**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 deductible?** | In-network/Out-of-network:<br>**$750/$1,500** employee only;<br>**$1,125/$2,250** employee + child(ren);<br>**$1,500/$3,000** employee + spouse;<br>**$1,875/$3,750** employee + spouse + child(ren) | 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.** 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 primary and specialist office visits, behavioral health and substance use, routine x-rays, labs, and diagnostics, reading, interpretation and results, telehealth, chiropractic and acupuncture, convenience clinics, urgent care, and pharmacy. | This plan covers some items and services even if you haven't 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/Out-of-network:<br>**$3,600/$7,200** employee only;<br>**$5,400/$10,800** employee + child(ren);<br>**$7,200/$14,400** employee + spouse;<br>**$9,000/$18,000** employee + spouse + child(ren) | 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?** | Premiums, balance-billing charges, health care this plan doesn't cover, and penalties for failure to obtain preauthorization or failure to follow the Dispense as Written (DAW) provisions of the prescription drug benefit. | 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. See www.bcbst.com/members/tn_state/ or call 1-800-558- 6213 for a list of participating BCBST network providers.<br>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.

| Common Medical Event | Services You May Need | What You Will Pay<br>Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(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 | $25 copay/visit | $45 copay/visit | Deductible does not apply |
| | Specialist visit | $45 copay/visit | $70 copay/visit | Deductible does not apply |
| | Preventive care/screening/ immunization | No charge | $45 copay/visit | Deductible does not apply.<br>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) | 15% coinsurance/test | 15% coinsurance/test | Deductible does not apply. You pay a separate coinsurance for reading, interpretation and results. |
| | Imaging (CT/PET scans, MRIs) | 15% coinsurance/test | 40% 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. |

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

| Common Medical Event | Services You May Need | What You Will Pay: Network Provider (You will pay the least) | What You Will Pay: Out-of-Network Provider (You will pay the most) | What You Will Pay: Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at http://info.caremark.com/stateoftn | Generic drugs | $7 copay/prescription 30-day supply; $7 copay/prescription 90- day supply of some maintenance drugs; $14 copay/prescription 90-day supply of other drugs | copay/prescription plus charges exceeding the allowed amount for 30-day supply; No benefit for 90- day supply | Deductible does not apply.<br><br>90-day supply must be obtained from a Retail-90 network pharmacy or mail order.<br><br>There is no out-of-network benefit for a 90- day supply.<br><br>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.<br><br>Certain low-dose generic statins received in- network may be covered at no charge.<br><br>Members do not have to pay for specific medications used to treat opioid dependency. |
| | Preferred brand drugs | $40 copay/prescription 30-day supply; $40 copay/prescription 90- day supply of some maintenance drugs; $80 copay per prescription 90-day supply of other drugs | copay/prescription plus charges exceeding the allowed amount for 30-day supply; No benefit for 90- day supply | |
| | Non-preferred brand drugs | $90 copay/prescription 30-day supply; $160 copay/prescription 90-day supply of some maintenance drugs; $180 copay/prescription 90-day supply of other drugs | copay/prescription plus charges exceeding the allowed amount for 30-day supply; No benefit for 90- day supply | |
| | Specialty drugs | Tier 1 - generics 20% coinsurance<br><br>Tier 2 -preferred brands 30% coinsurance<br><br>Tier 3 – non-preferred brands 40% coinsurance | Not covered | Deductible does not apply.<br>30-day supply limit per prescription. Prescriptions must be obtained from a CVS/caremark Specialty Network Pharmacy.<br>Tier 1 generics – Min $100; Max $200; Tier 2 preferred brands – Min $200; Max $400; Tier 3 non-preferred brands – Min $300; Max $600 |

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

| Common Medical Event | Services You May Need | What You Will Pay<br>Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 15% coinsurance | 40% coinsurance | Preauthorization required. No Network benefits and Out-of-Network benefits reduced by half if you don't get preauthorization. |
| | Physician/surgeon fees | 15% coinsurance | 40% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | 15% coinsurance | 15% coinsurance | Deductible and coinsurance will apply for services like advanced imaging – CT, MRI, etc. |
| | Emergency medical transportation | 15% coinsurance | 15% coinsurance | None |
| | Urgent care | $45 copay/visit | $70 copay/visit | Deductible does not apply. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 15% coinsurance | 40% coinsurance | Preauthorization required. No network benefits and Out-of-Network benefits reduced by half if you don't get preauthorization. |
| | Physician/surgeon fees | 15% coinsurance | 40% coinsurance | Preauthorization required. No Network benefits and Out-of-Network benefits reduced by half if you don't get preauthorization. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 copay/visit | $45 copay/visit | Deductible does not apply. Preauthorization 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 preauthorization. |
| | Inpatient services | 15% coinsurance | 40% coinsurance | Preauthorization 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 preauthorization. |

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

| Common Medical Event | Services You May Need | What You Will Pay<br>Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| **If you are pregnant** | Office visits | $25 copay/visit | $45 copay/visit | Global billing for labor and delivery and routine services beyond the initial office visit. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services | 15% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 15% coinsurance | 40% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 15% coinsurance | 40% coinsurance | 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. Deductible does not apply to in-network, outpatient occupational, physical, speech and applied behavior analysis therapies. |
| | Rehabilitation services | 15% coinsurance | 40% coinsurance | |
| | Habilitation services | 15% coinsurance | 40% coinsurance | |
| | Skilled nursing care | 15% coinsurance | 40% coinsurance | |
| | Durable medical equipment | 15% coinsurance | 40% coinsurance | |
| | Hospice services | No charge | No charge | Deductible does not apply. 100% covered up to the MAC even if deductible has not been met. |
| **If your child needs dental or eye care** | Children's eye exam | $45 copay/visit | $70 copay/visit | Deductible does not apply. For illness or injury. No Routine refraction. |
| | Children's glasses | 15% coinsurance | 40% coinsurance | 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
- Long-term care
- Routine eye care (Adult)
- 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, kwiijigo holne' 1-866-576-0029.]

***To see examples of how this plan might cover costs for a sample medical situation, see the next section.***



[* 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 | $750 |
| Specialist copayment | $45 |
| Hospital (facility) coinsurance | 15% |
| Other coinsurance | 15% |

**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 | $750 |
| Copayments | $80 |
| Coinsurance | $1,860 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,750** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $750 |
| Specialist copayment | $45 |
| Hospital (facility) coinsurance | 15% |
| Other coinsurance | 15% |

**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 | $750 |
| Copayments | $1,030 |
| Coinsurance | $280 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$2,120** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $750 |
| Specialist copayment | $45 |
| Hospital (facility) coinsurance | 15% |
| Other coinsurance | 15% |

**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 | $750 |
| Copayments | $140 |
| Coinsurance | $240 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,130** |

The plan would be responsible for the other costs of these EXAMPLE covered services.

Anti-Discrimination and Civil Rights Compliance