BlueCross BlueShield of Tennessee

Douglas-Cherokee Economic Authority

Summary of Benefits	DentalBlue	Standard Plan
	Dental Option: 1	
	Effective Date: January 1, 2020	
Deductible Calendar Year Applies to Coverage B and C only	**Individual** $25	**Family** $75
Benefit Maximums Applies to Coverage B and C (per Calendar Year)	$1,250	
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 and Major Endodontics Basic and Major Periodontics Basic and Major Oral Surgery	80%
Coverage C Major Restorative and Prosthodontics	**12 month Waiting Period** 50%
Coverage D Orthodontics	Not Available
Preferred Option	Network Dentists paid at PPO fee schedule; non-network dentists paid 30% less than PPO fee schedule
National Network	Included
Blue365	Discounts on health and wellness services including routine vision care, Lasik surgery, weight loss and fitness centers, and more

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

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

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

COVERED SERVICES, LIMITATIONS, & EXCLUSIONS

Exams
Covered: Standard exams including comprehensive, periodic, detailed/ extensive and periodontal oral evaluations (exams). Emergency exams, including limited oral evaluations (exams).
Limitations: No more than one standard exam in any 6-month period. No more than one emergency exam in any 12-month period. No more than one comprehensive, detailed/extensive, or periodontal exam in any 36-month period.
Exclusions: Re-evaluations and consultations.
X-rays
Covered: Full mouth series, intraoral and bitewing radiographs (x-rays).
Limitations: No more than one full mouth set of x-rays in any 36-month period. A full mouth set of x-rays is defined as either an intraoral complete series or panoramic x-ray. Benefits provided for either include benefits for all necessary intraoral and bitewing films taken on the same day. No more than four bitewing films in any 12-month period. Bitewing films must be taken on the same date of service.
Exclusions: Extraoral, skull and bone survey, sialography, TMJ, and tomographic survey x-ray films, cephalometric films and diagnostic photographs. Cephalometric films and diagnostic photographs may be covered as orthodontic benefits under Coverage D.
Cleanings, Fluoride Treatment
Covered: Adult and child prophylaxis (cleaning). Child and adult (subject to age limitations) fluoride treatments, performed with or without a prophylaxis.
Limitations: No more than one of any prophylaxis or periodontal Maintenance procedure in any 6month period. Periodontal maintenance procedures are subject to additional limitations listed below under Basic Periodontics in Section VI, and may be subject to a different Coverage level under Attachment C: Schedule of Benefits. No more than one fluoride treatment in any 12-month period, for Members under age 19. Fluoride must be applied separately from prophylaxis paste.
Sealants, Space Maintainers
Covered: Other Preventive Services, including sealants, space maintainers.
Limitations: No more than one sealant per first or second molar tooth per lifetime, for Dependents under age 16. Space maintainers for Dependents under age 14. No more than one recementation in any 12month period.
Exclusions: Nutritional and tobacco counseling, oral hygiene instructions.
Basic Restorative Services
Covered: Basic restorative services, including amalgam restorations (silver fillings), resin composite restorations (tooth colored fillings), stainless steel crowns. Palliative (emergency) treatment for the relief of pain. Other restorative services, including repair of full and partial dentures.
Limitations: No more than one amalgam or resin restoration per tooth surface in any 12-month period. Replacement of existing amalgam and resin composite restorations Covered only after 12 months from the date of initial restoration. Replacement of stainless steel crowns Covered only after 36 months from the date of initial restoration. No more than one repair per denture per 24 months.
Exclusions: Gold foil restorations.
Major Restorative Services
Covered: Single tooth restorations, including crowns (resin, porcelain, ¾ cast, and full cast), inlays and onlays (metallic, resin and porcelain), and veneers.
Limitations: Only for the treatment of severe carious lesions or severe fracture on permanent teeth, and only when teeth cannot be adequately restored with an amalgam or resin composite restoration (filling). For permanent teeth only. For Dependents under age 12, benefits will not be provided for cast crowns or laminate veneers. Replacement of single tooth restorations Covered only after 60 months from the date of initial placement.
Exclusions: Temporary and provisional crowns.
Prosthodontic Services - Fixed Bridges
Covered: Fixed partial dentures (bridges), including pontics, retainers, and abutment crowns, inlays, and onlays (resin, porcelain, ¾ and full cast).
Limitations: Only for treatment where a missing tooth or teeth cannot be adequately restored with a removable partial denture. For permanent teeth only, no benefits for Dependents under age 16. Replacement of fixed partial dentures Covered only after 60 months from the date of initial placement.
Prosthodontic Services - Removable Dentures
Covered: Complete, immediate and partial dentures.
Limitations: If, in the construction of a denture, the Member and the Dentist decide on a personalized restoration or to employ special rather than standard techniques or materials, benefits provided shall be limited to those which would otherwise be provided for the standard procedures or materials (as determined by the Plan). Benefits are not provided for Dependents under age 16. Replacement of removable dentures Covered only after 60 months from the date of initial placement.
Exclusions: Interim (temporary) dentures.
Other Major Restorative & Prosthodontic Services
Covered: Crown and bridge services including core buildups, post and core, recementation, and repair. Denture services including adjustment, relining, rebasing and tissue conditioning.
Limitations: The benefits provided for crown and bridge restorations include benefits for the services of crown preparation, temporary or prefabricated crowns, impressions and cementation. Benefits will not be provided for a core build-up separate from those provided for crown construction, except in those circumstances where benefits are provided for a crown because of severe carious lesions or fracture is so extensive that retention of the crown would not be possible. Post and core services are Covered only when performed in conjunction with a Covered crown or bridge. Crown and bridge repair and re-cementation are Covered separately only after 12 months from the date of initial placement. Denture adjustments are Covered separately from the denture only after 6 months from the date of initial placement. No more than one denture reline or rebase in any 36 month period.
Exclusions: Other major restorative services including sedative fillings and coping. Other prosthodontic services including overdenture, precision attachments, connector bars, stress breakers and coping metal.
Basic Endodontics
Covered: Pulpotomy, pulpal therapy.
Limitations: For primary teeth only. Not Covered when performed in conjunction with major endodontic treatment. The benefits for basic endodontic treatment include benefits for x-rays, pulp vitality tests, and sedative fillings provided in conjunction with basic endodontic treatment.
Exclusions: Pulpal debridement.
Major Endodontics
Covered: Root canal treatment and re-treatment, apexification, apicoectomy services, root amputation, retrograde filling, hemisection, pulp cap.
Limitations: No more than one root canal treatment, re-treatment or apexification per tooth in 60month period. No more than one apicoectomy per root per lifetime. The benefits for major endodontic treatment include benefits for x-rays, pulp vitality tests, pulpotomy, pulpectomy and sedative fillings and temporary filling material provided in conjunction with major endodontic treatment.
Exclusions: Implantation, canal preparation, and incomplete endodontic therapy.
Basic Periodontics
Covered: Non-surgical periodontics, including periodontal scaling and root planing, full mouth debridement and periodontal maintenance procedure.
Limitations: No more that one periodontal scaling and root planing per quadrant in any 24month period. No more than one full mouth debridement per lifetime. No more than one of any prophylaxis (cleanings) or periodontal maintenance procedure in any 6month period. Cleanings are subject to additional limitations listed under Preventive Services, and may be subject to a different Coverage level under Attachment C: Schedule of Benefits. Benefits for periodontal maintenance are provided only after active periodontal treatment (surgical or non-surgical), and no sooner than 90 days after completion of such treatment. Benefits for periodontal scaling and root planing, full mouth debridement, periodontal maintenance and prophylaxis are not provided when more than one of these procedures is performed on the same day.
Exclusions: Provisional splinting, scaling in the presence of gingival inflammation, antimicrobial medication and dressing changes.
Major Periodontics
Covered: Surgical periodontics including gingivectomy, gingivoplasty, gingival flap procedure, crown lengthening, osseous surgery and bone and tissue grafting.
Limitations: No more than one major periodontal surgical procedure in any 36-month period. Benefits provided for major periodontics include benefits for services related to 90 days of postoperative care.
Exclusions: Tissue regeneration and apically positioned flap procedure.
Basic Oral Surgery
Covered: Non-surgical or simple extractions.
Limitations: Benefits provided for basic oral surgery include benefits or suturing and postoperative care.
Exclusions: Benefits for general anesthesia or intravenous sedation when performed in conjunction with basic oral surgery.
Major Oral Surgery
Covered: Surgical extractions (including removal of impacted teeth and wisdom teeth), and other oral surgical procedures typically not Covered under a medical plan.
Limitations: Benefits provided for major oral surgery include benefits for local anesthesia, suturing and postoperative care. Benefits for general anesthesia or intravenous (IV) sedation are provided only in connection with major oral surgery procedures, and only when provided by a Dentist licensed to administer such agents.
Exclusions: Implants and any related oral surgery typically Covered under a medical plan, including but not limited to, excision of lesions and bone tissue, treatment of fractures, suturing, wound and other repair procedures, TMJ and related procedures. Orthognathic surgery and treatment for congenital malformations.
Orthodontics Services
Covered: Exams, photographic images, diagnostic casts, cephalometric xrays, installation and adjustment of orthodontic appliances and treatment to reduce or eliminate an existing malocclusion.
Limitations: The need for orthodontic services must be diagnosed, identifying a handicapping malocclusion that is both abnormal and correctable, and a Treatment Plan must be submitted to and approved by the Plan. The Plan reserves the right to review the Member's dental records, including necessary x-rays, photographs, and models to determine whether orthodontic treatment is Covered. Orthodontic services may be limited to Dependents under a specified age limit, as defined on Attachment C: Schedule of Benefits. Orthodontic services may be limited by a Maximum Allowable Charge, Calendar Year Deductible and lifetime maximum as defined on Attachment C: Schedule of Benefits. Multiple occurrences of orthodontic treatment may be allowed subject to the lifetime maximum. All orthodontic services shall be deemed to have been concluded on the last date treatment performed during Member's Coverage, even if a prior approved Treatment Plan has not been completed.
Exclusions: Replacement or repair of any lost, stolen and damaged appliance furnished under the Treatment Plan. Surgical procedures to aid in orthodontic treatment.
Other Exclusions From Coverage
1) This EOC does not provide benefits for the following services supplies or charges:
2) Dental services received from a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trustee or similar person or group.
3) Charges for services performed by You or Your spouse, or Your or Your spouse's parent, sister, brother or child.
4) Services rendered by a Dentist beyond the scope of his or her license.
5) Dental services which are free, or for which You are not required or legally obligated to pay or for which no charge would be made if You had no dental Coverage.
6) Dental services to the extent that charges for such services exceed the charge that would have been made and collected if no Coverage existed hereunder.
7) Dental services covered by any medical insurance coverage, or by any other non-dental contract or certificate issued by BlueCross BlueShield of Tennessee or any other insurance company, carrier, or plan. For example, removal of impacted teeth, tumors of lip and gum, accidental injuries to the teeth, etc.
8) Any court-ordered treatment of a Member unless benefits are otherwise payable.
9) Courses of treatment undertaken before You become Covered under this program.
10) Any services performed after You cease to be eligible for Coverage.
11) Dental care or treatment not specifically listed in Attachment C: Schedule of Benefits.
12) Any treatment or service that the Plan determines is not Necessary Dental Care, that does not offer a favorable prognosis that does not meet generally accepted standards of professional dental care, or that is experimental in nature.
13) Services or supplies for the treatment of work related illness or injury, regardless of the presence or absence of workers' compensation coverage. This exclusion does not apply to injuries or illnesses of an employee who is (1) a sole-proprietor of the Group; (2) a partner of the Group; or (3) a corporate officer of the Group, provided the officer filed an election not to accept Workers' Compensation with the appropriate government department.
14) Charges for any hospital or other surgical or treatment facility and any additional fees charged by a Dentist for treatment in any such facility.
15) Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes. This does not exclude those services provided under Orthodontic benefits (if applicable.)
16) Replacement of tooth structure lost from wear or attrition.
17) Dental services resulting from loss or theft of a denture, crown, bridge or removable orthodontic appliance.
18) Charges for a prosthetic device that replaces one or more lost, extracted or congenitally missing teeth before Your Coverage becomes effective under the Plan unless it also replaces one or more natural teeth extracted or lost after Your Coverage became effective.
19) Diagnosis for, or fabrication of, appliances or restorations necessary to correct bite problems or restore the occlusion or correct temporomandibular joint dysfunction (TMJ) or associated muscles.
20) Implant supported prosthetics. Alternate benefits may be provided for a standard crown, bridge or denture, at Our sole discretion.
21) Diagnostic dntal services such as diagnostic tests and oral pathology services.
22) Adjunctive dental services including all local and general anesthesia, sedation, and analgesia (except as provided under major oral surgery).
23) Charges for the treatment of desensitizing medicaments, drugs, occlusal guards and adjustments, mouthguards, microabrasion, behavior management, and bleaching.
24) Charges for the treatment of professional visits outside the dental office or after regularly scheduled hours or for observation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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.*

BlueCross BlueShield of Tennessee
An Independent Licensee of the BlueCross BlueShield Association

Group Name: Douglas-Cherokee Economic Authority Inc
Group Number: 123339
Effective Date: 01/01/2020

VisionBlue Insight

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	$40 Copayment	Up to $0	
Premium	10% off retail	Up to $0	
VISION MATERIALS			
Standard Plastic Lenses			One set of lenses within a 12 month period for each member covered under the plan.
Single Vision	$25 Copayment	Up to $30	
Bifocal	$25 Copayment	Up to $45	
Trifocal	$25 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)	Lens + Additional Copayment See fixed tier price list	$0 Additional *	
Standard Anti-Reflective Coating	$45 Copayment	Up to $0	
Premium Anti-Reflective Coating	See fixed tier price list	Up to $0	
Photchromatic Lenses	$75 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.

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- 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.

Premium Tiered Price List

Premium Progressive Tiered Pricing	Additional Member In-Network Cost*
Tier 1	$85 Copay*
Tier 2	$95 Copay*
Tier 3	$110 Copay*
Tier 4	$65 Copay, 80% of charge less $120 Allowance*

Premium Anti-Reflective Coating	Additional Member In-Network Cost
Tier 1	$57
Tier 2	$68
Tier 3	80% of Charge

*** In addition to In-network lens copay**

BlueCross BlueShield of Tennessee
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EyeMed Progressive and Anti-Reflective Tier Classifications

Progressive Classification*
Standard Progressives as Follows:
Adaptar / Adatar Short / Essilor Computer / Essilor Interview / Natural / Navigator / Navigator Short / Ovation / Super No Line / Amplitude / Amplitude Mini / GP / HoyaLux Tact / Seiko AF 2 / Seiko AF 2 Mini / Seiko Diamond Clear Mini / Synchrony Access / AO Compact / Gradal RD / Instictive / Sola Max / VIP / Zeiss Business / Freedom 5 / Freedom Fit / Freedom ID / Outlook / Shoreview / Shoreview Mini / Unique Softwear / Synchrony Easy M / Synchrony Easy View / Synchrony Access / MVC Standard Progressive
Premium Progressives as Follows:
TIER 1 - Adaptar Digital / Adaptar Digital Short / Natural Digital / Ovation Digital / Small Fit / Small Fit Digital / Amplitude BKS / Amplitude Mini BKS / Amplitude IQ / Amplitude IQ Mini / GP Wide / Tact BKS / Navigator FBS / Navigator Short FBS / Proceed II / Proceed III / Gradal Top / Instinctive HD / AO Easy / Synchrony / Synchrony Easy S / Adage / Concise / Illumina / Image / Image Wrap / Novel / Novella / Precise / Precise Short / Xplorer / Shamir 1st Pal / MVP / Premium Progressive / Short Fit Progressive / LC Design 1.0
TIER 2 - Ideal / Ideal Short / Varilux Comfort 2 / Varilux Comfort 2 Short / Varilux Comfort DRx / Varilux Comfort DRx Short / Summit CD / Summit ECP / Seiko PC Wide Computer / Succeed / Succeed WS / Element / Compact Ultra / GT2 / GT2 Short / Sola One / Zeiss Choice / Ziess Digital / Zeiss Digital Wrap / DST Custom Plus / HD Workspace / Kodak Precise PB / Kodak Precise PB Short / IOT Everyday / TruClear / Nikon Presio I Digital / Instinctive Preformance / Synchrony Easy View HD / Synchrony Easy View M HD / Synchrony Easy View S HD / Synchrony Easy Adapt / Synchrony Access HD / Synchrony Easy Wear / Signet Armorlite DirecTek / Signet Armorlite DirecTek Short / Workspace
TIER 3 - Definity / Definity Short / Ideal Advanced / Ideal Advanced Wrap / Varilux Comfort W2 + / Varilux Comfort W2+ Fit / Varilux Ellipse / Varilux Panamic / Varilux Physio / Varilux Physio Short / Varilux Physio DRx / Varilux Physio DRx Short / Varilux Stylistic Wrap / Supercede II / Autograph II Attitude Wrap / Autograph II Fixed / Autograph II Office / Autograph II Variable / Shamir Computer / Shamir Golf Progressive / Shamir InTouch / Shamir Work Space / Shamir Spectrum / Shamir Spectrum + / AO Easy HD / Compact Ultra HD / GT2 3D / GT2 3D Short / Sola One HD / Zeiss Choice Plus / Zeiss Offilens / Concise Digital / DST Custom Plus HD / DST Custom Plus HD Sun Wrap / Precise Digital / Precise Digital Short / Unique / IOT Ultimate / IOT Universal / IsSential / TruClear SD / Nikon Digi Life / Synchrony Performance HD / Synchrony Easy Wear HD / Synchrony Ultra HD / Synchrony Work & Go HD / Synchrony Work & Read HD / Synchrony Work & Office HD / Synchrony PAL Starter HD / Hoya Array Fixed / Hoya Array VL / Hoya Summit ECP IQ / Hoya Summit CD IQ / Zeiss Energize Me
TIER 4 - Other Premium Progressives
Anti-Reflective Classification*
Standard Anti-Reflective Coatings as Follows:
Sharp View Plus / Crizal Kids w/UV / Hoya Premium Coating / Zeiss Super ET / Backside AR / Custom CleAR / Custom CleAR Sun / Clean Shield AR / ProClean / Reflection Free / RF Endura / Trion AR / HMC Plus / Blue Shield AR / SYNGERY Crystal AR / SYNGERY Crystal UV AR / RayBan Sun AR / Synchrony

HMC / Standard AR / Standard Backside AR / Anti-Reflective AR / CleAR
Premium Anti-Reflective Coatings as Follows:
TIER 1 - Crizal Easy w/UV / Crizal Prevencia Kids / Xperio Sun UV / Xperio Sun UV w/Mirrors / VISO / HiVision / Hoya Premium w/ViewProtect / BluCrystal / Kodak CleAR / RF Endura EZ / Zeiss DuraVision Chrome
TIER 2 - Crizal Alize w/UV / Crizal SunShield w/UV / VISO XC / HiVision w/ViewProtect / Allure AR / Zeiss DuraVision Silver / Custom CleAR Plus / Custom CleAR Plus Sun / Clean Shield Elite AR / Clean Shield Elite Sun AR / ECC AR / Kodak Clean'N CleAR / Kodak Clean N Clear AR UV / Kodak Total Blue AR / Vivid AR / RayBan Premium AR / Synchrony HMC+ / Premium AR / EasyCare Premium AR / EZ Premium CleAR
TIER 3 - Other Premium Anti-Reflective Coatings

EyeMed Vision Care reserves the right to make changes to the products on each tier and the member out-of-pocket amounts

* Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels

Nondiscrimination Notice

BlueCross BlueShield of Tennessee (BlueCross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

BlueCross:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language services to people whose primary language is not English, such as: (1) qualified interpreters and (2) written information in other languages.

If you need these services, contact a consumer advisor at the number on the back of your Member ID card (for TTY help, call 1-800-848-0298 or 711).

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance ("Nondiscrimination Grievance"). For help with preparing and submitting your Nondiscrimination Grievance, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Compliance Coordinator; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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

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

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

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

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

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

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

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