

 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-565-9140 (TTY: 1-800-848-0299) or visit us at www.bcbst.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-565-9140 to request a copy.

| Important Questions | Answers | Why This Matters: |
|--|---|--|
| What is the overall deductible? | In-network: \$1,125 person/\$3,375 family Out-of-network: \$1,725 person/\$5,175 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 deductible? | Yes. Preventive services, 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 <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 deductibles for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the out-of-pocket limit for this plan? | In-network: \$6,850 person/\$13,700 family Out-of-network: Unlimited person/unlimited 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 out-of-pocket limit? | <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> . |
| Will you pay less if you use a network provider? | Yes. This <u>plan</u> uses Network P. See www.bcbst.com/NetPP or call 1-800-565-9140 for a list of <u>in-network providers</u> . | 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 charge</u> 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. |

| Important Questions | Answers | Why This Matters: |
|--|---------|--|
| 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 |
|---|--|---|--|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (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 | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| | Specialist visit | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| | <u>Preventive care/screening/immunization</u> | No Charge | 50% <u>coinsurance</u> | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| | Imaging (CT/PET scans, MRIs) | 30% <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 www.bcbst.com/rxp | Generic drugs | 10% or \$60 max, or actual cost of drug whichever is less | 50% <u>coinsurance</u> | Mail order Up to 34 day supply Generic – 10%, max \$60 or actual cost whichever is less, Preferred Brand – 25%, max \$140 or actual cost whichever is less, Non-Preferred Brand – 35%, max \$240 or actual cost whichever is less |
| | Preferred brand drugs | 25% or \$140 max or actual cost of drug whichever is less | 50% <u>coinsurance</u> | 34 to 60 day supply Generic - 10%, max \$120 or actual cost whichever is less, Preferred Brand -25%, ma, \$280 or actual cost whichever is less, Non-preferred Brand – 35%, max \$480 or actual cost whichever is less |
| | Non-preferred brand drugs | 35% or \$240 max or actual cost of drug whichever is less | 50% <u>coinsurance</u> | 61 to 90 day supply Generic – 10%, max \$180 or actual cost whichever is less, Preferred Brand – 25%, max \$420 or actual cost whichever is less, |

| 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) | |
| | | | | Non-preferred Brand – 35%, max \$720 or actual cost whichever is less |
| | <u>Specialty drugs</u> | \$240 <u>copayment</u> . | 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) | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained. |
| | Physician/surgeon fees | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained. |
| If you need immediate medical attention | <u>Emergency room care</u> | \$250 <u>copay</u> /then 30% <u>coinsurance</u> | \$250 <u>copay</u> /visit <u>deductible</u> does not apply. | None |
| | <u>Emergency medical transportation</u> | 40% Independent 30% Facility Based | 30% <u>coinsurance</u> | None |
| | <u>Urgent care</u> | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | Prior Authorization required. Your cost share may increase to 60% if not obtained. |
| | Physician/surgeon fees | 30% <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 | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | Prior Authorization required for electroconvulsive therapy (ECT). Your cost share may increase to 60% if not obtained. |
| | Inpatient services | 30% <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 | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| | Childbirth/delivery professional services | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| | Childbirth/delivery facility services | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| | <u>Rehabilitation services</u> | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | Cardiac/Pulmonary rehab limited to 36 visits per type per year. |
| | <u>Habilitation services</u> | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | Cardiac/Pulmonary rehab limited to 36 visits per type per year. |

| 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) | |
| | <u>Skilled nursing care</u> | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | Skilled nursing and rehabilitation facility unlimited |
| | <u>Durable medical equipment</u> | 30% <u>coinsurance</u> | 50% <u>coinsurance</u> | Prior Authorization may be required for certain <u>durable medical equipment</u> . Your cost share may increase to 60% if not obtained. |
| | <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 | Not Covered | Not Covered | None |
| | Children's glasses | Not Covered | Not Covered | None |
| | Children's dental check-up | Not Covered | Not Covered | None |

Excluded Services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.) | | |
|---|---|--|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult) • Dental care (Children) | <ul style="list-style-type: none"> • Infertility treatment • Long-term care • Private-duty nursing | <ul style="list-style-type: none"> • Routine eye care (Adult) • Routine eye care (Children) • Routine foot care for non-diabetics • Weight loss programs |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|---|--|--|
| <ul style="list-style-type: none"> • Chiropractic care • Hearing aids 19 and over max \$6000 every 5 years | <ul style="list-style-type: none"> • Hearing aids for children under 18 | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For plans subject to ERISA, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental plans, the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- For church plans, the State Division of Benefits Administration at 1-866-576-0029.
- BlueCross at 1-800-565-9140 or www.bcbst.com, or contact your plan administrator.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- BlueCross at 1-800-565-9140 or www.bcbst.com, or your plan administrator.
- For plans subject to ERISA, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- The State Division of Benefits Administration at 1-866-576-0029.

Additionally, a consumer assistance program can help you file your appeal. Contact the Tennessee Department of Commerce and Insurance (TDCI) at 1-800-342-4029, <https://sbs-tn.naic.org/Lion-Web/servlet/org.naic.sbs.ext.onlineComplaint.OnlineComplaintCtrl?spanishVersion=N>, or email them at CIS.Complaints@state.tn.us. You may also write them at 500 James Robertson Pkwy, Davy Crockett Tower, 6th Floor, Nashville, TN 37243.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible **\$1,125**
- Specialist coinsurance **30%**
- 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 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <u>Cost Sharing</u> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$1,100 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$3,400 |
| <u>What isn't covered</u> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$4,560 |

Managing Joe's type 2 Diabetes

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

- The plan's overall deductible **\$1,125**
- Specialist coinsurance **30%**
- 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 | \$7,400 |
|---------------------------|----------------|

In this example, Joe would pay:

| <u>Cost Sharing</u> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$1,100 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$100 |
| <u>What isn't covered</u> | |
| Limits or exclusions | \$50 |
| The total Joe would pay is | \$1,250 |

Mia's Simple Fracture

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

- The plan's overall deductible **\$1,125**
- Specialist coinsurance **30%**
- 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 | \$1,900 |
|---------------------------|----------------|

In this example, Mia would pay:

| <u>Cost Sharing</u> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$1,100 |
| <u>Copayments</u> | \$500 |
| <u>Coinsurance</u> | \$70 |
| <u>What isn't covered</u> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,670 |

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

Nondiscrimination Notice

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

BlueCross:

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

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

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

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

