




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 <https://www.healthcare.gov/sbc-glossary/> or call 1-800-565-9140 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	In-network: \$4,000 person/\$8,000 family Out-of-network: \$8,000 person/\$16,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive services</u> , Office visits, Prescriptions drugs, and Emergency room visits are covered before you meet your <u>deductible</u> (unless specified).	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without cost-sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	In-network: \$6,300 person/\$12,600 family Out-of-network: \$18,900 person/\$37,800 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premium</u> , <u>balance-billing</u> charges, penalties, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

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

 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
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit <u>deductible</u> does not apply.	50% <u>coinsurance</u>	Teladoc Health Covered at 100%.
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit <u>deductible</u> does not apply.	50% <u>coinsurance</u>	Office surgery subject to <u>deductible/coinsurance</u> .
	<u>Preventive care/screening/immunization</u>	No charge	50% <u>coinsurance</u>	A1c testing will be covered at 100%. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Travel immunization not covered in office or clinic setting.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$25 <u>copay</u> /visit <u>deductible</u> does not apply.	50% <u>coinsurance</u>	Diagnostic testing benefits are determined by place of service, such as office or ER.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at http://www.bcbst.com/Essential	Generic drug	\$5 <u>copay</u> /prescription <u>deductible</u> does not apply.	50% <u>coinsurance</u>	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 with Maintenance Matters. <u>Copayment</u> per 30 day supply.
	Preferred brand drugs	\$25 <u>copay</u> /prescription <u>deductible</u> does not apply.	50% <u>coinsurance</u>	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 with Maintenance Matters. <u>Copayment</u> per 30 day supply.
	Non-preferred brand drugs	\$50 <u>copay</u> /prescription <u>deductible</u> does not apply.	50% <u>coinsurance</u>	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

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)	
				generic drug, plus the non-preferred brand drug <u>copayment</u> or <u>coinsurance</u> .
	<u>Specialty drug</u>	50% <u>coinsurance</u> /prescription <u>deductible</u> 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% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained. *See Prior Authorization section.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained. *See Prior Authorization section.
If you need immediate medical attention	<u>Emergency room care</u>	\$500 <u>copay</u> /visit <u>deductible</u> does not apply.	\$500 <u>copay</u> /visit <u>deductible</u> does not apply.	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$50 <u>copay</u> /visit <u>deductible</u> does not apply.	50% <u>coinsurance</u>	Office surgery subject to deductible/coinsurance
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization required. Your cost share may increase to 60% if not obtained.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> /visit <u>deductible</u> does not apply for office visits and 20% <u>coinsurance</u> for other outpatient services	50% <u>coinsurance</u>	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained. *See Prior Authorization section.
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you are pregnant	Office visits	\$25 <u>copay</u> /visit <u>deductible</u> does not apply.	50% <u>coinsurance</u>	Cost sharing does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Childbirth/delivery facility	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	services			
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Unlimited
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Therapy limited to 20 visits per type per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Therapy limited to 20 visits per type per year.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Skilled nursing and rehabilitation facility limited to 60 days combined per year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization may be required for certain durable medical equipment. Your cost share may increase to 60% if not obtained. *See Prior Authorization section.
	<u>Hospice services</u>	No charge	50% <u>coinsurance</u>	Prior Authorization required for inpatient hospice. Your cost share may increase to 60% if not obtained.
If your child needs dental or eye care	Children's eye exam	No charge	40% <u>coinsurance</u>	Limited to 1 visit per year.
	Children's glasses	No charge	40% <u>coinsurance</u>	Lenses and frames are each limited to 1 set per year.
	Children's dental check-up	No charge	No charge	Limited to 1 visit every 6 months.

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 <u>excluded services</u>.)		
<ul style="list-style-type: none"> • Bariatric surgery • Cosmetic surgery • Dental care (Adult) • Infertility treatment 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing 	<ul style="list-style-type: none"> • Routine eye care (Adult) • 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.)		
<ul style="list-style-type: none"> • Acupuncture 	<ul style="list-style-type: none"> • Chiropractic care 	<ul style="list-style-type: none"> • Hearing aids

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.naic.org/solar-web/pages/public/onlineComplaintForm/onlineComplaintForm.jsf?state=tn&dswid=-8432>, 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 <u>plan's</u> overall <u>deductible</u>	\$4,000
■ <u>Specialist copay</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$4,000
<u>Copayments</u>	\$30
<u>Coinsurance</u>	\$1,500
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Peg would pay is	\$5,550

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$4,000
■ <u>Specialist copay</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$10
<u>Copayments</u>	\$1,000
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$30
The total Joe would pay is	\$1,040

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$4,000
■ <u>Specialist copay</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,600
<u>Copayments</u>	\$900
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,500

Nondiscrimination Notice

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

BlueCross:

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

If you need these services, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711).

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

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

Language Access Services:

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

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

ໂບດຊາບ: ຖ ໑໐ ໑ ທ່ ານເວ ໑ພາສາ ລາວ, ການບ ໒ ການຊ ວຍເຫ ື່ອ ານພາສາ, ໂດຍບ ເສັ້ນຊ ໑, ແມ ນມ ພ ອມໃຫ ທ່ ານ.
ໂທຮ 1-800-565-9140 (TTY: 1-800-848-0298).

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

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

સુચના: જો તમો ગુજરાતી બોલોવતા હોમો, તો નનિઃશુલ્ક ભાષા સુહોય સુવાઓ તમેરાા મોટો ઉપવબ્ધ છો. ફોનોના કરાો 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).

धुयान दें: याददिं आप दाँदी बोलते तो आपके दलिए मुफ्त मुं भाषा स ायातो सेवाएं उपलब्धु । 1-800-565-9140 (TTY: 1-800-848-0298) पर कॉल कर।

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 (TTY: 1-800-848-0298) (1-800-565-9140) 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 nínfizin: Díí saad bee yánílti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éi ná hóló, koji' hódíílnih 1-800-565-9140 (TTY: 1-800-848-0298).

WICHDICH: Wann du Deitsch schwetztscht un witt en Translator, kenne mer eener griege fer dich unni as es dich ennich ebbes koschte zellt.
Ruf 1-800-565-9140 (TTY: 1-800-848-0298) uff.

FAAMATALAGA: Afai e te tautala i le Gagana Samoa, o lo'o avanoa mo oe auaunaga fesoasoani i le gagana e leai se totogi. Valaau 1-800-565-9140 (TTY: 1-800-848-0298).

ATENSHUN: Gare iga gogal Kapasal Falawasch, ye fri ngalug yamem bwe tepangug rel iye kepat kaale. Kol yegili 1-800-565-9140 (TTY: 1-800-848-0298).

ATENSIÓN: Kumu un tungo fuminu' Chamoru, guaha dibatdi na setbision asistimentun lengguahi para hâgu. Agang 1-800-565-9140 (TTY: 1-800-848-0298).