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](http://www.ccciio.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](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

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Why This Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>In-network: $500 person/$1,500 family</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Out-of-network: $500 person/$1,500 family</td>
<td></td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Preventive services, Prescriptions drugs, and Emergency room visits are covered before you meet your deductible (unless specified).</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>In-network: $1,500 person/$4,500 family</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Out-of-network: $3,000 person/$9,000 family</td>
<td></td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premium, balance-billing charges, penalties, and health care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
</tbody>
</table>
### Important Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. This plan uses Network S. See <a href="http://www.bcbst.com/Network-S">http://www.bcbst.com/Network-S</a> or call 1-800-565-9140 for a list of in-network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

---

**Important Questions and Answers**

- **Will you pay less if you use a network provider?**
  - Yes. This plan uses Network S. See [http://www.bcbst.com/Network-S](http://www.bcbst.com/Network-S) or call 1-800-565-9140 for a list of in-network providers.

- **Why This Matters:**
  - 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.

---

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

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay In-Network Provider (You will pay the least)</th>
<th>What You Will Pay Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>Teladoc Health: 20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>30% coinsurance</td>
<td>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.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>Prior Authorization required. Your cost share may increase to 50% if not obtained.</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Preferred Generic drugs / Non-Preferred Generic drugs</td>
<td>$10 copay/prescription deductible does not apply.</td>
<td>30% coinsurance</td>
<td>30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network Copayment per 30 day supply.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$45 copay/prescription deductible does not apply.</td>
<td>30% coinsurance</td>
<td>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</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$90 copay/prescription deductible does not apply.</td>
<td>30% coinsurance</td>
<td>30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network Copayment per 30 day supply.</td>
</tr>
</tbody>
</table>

---

More information about prescription drug coverage is available at [www.bcbst.com/rxp](http://www.bcbst.com/rxp)
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$180 copay/prescription deductible does not apply.</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Preferred Specialty drugs / Non-Preferred Specialty drugs</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Emergency room care</td>
<td>$300 copay/visit deductible does not apply.</td>
<td>$300 copay/visit deductible does not apply.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Outpatient services</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>$200 copay</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$25 copay/visit</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$25 copay/visit</td>
<td>30% coinsurance</td>
</tr>
</tbody>
</table>

- **Preferred Specialty drugs / Non-Preferred Specialty drugs**
  - $180 copay/prescription deductible does not apply.
  - Up to a 30 day supply. Must use a pharmacy in the Preferred Specialty Pharmacy Network.
- **Facility fee (e.g., ambulatory surgery center)**
  - 20% coinsurance
  - Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained.
- **Physician/surgeon fees**
  - 20% coinsurance
  - Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained.
- **Emergency room care**
  - $300 copay/visit deductible does not apply.
  - Prior Authorization required. Your cost share may increase to 50% if not obtained.
- **Emergency medical transportation**
  - 20% coinsurance
  - None
- **Urgent care**
  - 20% coinsurance
  - None
- **Outpatient services**
  - 20% coinsurance
  - Prior Authorization required for electro-convulsive therapy (ECT). Your cost share may increase to 50% if not obtained.
- **Inpatient services**
  - 20% coinsurance
  - Prior Authorization required. Your cost share may increase to 50% if not obtained.
- **Office visits**
  - 20% coinsurance
  - Teladoc Health: 20% coinsurance
- **Childbirth/delivery professional services**
  - $200 copay
  - Global Maternity Care - $200 copay per pregnancy
- **Childbirth/delivery facility services**
  - 20% coinsurance
  - None
- **Home health care**
  - 20% coinsurance
  - Unlimited
- **Rehabilitation services**
  - $25 copay/visit
  - Therapy limited to 60 visits per type per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
- **Habilitation services**
  - $25 copay/visit
  - Therapy limited to 60 visits per type per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
### Common Medical Event Services You May Need

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>Skilled nursing and rehabilitation facility limited to 100 days combined per year.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>30% coinsurance</td>
<td>Prior Authorization may be required for certain durable medical equipment. Your cost share may increase to 50% if not obtained.</td>
</tr>
<tr>
<td>Hospice services</td>
<td>No Charge</td>
<td>30% coinsurance</td>
<td>Prior Authorization required for inpatient hospice. Your cost share may increase to 50% if not obtained.</td>
</tr>
</tbody>
</table>

#### If your child needs dental or eye care
- Children’s eye exam: Not Covered
- Children’s glasses: Not Covered
- Children’s dental check-up: Not Covered

### 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
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Children)
- Routine foot care for non-diabetics
- 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](http://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](http://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](http://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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
<tr>
<td><strong>The plan’s overall deductible</strong></td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td><strong>Specialist coinsurance</strong></td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Other coinsurance</strong></td>
<td>20%</td>
<td>20%</td>
</tr>
</tbody>
</table>

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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$40</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What isn’t covered</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits or exclusions</td>
<td>$20</td>
</tr>
</tbody>
</table>

**The total Peg would pay** | $1,520

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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$900</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$50</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What isn’t covered</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits or exclusions</td>
<td>$30</td>
</tr>
</tbody>
</table>

**The total Joe would pay** | $1,480

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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$800</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$200</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What isn’t covered</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limits or exclusions</td>
<td>$0</td>
</tr>
</tbody>
</table>

**The total Mia would pay** | $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).

Language Access Services:


أتمنى أن تكون هذه اللغةً، فإن خدمات المساعدة اللغوية تتوفر لك بالفعل. اتصل رقم 800-565-9140 (ارقم هاتف الصم والكم: 800-848-0298-1)

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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)。

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).


¡ATENCIÓN!: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 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。


注意事項：如果您在粵語，可以使用免費的語言支援服務。請致電 1-800-565-9140 (TTY:1-800-848-0298)。

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

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


# Benefit Summary

## Option: 1

<table>
<thead>
<tr>
<th>Benefit Plan Features</th>
<th>Your Cost In-Network</th>
<th>Your Cost Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual/Family</td>
<td>$500 / $1,500</td>
<td>$500 / $1,500</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(includes copay, coinsurance and deductibles)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual/Family</td>
<td>$1,500 / $4,500</td>
<td>$3,000 / $9,000</td>
</tr>
</tbody>
</table>

## 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: 20% after deductible, 30% after deductible
- Routine Diagnostic Lab, X-Ray & Injections: 20% after deductible, 30% after deductible
- Advanced Radiological Imaging: 20% after deductible, 30% after deductible
- Teladoc Health Virtual Care: 20% after deductible, Not Covered

### Services Received at a Facility
- (includes professional and facility charges)
  - Inpatient Services: 20% after deductible, 30% after deductible
  - Outpatient Surgery: 20% after deductible, 30% after deductible
  - Routine Diagnostic Services - Outpatient: 20% after deductible, 30% after deductible
  - Advanced Radiological Imaging - Outpatient: 20% after deductible, 30% after deductible
  - Other Outpatient Services: 20% after deductible, 30% after deductible
  - Urgent Care Center Services: 20% after deductible, 30% after deductible
  - Emergency Care Services: $300 copay, $300 copay
  - Emergency Care Advanced Radiological Imaging: 20% after deductible, 20% after deductible

### Medical Equipment Services
- Durable Medical Equipment: 20% after deductible, 30% after deductible
- Prosthetic or Orthotics: 20% after deductible, 30% after deductible
- Hearing Aids: 20% after deductible, 30% after deductible

### Behavioral Health Services
- Inpatient: Unlimited days per annual benefit period: 20% after deductible, 30% after deductible
- Outpatient: Unlimited visits per annual benefit period: 20% after deductible, 30% after deductible
- Therapeutic Services: $25 copay, 30% after deductible

### Skilled Nursing & Rehabilitation Facility Services
- Limited to 100 days combined per annual benefit period: 20% after deductible, 30% after deductible

### Home Health Care Services
- 20% after deductible, 30% after deductible

### Hospice Services
- Inpatient: Covered at 100%, 30% after deductible
- Outpatient: Covered at 100%, 30% after deductible

### Ambulance Services
- 20% after deductible, 20% after deductible

### Prescription Drugs
- Covered at 100%, 30% after deductible

### Prescription Contraceptives
- Covered at 100%, 30% after deductible

### Retail RX03 Network up to 30 day supply
- Preferred Generic: $10 copay, 30% after deductible
- Non-Preferred Generic: $10 copay, 30% after deductible
- Preferred Brand: $45 copay, 30% after deductible
- Non-Preferred Brand: $90 copay, 30% after deductible
<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plus90 or Home Delivery Network up to 90 day supply</td>
<td>Preferred Generic $30 copay</td>
<td>30% after deductible</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Generic $30 copay</td>
<td>30% after deductible</td>
</tr>
<tr>
<td></td>
<td>Preferred Brand $135 copay</td>
<td>30% after deductible</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Brand $270 copay</td>
<td>30% after deductible</td>
</tr>
<tr>
<td>Self-Administered Specialty Drugs</td>
<td>Preferred Specialty Drugs $180 copay</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Specialty Drugs $180 copay</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Provider-Administered Specialty Drugs</td>
<td>$180 copay</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

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 emergency care services received at an out-of-network facility, covered items and services received from an out-of-network provider at an in-network facility (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 per therapy type 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. You must use one of the Specialty Pharmacy Network providers listed on www.bcbst.com/rx to receive benefits for self-administered specialty drugs, and 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. Use Teladoc Health’s virtual care platform to access doctors or professionals for 24/7 urgent care, mental health care, dermatology services, and more. Visit www.bcbst.com/teladoc or call 1-800-TELADOC (1-800-835-2362) 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 your health care plan benefits. Your Evidence of Coverage (EOC) defines the full terms and conditions, limitations, and exclusions in greater detail. Should any questions arise concerning benefits, the EOC will govern.
### Summary of Preventive Care Services

**Covered at 100% In-Network**

<table>
<thead>
<tr>
<th>In-network preventive care services that are covered with no member cost share include, but are not limited to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Primary care services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF)</td>
</tr>
<tr>
<td>• Immunizations recommended by the Advisory Committee on Immunization Practices that have been adopted by the Centers for Disease Control and Prevention (CDC)</td>
</tr>
<tr>
<td>• Bright Futures recommendations for infants, children and adolescents that are supported by the Health Resources and Services Administration (HRSA)</td>
</tr>
<tr>
<td>• Preventive care and screening for women as provided in the guidelines supported by HRSA</td>
</tr>
</tbody>
</table>

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 iron deficiency, bacteriuria, hepatitis B virus, Rh factor incompatibility, gestational diabetes
- Breastfeeding support/counseling & supplies, including lactation support services and counseling by a trained provider and one 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 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 &quot;Nondiscrimination Grievance&quot;). 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, Office Operations, Member Benefits Administration, 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 561-9208 (fax); Nondiscrimination: OfficeGM@bcbs.com (email).


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.

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Dí bá ‘a fúr ní níng: Dí saad bee yánítt’ço fíné bázag, saad bee akánzé awo jëf, (‘áa jikènh, ën na hólà, koi’ hodilinh 1-800-565-9140 (TTY: 1-800-848-0298)).
# Dental Option: 1
## Effective Date: July 1, 2023

### Deductible Calendar Year
- Applies to Coverage B and C only

<table>
<thead>
<tr>
<th></th>
<th>Individual In-Network</th>
<th>Individual Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
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<td>$50</td>
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</tbody>
</table>

### Benefit Maximums
- Applies to Coverage B and C (per Calendar Year)
- Coverage D (per Lifetime)

<table>
<thead>
<tr>
<th></th>
<th>Individual In-Network</th>
<th>Individual Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

### Benefit Percentages apply to
- Any Dentist*

### Covered Services
#### Coverage A
- Exams, X-rays
- Cleanings, Fluoride
- Sealants, Space Maintainers

<table>
<thead>
<tr>
<th></th>
<th>Benefit Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100%</td>
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</tbody>
</table>

#### Coverage B
- Basic Restorative Services
- Basic Endodontics
- Basic Oral Surgery

<table>
<thead>
<tr>
<th></th>
<th>Benefit Percentages</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>80%</td>
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</tbody>
</table>

#### Coverage C
- Major Restorative and Prosthodontics
- Basic and Major Periodontics
- Major Endodontics
- Major Oral Surgery
- Implants

<table>
<thead>
<tr>
<th></th>
<th>Benefit Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>50%</td>
</tr>
</tbody>
</table>

#### Coverage D
- Orthodontics-Child to age 18

<table>
<thead>
<tr>
<th></th>
<th>Benefit Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>12 month Waiting Period</td>
</tr>
</tbody>
</table>

### 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

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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.

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COVERED SERVICES AND EXCLUSIONS

BASICS
Covered: One periodontal examination in any 6-month period. One limited oral evaluation in any 12-month period. One comprehensive, detailed/extended, or periodontal exam in any 24-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-rays. 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: Extracural, skull and bone, sialography, temporomandibular joint dysfunction (TMJ), and tomographic survey x-ray films, cephalometric films and diagnostic photographs, unless otherwise stated in this Dental EOC.

CLEANINGS, FLUIDOIRE TREATMENT
Covered: One prophylaxis in any 6-month period, except when replaced as described below in Basic Periodonitics. 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 re-appointment per space maintainer in any 12-month period.

BASIC PERIODONTICS
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 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. Sealsants/Preventive resins are subject to additional limitations listed under Preventive Services, and may be subject to a different Coverage level under Additional 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 surgery procedures and implants when provided by a Dentist licensed to administer such agents.

Exclusions: Gold foil fillings.

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. Venues for anterior permanent teeth.

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

PROTHETIC SERVICES—FIXED BRIDGES
Covered: Fixed partial dentures (bridges), including pontics, retainers, and abutment crowns, inlays, and onlays (resin, porcelain, 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.

PROTHODONTIC 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: Endodontic services: Core build-ups 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, 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 relinse, relase, 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 prostheses 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: Pulpectomy, pulp therapy for primary teeth but not when performed in conjunction with major endodontic treatment.


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

Exclusions: Guided tissue regeneration. Intentional re-implantation (including necessary splinting and/or surgical 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 for periodontal maintenance procedure.

Exclusions: Provisional splinting, and antimicrobial medication and dressing changes. Periodontal probing and scaling or periodontal maintenance procedures, periodontal maintenance procedures, periodontal scaling and root planing. One 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 (pulping 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 ORTHODONTIC 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 related to 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, brother, sister, or child.

4. Charges for 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 for which the Plan does not consider to be 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 incurred while serving as a covered employee of a plan participant.

14. Exclusions of benefits (if applicable.)

15. Replacement of tooth structure lost from wear or attrition.

16. Dental services resulting from loss or theft of a denture, crown, bridge or removable orthodontic appliance.

17. 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.

18. Diagnosis of, or fabrication of, adjustment or maintenance and cleaning of maxillofacial prosthesis, appliances or restorations necessary to correct bite problems or to restore the exclusion or correct temporomandibular joint dysfunction (TMJ) or associated muscles.

19. Diagnostic dental services such as diagnostic tests and oral pathology services.

20. 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.

21. Any court-ordered treatment of a Member unless benefits are otherwise payable.

22. 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.)

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/anesthesia, anesthetics.

25. Dental consultations including but not limited to re-evaluations, teledentistry, nutritional and tobacco counseling and oral hygiene instruction.
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### VisionBlue

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network Member Cost</th>
<th>Out-of-Network Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VISION EXAMINATION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive Eye Examination</td>
<td>$10 Copayment</td>
<td>Up to $35</td>
</tr>
<tr>
<td>Retinal Imaging</td>
<td>Up to $39</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Contact Lenses Fit and Follow-Up</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard</td>
<td>$55 Copayment</td>
<td>N/A</td>
</tr>
<tr>
<td>Premium</td>
<td>10% off retail</td>
<td>N/A</td>
</tr>
</tbody>
</table>

| **VISION MATERIALS** | | |
| **Standard Plastic Lenses** | | |
| 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 |

| **Contacts** | | |
| 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** | | |
| 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)

<table>
<thead>
<tr>
<th>Service</th>
<th>Copayment</th>
<th>Frequency Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>$0</td>
<td>Up to $77</td>
</tr>
<tr>
<td>Retinal Imaging</td>
<td>$0</td>
<td>Up to $50</td>
</tr>
<tr>
<td>Extended Ophthalmoscopy</td>
<td>$0</td>
<td>Up to $15</td>
</tr>
<tr>
<td>Gonioscopy</td>
<td>$0</td>
<td>Up to $15</td>
</tr>
<tr>
<td>Scanning Laser</td>
<td>$0</td>
<td>Up to $33</td>
</tr>
</tbody>
</table>

*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.
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.

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