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	Teladoc Health: 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	Teladoc Health: 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/visit	30% coinsurance	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	30% coinsurance	Therapy limited to 60 visits per type per year. Cardiac/Pulmonary rehab limited to 36

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)	
				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
- 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
- Chiropractic care
- Hearing aids for adults
- Hearing aids for children under 18

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	$800
Coinsurance	$200
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 800-565-9140-1 (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, ແມ່ນມີ ພ້ອມໃຫ້ ທ່ານ. 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).

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

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

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

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

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

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

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

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

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

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

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

of Tennessee

East Tennessee State University Residents | Effective Date: July 1, 2023

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
Teladoc™ Health Virtual Care [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	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 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

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 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 ("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).

ໃປດຊາບ: ຖ້າ ວ່າ ທ່ ານ ເວ ົ້ າ ພາ ສາ ລ າ ວ, ການ ບ ໍ ລ ິ ການ ຊ ່ ວ ຍ ເ ຫ ລ ື ອ ດ ້ ານ ພ າ ສ າ, ໂ ດ ຍ ບ ໍ ເ ສ ັ ຽ ຄ ່ າ, ແ ມ ່ ນ ມ ີ ພ ້ ອ ມ ໃ ຫ ້ ທ ່ ານ. ໂ ທ 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).

સૂચના: 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 मुफ़्त 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' hódíilnih 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 In-Network** $0	**Individual Out-of-Network** $50
	Family $150 (maximum)	
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.

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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)

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

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

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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 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
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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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.

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