/3/1993	37615
45	$ 64,329.84	Male	Family	2/3/1993	37643
46	$ 59,820.00	Female	Single	5/1/1995	37604

	A	B	C	D	E
47	$ 58,084.32	Male	Single	12/20/1994	37604
48	$ 61,960.80	Male	Family	8/22/1990	37604
49	$ 66,687.12	Male	Single	9/14/1993	37604
50	$ 64,329.84	Male	Family	3/27/1990	37604
51	$ 61,960.80	Male	Single	4/11/1996	37601
52	$ 58,084.32	Female	No Coverage	7/6/1994	37604
53	$ 59,820.00	Male	Family	10/14/1993	37604
54	$ 59,820.00	Male	Family	10/28/1983	37604
55	$ 59,820.00	Male	Single	8/4/1990	37604
56	$ 61,960.80	Male	Family	4/4/1985	37601
57	$ 69,218.04	Male	Family	12/25/1985	37604
58	$ 59,820.00	Female	Single	5/3/1993	37604
59	$ 66,687.12	Female	Family	5/13/1992	37601
60	$ 61,960.80	Female	Single	4/29/1995	37604
61	$ 48,000.00	Male	Family	2/14/1994	37604
62	$ 64,329.84	Female	Family	12/12/1993	37604
63	$ 59,820.00	Male	Single	8/7/1995	37601
64	$ 58,084.32	Male	Single	2/23/1992	37601
65	$ 61,960.80	Male	Single	4/28/1996	37604
66	$ 58,084.32	Male	Single	12/11/1996	37604
67	$ 58,084.32	Male	Single	6/6/1989	37604
68	$ 66,687.12	Female	Family	11/9/1991	37601
69	$ 48,000.00	Female	Single	12/7/1996	37604
70	$ 58,084.32	Male	Single	12/7/1990	37660
71	$ 66,687.12	Male	Family	12/17/1989	37601
72	$ 64,329.84	Male	Family	9/18/1987	37615
73	$ 58,084.32	Male	Family	6/29/1996	37601
74	$ 59,820.00	Male	Single	4/9/1998	37604
75	$ 58,084.32	Female	Family	3/28/1996	37711
76	$ 58,084.32	Male	Single	9/25/1992	37660
77	$ 61,960.80	Male	Single	7/4/1990	37659
78	$ 59,820.00	Male	Single	12/2/1993	37811
79	$ 58,084.32	Male	Single	9/26/1995	37604
80	$ 61,960.80	Female	Single	7/14/1994	37604
81	$ 59,820.00	Female	No Coverage	11/16/1994	37604
82	$ 59,820.00	Female	Family	6/16/1993	37601
83	$ 61,960.80	Female	Family	10/22/1994	37663
84	$ 58,084.32	Female	Single	10/25/1996	37604
85	$ 61,960.80	Male	Family	1/25/1992	37604
86	$ 59,820.00	Male	Single	5/21/1993	37620
87	$ 58,084.32	Male	Single	9/2/1997	37601
88	$ 64,329.84	Male	Single	3/21/1991	37604
89	$ 61,960.80	Female	Family	4/24/1994	37664
90	$ 59,820.00	Female	Family	3/1/1996	37615
91	$ 61,960.80	Female	Family	10/12/1994	37604
92	$ 59,820.00	Male	Ssingle	8/4/1992	37604

	A	B	C	D	E
93	$ 58,084.32	Female	Family	3/7/1996	37659
94	$ 59,820.00	Female	Single	11/24/1994	37664
95	$ 66,687.12	Male	Family	12/4/1989	37659
96	$ 64,329.84	Female	Family	1/31/1979	37604
97	$ 58,084.32	Male	Family	3/18/1985	37604
98	$ 61,960.80	Female	Single	7/19/1995	37604
99	$ 66,687.12	Female	Single	4/2/1993	37604
100	$ 59,820.00	Male	Family	11/12/1995	37660
101	$ 69,218.04	Female	Single	5/13/1991	37604
102	$ 59,820.00	Male	Family	6/2/1992	37604
103	$ 64,329.84	Female	Family	4/28/1989	37604
104	$ 61,960.80	Female	Single	4/17/1992	37604
105	$ 61,960.80	Male	Single	11/11/1993	37604
106	$ 61,960.80	Female	Single	10/13/1992	37604
107	$ 64,329.84	Female	Family	8/7/1986	37604
108	$ 59,820.00	Male	Family	7/5/1996	37615
109	$ 64,329.84	Male	Single	7/1/1995	37604
110	$ 61,960.80	Male	Single	5/5/1994	37604
111	$ 66,687.12	Male	Family	12/15/1992	37601
112	$ 64,329.84	Male	Single	2/2/1991	37604
113	$ 59,820.00	Female	Single	2/28/1996	37604
114	$ 59,820.00	Female	Single	12/6/1995	37659
115	$ 58,084.32	Male	Family	5/13/1996	37659
116	$ 58,084.32	Female	Single	12/7/1995	37620
117	$ 59,820.00	Female	Single	7/28/1992	37601
118	$ 61,960.80	Female	Single	12/23/1994	37660
119	$ 64,329.84	Female	Single	1/16/1984	37604
120	$ 64,329.84	Male	Family	8/25/1993	37604
121	$ 58,084.32	Male	Family	12/16/1992	37601
122	$ 59,820.00	Female	Single	8/12/1994	37604
123	$ 61,960.80	Female	Single	8/12/1994	37604
124	$ 69,218.04	Male	Single	9/10/1989	37615
125	$ 58,084.32	Female	Single	8/4/1996	37601
126	$ 64,329.84	Female	Single	11/29/1993	37604
127	$ 59,820.00	Male	Family	10/8/1986	37604
128	$ 58,084.32	Female	Family	6/17/1994	37617
129	$ 61,960.80	Female	Single	2/7/1995	37604
130	$ 61,960.80	Female	Single	12/17/1990	37604
131	$ 64,329.84	Male	Family	9/3/1989	37604
132	$ 61,960.80	Male	Family	12/9/1986	37664
133	$ 58,084.32	Male	Single	3/28/1992	37601
134	$ 58,084.32	Female	Single	11/14/1996	37604
135	$ 59,820.00	Male	Family	1/11/1996	37660
136	$ 69,218.04	Male	Single	6/25/1987	37604
137	$ 58,084.32	Male	Single	10/5/1991	37604
138	$ 61,960.80	Female	Family	5/27/1993	37601

	A	B	C	D	E
139	$ 66,687.12	Male	Family	7/28/1987	37664
140	$ 66,687.12	Male	Single	4/21/1993	37604
141	$ 59,820.00	Male	Single	7/28/1997	37604
142	$ 66,687.12	Male	Family	9/15/1992	37604
143	$ 59,820.00	Male	Single	11/20/1993	37604
144	$ 66,687.12	Male	Single	11/30/1990	37604
145	$ 61,960.80	Male	Family	10/11/1993	37604
146	$ 58,084.32	Female	Single	9/14/1997	37604
147	$ 59,820.00	Female	Family	7/13/1993	37604
148	$ 58,084.32	Male	Single	8/21/1995	37604
149	$ 61,960.80	Female	Family	1/11/1990	37660
150	$ 64,329.84	Male	Single	2/14/1994	37604
151	$ 58,084.32	Female	Single	6/7/1995	37615
152	$ 58,084.32	Male	Family	4/18/1996	37604
153	$ 59,820.00	Female	Family	7/25/1994	37643
154	$ 61,960.80	Female	Family	5/9/1987	37604
155	$ 64,329.84	Female	Single	10/17/1990	37604
156	$ 61,960.80	Male	Single	10/21/1992	37604
157	$ 59,820.00	Male	Single	3/14/1995	37604
158	$ 64,329.84	Female	Single	5/9/1991	37604
159	$ 58,084.32	Female	Single	9/18/1997	37615
160	$ 59,820.00	Male	Single	6/8/1996	37604
161	$ 58,084.32	Male	Single	5/14/1993	37659
162	$ 59,820.00	Male	Single	8/29/1996	37604
163	$ 58,084.32	Male	Single	6/29/1996	37659
164	$ 66,687.12	Female	Family	10/3/1983	37760
165	$ 58,084.32	Female	Single	5/7/1994	37604
166	$ 61,960.80	Female	Family	12/6/1987	37615
167	$ 59,820.00	Male	Single	7/21/1991	37604
168	$ 58,084.32	Male	Single	1/25/1990	37660
169	$ 61,960.80	Female	Family	8/17/1994	37615
170	$ 59,820.00	Female	Single	1/24/1993	37660
171	$ 59,820.00	Male	Single	8/4/1990	37601
172	$ 58,084.32	Male	Family	4/15/1988	37604
173	$ 58,084.32	Male	Family	9/1/1995	37659
174	$ 59,820.00	Male	Family	3/29/1992	37659
175	$ 61,960.80	Male	Family	6/16/1992	37604
176	$ 61,960.80	Male	Family	12/7/1988	37604
177	$ 66,687.12	Female	Family	6/10/1987	37604
178	$ 58,084.32	Male	Family	11/12/1990	37620
179	$ 61,960.80	Male	Family	10/20/1989	37618
180	$ 59,820.00	Female	Single	3/22/1996	37660
181	$ 58,084.32	Female	No Coverage	3/13/1985	37601
182	$ 66,687.12	Female	Single	6/28/1991	37604
183	$ 64,329.84	Male	No Coverage	2/10/1987	37601
184	$ 61,960.80	Female	Family	4/5/1993	37663

	A	B	C	D	E
185	$ 61,960.80	Male	Single	11/27/1995	37604
186	$ 59,820.00	Male	Family	3/30/1995	37620
187	$ 61,960.80	Female	Single	3/12/1992	37604
188	$ 58,084.32	Female	Single	5/25/1995	37620
189	$ 66,687.12	Female	Single	2/3/1993	37604
190	$ 58,084.32	Female	Single	6/17/1997	37615
191	$ 59,820.00	Male	Single	2/14/1994	37601
192	$ 61,960.80	Male	Single	9/4/1989	37604
193	$ 66,687.12	Male	Family	9/27/1989	37615
194	$ 59,820.00	Female	Single	1/26/1996	37604
195	$ 61,960.80	Male	Family	2/14/1976	37604
196	$ 58,084.32	Female	Single	6/16/1995	37601
197	$ 59,820.00	Male	Single	3/13/1994	37620
198	$ 59,820.00	Female	Single	3/15/1996	37601
199	$ 61,960.80	Female	Single	12/28/1993	37601
200	$ 61,960.80	Female	Single	4/13/1996	37659
201	$ 59,820.00	Male	Single	4/26/1996	37604
202	$ 59,820.00	Male	Single	8/24/1993	37604
203	$ 59,820.00	Male	Family	10/23/1995	37643
204	$ 59,820.00	Male	Family	5/24/1996	37640
205	$ 58,084.32	Male	Family	4/27/1994	37604
206	$ 59,820.00	Male	Family	10/21/1993	37643
207	$ 58,084.32	Male	Family	5/11/1994	37601
208	$ 61,960.80	Female	Family	9/28/1995	37604
209	$ 59,820.00	Male	Single	4/29/1994	37604
210	$ 64,329.84	Male	Single	9/26/1985	37604
211	$ 61,960.80	Male	Family	11/29/1991	37642
212	$ 64,329.84	Male	Family	7/2/1992	37604
213	$ 61,960.80	Female	Single	2/11/1995	37660
214	$ 64,329.84	Female	Single	4/20/1995	24210
215	$ 59,820.00	Male	Single	2/23/1996	37601
216	$ 59,820.00	Female	Single	9/27/1991	37615
217	$ 59,820.00	Male	Family	12/30/1995	37604
218	$ 61,960.80	Male	Single	9/21/1994	37604
219	$ 58,084.32	Female	Family	6/8/1996	24201
220	$ 59,820.00	Male	Single	10/10/1994	37664
221	$ 61,960.80	Female	Single	2/9/1995	37664
222	$ 58,084.32	Female	Family	3/15/1986	37604
223	$ 58,084.32	Male	Single	5/12/1995	37604
224	$ 64,329.84	Female	Single	2/8/1994	37615
225	$ 58,084.32	Female	Single	10/29/1995	37659
226	$ 58,084.32	Female	Single	4/13/1995	37604
227	$ 61,960.80	Male	Single	6/27/1994	37604
228	$ 64,329.84	Male	Family	5/18/1989	37604
229	$ 61,960.80	Female	Family	3/11/1995	37620
230	$ 61,960.80	Female	Single	8/8/1990	37604

	A	B	C	D	E
231	$ 59,820.00	Female	Single	7/7/1996	37659
232	$ 59,820.00	Male	Single	12/4/1995	37601
233	$ 58,084.32	Female	Family	7/31/1995	37664
234	$ 61,960.80	Male	Family	5/7/1983	37604
235	$ 58,084.32	Male	Family	3/18/1992	37659
236	$ 59,820.00	Male	Family	8/24/1993	37659
237	$ 58,084.32	Male	Single	11/28/1992	37604
238	$ 58,084.32	Female	Single	7/14/1986	37660
239	$ 59,820.00	Male	Single	6/10/1994	37604
240	$ 58,084.32	Male	Single	4/6/1986	37620
241	$ 69,218.04	Female	Family	7/15/1987	37604
242	$ 64,329.84	Female	Family	3/8/1989	37604
243	$ 61,960.80	Male	Family	8/30/1988	37604