



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 Benefits Administration at 1-800-253-9981 or visit <https://www.tn.gov/partnersforhealth>. 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 1-800-253-9981 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In-network/Out-of-network: \$1,800/\$3,600 employee only; \$2,500/\$4,800 employee + child(ren); \$2,800/\$5,550 employee + spouse; \$3,600/\$7,200 employee + spouse + child(ren)	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. In-network preventive care screenings at outpatient facilities; In-network outpatient occupational, physical, speech and applied behavior analysis therapies; other in-network preventive care; other outpatient services, including <u>primary</u> and <u>specialist</u> office visits, behavioral health and substance use, routine x-rays, labs, and diagnostics, reading, interpretation and results, telehealth, chiropractic and acupuncture, convenience clinics, <u>urgent care</u> , and pharmacy.	This <u>plan</u> covers some items and services even if you haven't 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 <u>cost sharing</u> 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/Out-of-network: \$6,800/\$13,600 employee only; \$13,600/\$27,200 employee + child(ren); \$13,600/\$27,200 employee + spouse; \$13,600/\$27,200 employee + spouse + child(ren)	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> ?	Premiums, <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, and penalties for failure to obtain <u>preauthorization</u> or failure to follow the Dispense as Written (DAW) provisions of the <u>prescription drug</u> benefit.	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 network provider ?	Yes. See www.bcbst.com/members/tn_state/ or call 1-800-558- 6213 for a list of participating BCBST network providers . See www.cigna.com/sites/stateoftn/ or call 1-800-997-1617 for a list of Cigna 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.

What You Will Pay				
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 copay /visit	\$55 copay /visit	Deductible does not apply
	Specialist visit	\$55 copay /visit	\$80 copay /visit	Deductible does not apply
	Preventive care/screening/immunization	No charge	\$50 copay /visit	Deductible does not apply. 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.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance /test	50% coinsurance /test	Deductible does not apply. You pay a separate coinsurance for reading, interpretation and results.
	Imaging (CT/PET scans, MRIs)	30% coinsurance /test	50% coinsurance /test	You pay a separate coinsurance for reading, interpretation and results. Preauthorization is required. No Network benefits, and Out-of-Network benefits reduced by half if you don't get preauthorization .

What You Will Pay				
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
<p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://info.caremark.com/stateoftn</p>	Generic drugs	\$14 copay/prescription 30-day supply; \$14 copay/prescription 90-day supply of some maintenance drugs; \$28 copay/prescription 90-day supply of other drugs	<u>copay/prescription</u> plus charges exceeding the <u>allowed amount</u> for 30-day supply; No benefit for 90-day supply	<u>Deductible</u> does not apply. 90-day supply must be obtained from a Retail-90 network pharmacy or mail order. There is no out-of-network benefit for a 90-day supply.
	Preferred brand drugs	\$60 <u>copay/prescription</u> 30-day supply; \$60 <u>copay/prescription</u> 90-day supply of some maintenance drugs; \$120 copay per <u>prescription</u> 90-day supply of other drugs	<u>copay/prescription</u> plus charges exceeding the <u>allowed amount</u> for 30-day supply; No benefit for 90-day supply	Maintenance drugs include some medications for high blood pressure, high cholesterol, coronary artery disease (CAD), congestive heart failure (CHF), depression, osteoporosis, asthma/chronic obstructive pulmonary disease (COPD), and diabetes (oral medications, insulins, needles, test strips and lancets). Does not include any specialty drugs.
	Non-preferred brand drugs	\$110 <u>copay</u> per <u>prescription</u> 30-day supply; \$200 <u>copay/prescription</u> 90-day supply of some maintenance drugs; \$220 <u>copay/prescription</u> 90-day supply of other drugs	<u>copay/prescription</u> plus charges exceeding the <u>allowed amount</u> for 30-day supply; No benefit for 90-day supply	Certain low-dose generic statins received in-network may be covered at no charge. Members do not have to pay for specific medications used to treat opioid dependency.
	Specialty drugs	Tier 1 - generics 20% <u>coinsurance</u> Tier 2 - preferred brands 30% <u>coinsurance</u> Tier 3 – non-preferred brands 40% <u>coinsurance</u>	Not covered	<u>Deductible</u> does not apply. 30-day supply limit per <u>prescription</u> . <u>Prescriptions</u> must be obtained from a CVS/caremark Specialty Network Pharmacy. Tier 1 generics – Min \$100; Max \$200; Tier 2 preferred brands – Min \$200; Max \$400; Tier 3 non-preferred brands – Min \$300; Max \$600

What You Will Pay				
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required. No Network benefits and Out-of-Network benefits reduced by half if you don't get <u>preauthorization</u> .
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Deductible</u> and <u>coinsurance</u> will apply for services like advanced imaging – CT, MRI, etc.
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$55 <u>copay</u> /visit	\$80 <u>copay</u> /visit	<u>Deductible</u> does not apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required. No network benefits and Out-of-Network benefits reduced by half if you don't get <u>preauthorization</u> .
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required. No Network benefits and Out-of-Network benefits reduced by half if you don't get <u>preauthorization</u> .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 <u>copay</u> /visit	\$55 <u>copay</u> /visit	<u>Deductible</u> does not apply. <u>Preauthorization</u> is required for psychological testing, transcranial magnetic stimulation, electroconvulsive therapy, and Applied Behavior Analysis. No Network benefits and Out-of-Network benefits reduced by half if you don't get <u>preauthorization</u> .
	Inpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required. Residential treatment, partial hospitalization/day treatment programs and intensive outpatient therapy are considered inpatient services. No Network benefits and Out-of-Network benefits reduced by half if you don't get <u>preauthorization</u> .

What You Will Pay				
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	\$35 <u>copay</u> /visit	\$55 <u>copay</u> /visit	Global billing for labor and delivery and routine services beyond the initial office visit. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	Home health care	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization required for home health Care, Skilled nursing care, inpatient services and some equipment. No Network benefits and Out-of-Network benefits reduced by half if you don't get preauthorization. Home nursing care limited to 125 visits/plan year. Home health aide care limited to 30 visits/ plan year. Skilled nursing facility care limited to 100 days/plan year. <u>Deductible</u> does not apply to in-network, outpatient occupational, physical, speech and applied behavior analysis therapies.
	Rehabilitation services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Habilitation services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Skilled nursing care	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Durable medical equipment	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Hospice services	No charge	No charge	<u>Deductible</u> does not apply. 100% covered up to the MAC even if <u>deductible</u> has not been met.
If your child needs dental or eye care	Children's eye exam	\$55 <u>copay</u> /visit	\$80 <u>copay</u> /visit	<u>Deductible</u> does not apply. For illness or injury. No Routine refraction.
	Children's glasses	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to the first pair of eyeglasses following cataract surgery.
	Children's dental check-up	Not Covered	Not Covered	No coverage for dental check-ups.

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](#).)

- Cosmetic Surgery
- Routine eye care (Adult)
- Long-term care
- Weight loss programs (all programs not approved or sponsored by the plan)

[* For more information about limitations and exceptions, see the [plan](#) or policy document at www.tn.gov/partnersforhealth.]

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture (50 visits per plan year)
- Bariatric surgery
- Chiropractic care (50 visits per plan year)
- Dental care (Adult) – extraction of impacted wisdom teeth, excision of solid-based oral tumors, accidental injury or damage to sound natural teeth and/or jaw, orthodontic treatment for facial hemiatrophy or congenital birth defect)
- Hearing aids (every 3 years; children under 18; bone anchored hearing aid devices with preauthorization)
- Infertility treatment (testing and medically necessary services for correction of underlying causes; no services or supplies intended to create pregnancy)
- Non-emergency care when traveling outside the U.S. (for business or pleasure; out-of-network benefits apply)
- Private-duty nursing (included with Home Health Care)
- Routine foot care (diabetics only)

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 on how 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 BlueShield 1-800-558-6213, Cigna 1-800-997-1617, Benefits Administration 1-800-253-9981 or or Tennessee Department of Commerce & Insurance 615-741-2241, <https://www.tn.gov/commerce/consumer-services.html>.

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 the 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](#).

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-866-576-0029.]

[[Arabic (Árabe): Para obtener ayuda en árabe, llame al 1-866-576-0029.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-866-576-0029.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-576-0029.]

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

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[* For more information about limitations and exceptions, see the [plan](#) or policy document at www.tn.gov/partnersforhealth.]

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	\$1,800
■ Specialist copayment	\$55
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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:
Cost Sharing

Deductibles	\$1,800
Copayments	\$130
Coinsurance	\$3,720

What isn't covered

Limits or exclusions	\$60
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The total Peg would pay is	\$5,710
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Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$1,800
■ Specialist copayment	\$55
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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:
Cost Sharing

Deductibles	\$1,210
Copayments	\$1,600
Coinsurance	\$560

What isn't covered

Limits or exclusions	\$60
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The total Joe would pay is	\$3,430
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Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,800
■ Specialist copayment	\$55
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

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:
Cost Sharing

Deductibles	\$970
Copayments	\$170
Coinsurance	\$490

What isn't covered

Limits or exclusions	\$0
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The total Mia would pay is	\$1,630
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.