This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.tn.gov/finance/ins/publications.shtml or by calling **1-800-253-9981**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network/Out-of-network: **$450/$800** employee only; **$700/$1,250** employee + child(ren); **$900/$1,600** employee + spouse; **$1,150/$2,050** employee + spouse + child(ren) Does not apply to preventive care, outpatient services, pharmacy, urgent care and emergency care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-network/Out-of-network: **$2,300/$3,500** employee only; **$3,200/$4,600** employee + child(ren); **$3,700/$5,800** employee + spouse; **$4,600/$7,500** employee + spouse + child(ren) There is a separate limit on in-network pharmacy copayments- $2,500 for employee only and $5,000 for all other tiers.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain prior authorization 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Does this plan use a network of providers?	Yes. See www.bcbst.com/members/tn_state/ or call 1-800-558-6213 for a list of participating BCBST providers. For a list of participating Cigna providers, see www.cigna.com/sites/stateoftn/index.html or call 1-800-997-1617.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25/visit	$45/visit	None
	Specialist visit	$45/visit	$70/visit	None
	Other practitioner office visit	Chiropractor $25 visits 1-20 $45 visits 21 and up	Chiropractor $45 visits 1-20 $70 visits 21 and up	None
	Preventive care/ screening/ immunization	No Charge	$45/visit	None

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	No Charge up to the allowed amount	None
	Imaging (CT/PET scans, MRIs)	10% co-insurance	40% co-insurance	No in-network benefits without prior authorization (PA). Out-of-network benefits are reduced by half if PA is not obtained.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at info.caremark.com/stateoftn	Generic drugs	$5/prescription for a 30-day supply or a 90-day supply of some maintenance drugs $10/prescription for 90-day supply of other drugs	Copay plus charges exceeding the allowed amount	90-day supply must be obtained from a 90-day retail network pharmacy or mail order. Maintenance drugs include some antihypertensives, oral diabetic medications, insulin and diabetic supplies (needles, test strips and lancets) and statins.
	Preferred brand drugs	$35/prescription for a 30-day supply $30/prescription for a 90-day supply of some maintenance drugs $65/prescription for 90-day supply of other drugs	Copay plus charges exceeding the allowed amount	
	Non-preferred brand drugs	$85/prescription for a 30-day supply $160/prescription for a 90-day supply of some maintenance drugs $165/prescription for 90-day supply of other drugs	Copay plus charges exceeding the allowed amount	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Specialty drugs	$5/prescription Generic $35/prescription Preferred Brand $85/prescription Non-Preferred Brand	Not Covered	A 30-day supply limit applies to each prescription. Prescriptions must be obtained from a Caremark Specialty Network Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance	40% co-insurance	No in-network benefits without PA. Out-of-network benefits are reduced by half if PA is not obtained.
	Physician/surgeon fees	10% co-insurance	40% co-insurance	
If you need immediate medical attention	Emergency room services	$125/visit	$125/visit	Copayment waived if admitted. For out-of-network services, you will owe 100% of charges above the allowed amount if the situation was not an emergency. Durable medical equipment and advanced imaging services are subject to deductible and coinsurance.
	Emergency medical transportation	10% co-insurance	10% co-insurance	None
	Urgent care	$30/visit	$30/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance	40% co-insurance	No in-network benefits without PA. Out-of-network benefits are reduced by half if PA is not obtained.
	Physician/surgeon fee	10% co-insurance	40% co-insurance	

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25/visit	$45/visit	No in-network benefits for psychological testing, electroconvulsive therapy, applied behavior analysis, office-based opiate treatment, and transcranial magnetic stimulation without PA. Out-of-network benefits are reduced by half if PA is not obtained.
	Mental/Behavioral health inpatient services	10% co-insurance	40% co-insurance	
	Substance use disorder outpatient services	$25/visit	$45/visit	
	Substance use disorder inpatient services	10% co-insurance	40% co-insurance	
If you are pregnant	Prenatal and postnatal care	$25 initial prenatal visit $25/visit postnatal	$45 initial prenatal visit $45/visit postnatal	None
	Delivery and all inpatient services	10% co-insurance	40% co-insurance	None
If you need help recovering or have other special health needs	Home health care	10% co-insurance	40% co-insurance	Pre-authorized, part-time, intermittent home nursing care limited to 125 visits/plan year. Home health aide care limited to 30 visits per plan year.
	Rehabilitation services	10% co-insurance	40% co-insurance	Pre-authorized inpatient therapy. Outpatient restorative therapies limited to 90 days/plan year (speech, physical, and occupational therapies combined)
	Habilitation services	Not Covered	Not Covered	No coverage for habilitation services
	Skilled nursing care	10% co-insurance	40% co-insurance	No in-network benefits without prior authorization (PA). Out-of-network benefits are reduced by half if PA is not obtained.
	Durable medical equipment	10% co-insurance	40% co-insurance	No in-network benefits for more expensive items without PA. Out-of-network benefits are reduced by half if PA is not obtained
	Hospice service	No Charge	No Charge	100% coverage up to allowed amount even if deductible not met
If your child needs dental or eye care	Eye exam	$45/visit	$70/visit	Limited to illness or injury. Routine refraction not covered.
	Glasses	10% co-insurance	40% co-insurance	Limited to the first pair of eyeglasses following cataract surgery.
	Dental check-up	Not Covered	Not Covered	No coverage for dental check-ups

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Habilitation Services
- Long-term care
- Routine eye care (Adult)
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (if performed by a physician or registered nurse as an anesthetic in connection with a surgical procedure)
- Bariatric Surgery
- Chiropractic care
- Dental care (Adult) – limited to extraction of impacted wisdom teeth, excision of solid-based oral tumors, accidental injury, orthodontic treatment for facial hemiatrophy or congenital birth defect
- Hearing aids (every 3 years for children under age 18)
- Infertility Treatment (if fertilization services are initiated, benefits will cease)
- Non-emergency care when traveling outside the U.S (for business or pleasure)
- Private-duty nursing
- Routine foot care (diabetics only)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-800-253-9981. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: BlueCross BlueShield of Tennessee at 1-800-558-6213 or Cigna at 1-800-997-1617. You may also contact Benefits Administration at 1-800-253-9981.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.
Note: Examples are based on employee only deductible and out-of-pocket maximum amounts.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,320
- **Patient pays** $1,220

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$450
Copays	$10
Coinsurance	$610
Limits or exclusions	$150
Total	**$1,220**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,320
- **Patient pays** $1,080

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$450
Copays	$450
Coinsurance	$100
Limits or exclusions	$80
Total	**$1,080**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-253-9981 or visit us at www.tn.gov/finance/ins/.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.cciio.cms.gov or call 1-800-253-9981 to request a copy.