
 **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 1-888-796-0609 (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://healthcare.gov/sbc-glossary> or call 1-888-796-0609 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: \$300 person/\$900 family Out-of-network: \$550 person/\$1,650 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, Office visits, 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: \$2,000 person/\$4,000 family; Out-of-network: \$3,000 person/\$5,000 family Pharmacy (in-network only): \$2,000 person/\$4,000 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/network-P or call 1-888-796-0609 for a list of <u>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
		<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 office</u> or clinic	Primary care visit to treat an injury or illness	\$15 <u>copay</u> /visit	30% <u>coinsurance</u>	Teladoc Health \$15 <u>copay</u> St. Jude On-site Clinic (Employee Only) - \$10 <u>copay</u> /visit
	<u>Specialist</u> visit	\$25 <u>copay</u> /visit	30% <u>coinsurance</u>	In-Network Office surgery subject to Primary Care/Specialist <u>copayment</u> . Out-of-Network Office surgery subject to <u>deductible</u> and <u>coinsurance</u> .
	<u>Preventive care/screening/immunization</u>	No Charge	30% <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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u> without associated office visit On-Site Clinic: No Charge	30% <u>coinsurance</u>	Diagnostic testing benefits are determined by place of service, such as office or ER. St. Jude On-site Clinic (Employee Only) – If filed with Office Visit, <u>copay</u> will apply.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u> without associated office visit	30% <u>coinsurance</u>	Prior Authorization required.

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 need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Generic drugs	\$5 <u>copay</u> (retail) \$10 <u>copay</u> (mail order or Maintenance Choice retail)	Not Covered	No <u>copayment</u> applies for Generic preventive care drugs (e.g., covered tobacco cessation products or contraception).
	Preferred brand drugs	\$30 <u>copay</u> (retail) \$60 <u>copay</u> (mail order or Maintenance Choice retail)	Not Covered	If a Generic drug is available and you obtain a Preferred brand name drug instead, the Generic drug <u>copayment</u> above applies, plus you pay the difference in the cost of the Brand name drug and the Generic drug.
	Non-preferred brand drugs	\$60 <u>copay</u> (retail) \$120 <u>copay</u> (mail order or Maintenance Choice retail)	Not Covered	None
	<u>Specialty drugs</u>	\$75 <u>copay</u> (retail) \$150 <u>copay</u> (mail order or Maintenance Choice retail)	Not Covered	Step Therapy may apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Prior Authorization required for certain outpatient procedures.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Prior Authorization required for certain outpatient procedures.
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit	\$100 <u>copay</u> /visit	<u>Copayment</u> is waived if admitted as an inpatient, and hospital stay provisions below (including <u>coinsurance</u> and Prior Authorization requirement) will instead apply.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$35 <u>copay</u>	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Prior Authorization required.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Prior Authorization required.

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 need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <u>copay/visit</u> <u>deductible</u> does not apply for office visits and 10% <u>coinsurance</u> other outpatient services	30% <u>coinsurance</u>	Prior Authorization required for electro-convulsive therapy (ECT). St. Jude On-site Clinic (Employee Only) - \$10 <u>copay/visit</u>
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Prior Authorization required.
If you are pregnant	Office visits	\$15 <u>copay/visit</u>	30% <u>coinsurance</u>	Teladoc Health \$15 <u>copay</u> In-Network Office surgery subject to Primary Care/Specialist <u>copayment</u> . Out-of-Network Office surgery subject to <u>deductible</u> and <u>coinsurance</u> .
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	This service may be covered under the Specialty Care Program. Cost Share may vary; use a Blue Distinction Center for best benefit.
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	This service may be covered under the Specialty Care Program. Cost Share may vary; use a Blue Distinction Center for best benefit. Prior Authorization is required for hospital stays over 48 hours for a vaginal delivery and over 96 hours for a cesarean section delivery.
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Prior Authorization required and may be subject to a penalty if not obtained.
	<u>Rehabilitation services</u>	\$25 <u>copay/visit</u>	30% <u>coinsurance</u>	Physical, speech, occupational and spinal manipulation therapy limited to 36 visits per type per year (visit limit does not apply when therapy provided for autism diagnosis).
	<u>Habilitation services</u>	\$25 <u>copay/visit</u>	30% <u>coinsurance</u>	Physical, speech, occupational and spinal manipulation therapy limited to 36 visits per

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)	
				type per year (visit limit does not apply when therapy provided for autism diagnosis).
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Skilled nursing and rehabilitation facility limited to 120 days combined per year. Prior Authorization required and may be subject to a penalty if not obtained.
	<u>Durable medical equipment</u>	No charge with office visit; 10% <u>coinsurance</u> without office visit	30% <u>coinsurance</u>	Prior Authorization may be required for certain <u>durable medical equipment</u> .
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Prior Authorization required for inpatient hospice.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	May be covered under separate vision or dental plan, if you have one.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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 • Cosmetic surgery • Dental care (Adult) • Dental care (Children) 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. • Routine eye care (Adult) 	<ul style="list-style-type: none"> • 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"> • Bariatric surgery • Chiropractic care • Hearing aids for adults 	<ul style="list-style-type: none"> • Hearing aids for children under 18 • Infertility treatment (only if obtained through Progyny) 	<ul style="list-style-type: none"> • Prescription Drugs (only if obtained In-Network) • Private-duty nursing

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 or BlueCross at 1-888-796-0609 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 1-888-796-0609 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.

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.**

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>	\$300
■ <u>Specialist copay</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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>	\$300
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Peg would pay is	\$1,570

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>	\$300
■ <u>Specialist copay</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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>	\$300
<u>Copayments</u>	\$90
<u>Coinsurance</u>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$400
The total Joe would pay is	\$1,190

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$300
■ <u>Specialist copay</u>	\$25
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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>	\$300
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Mia would pay is	\$810

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>.

