



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.bcbst.com or by calling 1-800-565-9140. Coverage documents are not available until after the effective date of your coverage, but you may obtain a sample at <http://www.bcbst.com/samplepolicy/2017/LG>. This sample may not match your benefits exactly, so you should review your coverage document once it is available. Contributions made by you and/or your employer to health savings accounts (HSAs), flexible spending arrangements (FSAs), or health reimbursement arrangements (HRAs) may help pay your deductible or other out-of-pocket expenses.

| Important Questions | Answers | Why this Matters: |
|--|---|---|
| What is the overall <u>deductible</u>? | In-network: \$500 person/ \$1,000 family Out-of-network: \$1,000 person/ \$2,000 family Doesn't apply to preventive care. Copays do not apply to the deductible. | 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 <u>deductibles</u> 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 <u>out-of-pocket limit</u> on my expenses? | Yes. In-network: \$2,500 person/ \$5,000 family Out-of-network: \$7,500 person/ \$15,000 family | 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 <u>out-of-pocket limit</u>? | Premium, balance-billed charges, penalties, and health care this plan doesn't cover. | 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 <i>specific</i> covered services, such as office visits. |
| Does this plan use a <u>network of providers</u>? | Yes. For a list of in-network providers , see www.bcbst.com or call 1-800-565-9140. | 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 <u>specialist</u>? | No. You don't need a referral to see a specialist. | You can see the specialist you choose without permission from this plan. |

Questions: Call 1-800-565-9140 or visit us at www.bcbst.com.

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/pdf/SBCUniformGlossary.pdf or call 1-800-565-9140 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---------|---|
| 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 . |

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Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Co-insurance** 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 **co-insurance** 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**, **co-payments** and **co-insurance** amounts.

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions |
|---|--|---|--|---|
| | | In-Network Provider | Out-Of-Network Provider | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | 20% co-insurance | 40% co-insurance | —————none————— |
| | Specialist visit | 20% co-insurance | 40% co-insurance | —————none————— |
| | Other practitioner office visit | 20% co-insurance | 40% co-insurance | Therapy visits limited to 30 per type per year. Cardiac/Pulmonary Rehab visits limited to 36 per type per year. |
| | Preventive care/screening/immunization | No Charge | 40% co-insurance | —————none————— |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% co-insurance | 40% co-insurance | —————none————— |
| | Imaging (CT/PET scans, MRIs) | 20% co-insurance | 40% co-insurance | Prior Authorization required. Your cost share may increase to 50% if not obtained. |
| If you need drugs to treat your illness or condition | Level 1 Drugs 30 Day Retail 90 Day Retail 90 Day Mail Order | <u>Preventive</u> \$0.00 \$0.00 \$0.00 | <u>All Other</u> \$5.00 \$12.50 \$10.00 | Not Covered The Deductible does not apply. Co-pay applies per prescription. |

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions | |
|---|--|--|--|--------------------------|--|
| | | In-Network Provider | Out-Of-Network Provider | | |
| More information about prescription drug coverage is available at: www.optumrx.com | Level 2 Drugs 30 Day Retail 90 Day Retail 90 Day Mail Order | <u>Preventive</u> \$5.00 \$12.50 \$10.00 | <u>All Other</u> \$10.00 \$25.00 \$20.00 | Not Covered | The Deductible does not apply. Co-pay applies per prescription. |
| | Level 3 Drugs 30 Day Retail 90 Day Retail 90 Day Mail Order | <u>Preventive</u> \$10.00 \$25.00 \$20.00 | <u>All Other</u> \$20.00 \$50.00 \$40.00 | Not Covered | The Deductible does not apply. Co-pay applies per prescription. |
| | Level 4 Drugs 30 Day Retail 90 Day Retail 90 Day Mail Order | <u>Preventive</u> \$20.00 \$50.00 \$40.00 | <u>All Other</u> \$40.00 \$100.00 \$80.00 | Not Covered | The Deductible does not apply. Co-pay applies per prescription. |
| | Level 5 Drugs - Self-Administered Specialty 30 Day Retail 90 Day Retail and Mail | <u>Preventive</u> \$40.00 Not Covered | <u>All Other</u> \$80.00 Not Covered | Not Covered | The Deductible does not apply. Co-pay applies per prescription. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% co-insurance | 40% co-insurance | | Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained. |
| | Physician/surgeon fees | 20% co-insurance | 40% co-insurance | | Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained. |
| If you need immediate medical attention | Emergency room services | \$150 co-pay/visit | \$150 co-pay/visit | | —————none————— |
| | Emergency medical transportation | 20% co-insurance | 20% co-insurance | | —————none————— |
| | Urgent care | See Limitations & Exceptions | See Limitations & Exceptions | | Urgent Care benefits are determined by place of service, such as physician's office or ER. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% co-insurance | 40% co-insurance | | Prior Authorization required. Your cost share may increase to 50% if not obtained. |
| | Physician/surgeon fee | 20% co-insurance | 40% co-insurance | | —————none————— |

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions |
|---|--|------------------------|-------------------------|---|
| | | In-Network Provider | Out-Of-Network Provider | |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | 20% co-insurance | 40% co-insurance | Prior Authorization required for electro-convulsive therapy (ECT). Your cost share may increase to 50% if not obtained. |
| | Mental/Behavioral health inpatient services | 20% co-insurance | 40% co-insurance | Prior Authorization required. Your cost share may increase to 50% if not obtained. |
| | Substance use disorder outpatient services | 20% co-insurance | 40% co-insurance | Prior Authorization required for electro-convulsive therapy (ECT). Your cost share may increase to 50% if not obtained. |
| | Substance use disorder inpatient services | 20% co-insurance | 40% co-insurance | Prior Authorization required. Your cost share may increase to 50% if not obtained. |
| If you are pregnant | Prenatal and postnatal care | 20% co-insurance | 40% co-insurance | —————none————— |
| | Delivery and all inpatient services | 20% co-insurance | 40% co-insurance | —————none————— |
| If you need help recovering or have other special health needs | Home health care | 20% co-insurance | 40% co-insurance | Limited to 60 visits. |
| | Rehabilitation services | 20% co-insurance | 40% co-insurance | Therapy limited to 20 visits per type per year. Cardiac/Pulmonary Rehab limited to 36 visits per type per year. |
| | Habilitation services | 20% co-insurance | 40% co-insurance | |
| | Skilled nursing care | 20% co-insurance | 40% co-insurance | Skilled Nursing and Rehabilitation Facility limited to 60 days/year combined. |
| | Durable medical equipment | 20% co-insurance | 40% co-insurance | Prior Authorization may be required for certain durable medical equipment. |
| | Hospice service | No Charge | 40% co-insurance | Prior Authorization required for Inpatient Hospice. |
| If your child needs dental or eye care | Eye exam | Not Covered | Not Covered | —————none————— |
| | Glasses | Not Covered | Not Covered | —————none————— |
| | Dental check-up | Not Covered | Not Covered | —————none————— |

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**.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Hearing aids for adults
- Infertility treatment
- Long-term care
- Prescription Drugs
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Children)
- Routine foot care for non-diabetics
- 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.)

- Chiropractic care
- Hearing aids for children under 18
- Non-emergency care when traveling outside the U.S.

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 **1-800-565-9140**. 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:

- Your Plan at **1-800-565-9140** or www.bcbst.com.
- The Department of Labor's Employee Benefits Security Administration at **1-866-444-3272** or www.dol.gov/ebsa/healthreform.

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.



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.

- Amount owed to providers: \$7,540
- Plan pays \$5,680
- Patient pays \$1,860

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 | \$500 |
| Copays | \$0 |
| Co-insurance | \$1,360 |
| Limits or exclusions | \$0 |
| Total | \$1,860 |

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,420
- Patient pays \$980

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 | \$500 |
| Copays | \$0 |
| Co-insurance | \$480 |
| Limits or exclusions | \$0 |
| Total | \$980 |

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 **co-insurance** 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 **co-insurance**. 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.

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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>.

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Language Access Services:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-565-9140 (TTY: 1-800-848-0298).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-565-9140 (رقم هاتف الصم والبكم: 1-800-848-0298).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-565-9140 (TTY:1-800-848-0298)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-565-9140 (TTY:1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-565-9140 (TTY: 1-800-848-0298) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-565-9140 (ATS : 1-800-848-0298).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ຄມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-565-9140 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም አርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-800-565-9140 (መስማት ለተሳናቸው: 1-800-848-0298).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-565-9140 (TTY: 1-800-848-0298).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-565-9140 (TTY:1-800-848-0298)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-565-9140 (TTY:1-800-848-0298) まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-565-9140 (TTY:1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-565-9140 (TTY:1-800-848-0298) पर कॉल करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-565-9140 (телетайп: 1-800-848-0298).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-565-9140 (TTY:1-800-848-0298) تماس بگیرید.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-565-9140 (TTY: 1-800-848-0298).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-565-9140 (TTY: 1-800-848-0298).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-565-9140 (TTY: 1-800-848-0298).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-565-9140 (TTY: 1-800-848-0298).

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé',t'áá jiik'eh, éí ná hóló, kójj' hódíłnih 1-800-565-9140 (TTY: 1-800-848-0298).

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| What is not included in the <u>out-of-pocket limit</u>? | Premium, balance-billed charges, penalties, and health care this plan doesn't cover. | 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 <i>specific</i> covered services, such as office visits. |
| Does this plan use a <u>network of providers</u>? | Yes. For a list of in-network providers , see www.bcbst.com or call 1-800-565-9140. | 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 <u>specialist</u>? | No. You don't need a referral to see a specialist. | You can see the specialist you choose without permission from this plan. |

Questions: Call 1-800-565-9140 or visit us at www.bcbst.com.

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/pdf/SBCUniformGlossary.pdf or call 1-800-565-9140 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---------|---|
| 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.
- Co-insurance** 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 **co-insurance** 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**, **co-payments** and **co-insurance** amounts.

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions | |
|---|--|---|--|---|---|
| | | In-Network Provider | Out-Of-Network Provider | | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | 20% co-insurance | 40% co-insurance | —————none————— | |
| | Specialist visit | 20% co-insurance | 40% co-insurance | —————none————— | |
| | Other practitioner office visit | 20% co-insurance | 40% co-insurance | Therapy visits limited to 30 per type per year. Cardiac/Pulmonary Rehab visits limited to 36 per type per year. | |
| | Preventive care/screening/immunization | No Charge | 40% co-insurance | —————none————— | |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% co-insurance | 40% co-insurance | —————none————— | |
| | Imaging (CT/PET scans, MRIs) | 20% co-insurance | 40% co-insurance | Prior Authorization required. Your cost share may increase to 50% if not obtained. | |
| If you need drugs to treat your illness or condition | Level 1 Drugs 30 Day Retail 90 Day Retail 90 Day Mail Order | <u>Preventive</u> \$0.00 \$0.00 \$0.00 | <u>All Other</u> \$5.00 \$12.50 \$10.00 | Not Covered | The Deductible does not apply. Co-pay applies per prescription. |

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions | |
|---|--|--|--|--------------------------|--|
| | | In-Network Provider | Out-Of-Network Provider | | |
| More information about prescription drug coverage is available at: www.optumrx.com | Level 2 Drugs 30 Day Retail 90 Day Retail 90 Day Mail Order | <u>Preventive</u> \$5.00 \$12.50 \$10.00 | <u>All Other</u> \$10.00 \$25.00 \$20.00 | Not Covered | The Deductible does not apply. Co-pay applies per prescription. |
| | Level 3 Drugs 30 Day Retail 90 Day Retail 90 Day Mail Order | <u>Preventive</u> \$10.00 \$25.00 \$20.00 | <u>All Other</u> \$20.00 \$50.00 \$40.00 | Not Covered | The Deductible does not apply. Co-pay applies per prescription. |
| | Level 4 Drugs 30 Day Retail 90 Day Retail 90 Day Mail Order | <u>Preventive</u> \$20.00 \$50.00 \$40.00 | <u>All Other</u> \$40.00 \$100.00 \$80.00 | Not Covered | The Deductible does not apply. Co-pay applies per prescription. |
| | Level 5 Drugs - Self-Administered Specialty 30 Day Retail 90 Day Retail and Mail | <u>Preventive</u> \$40.00 Not Covered | <u>All Other</u> \$80.00 Not Covered | Not Covered | The Deductible does not apply. Co-pay applies per prescription. |
| | | | | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% co-insurance | 40% co-insurance | | Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained. |
| | Physician/surgeon fees | 20% co-insurance | 40% co-insurance | | Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained. |
| If you need immediate medical attention | Emergency room services | 20% co-insurance | 20% co-insurance | | —————none————— |
| | Emergency medical transportation | 20% co-insurance | 20% co-insurance | | —————none————— |
| | Urgent care | See Limitations & Exceptions | See Limitations & Exceptions | | Urgent Care benefits are determined by place of service, such as physician's office or ER. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% co-insurance | 40% co-insurance | | Prior Authorization required. Your cost share may increase to 50% if not obtained. |
| | Physician/surgeon fee | 20% co-insurance | 40% co-insurance | | —————none————— |

| Common Medical Event | Services You May Need | Your cost if you use a | | Limitations & Exceptions |
|---|--|------------------------|-------------------------|---|
| | | In-Network Provider | Out-Of-Network Provider | |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | 20% co-insurance | 40% co-insurance | Prior Authorization required for electro-convulsive therapy (ECT). Your cost share may increase to 50% if not obtained. |
| | Mental/Behavioral health inpatient services | 20% co-insurance | 40% co-insurance | Prior Authorization required. Your cost share may increase to 50% if not obtained. |
| | Substance use disorder outpatient services | 20% co-insurance | 40% co-insurance | Prior Authorization required for electro-convulsive therapy (ECT). Your cost share may increase to 50% if not obtained. |
| | Substance use disorder inpatient services | 20% co-insurance | 40% co-insurance | Prior Authorization required. Your cost share may increase to 50% if not obtained. |
| If you are pregnant | Prenatal and postnatal care | 20% co-insurance | 40% co-insurance | —————none————— |
| | Delivery and all inpatient services | 20% co-insurance | 40% co-insurance | —————none————— |
| If you need help recovering or have other special health needs | Home health care | 20% co-insurance | 40% co-insurance | Limited to 60 visits. |
| | Rehabilitation services | 20% co-insurance | 40% co-insurance | Therapy limited to 20 visits per type per year. Cardiac/Pulmonary Rehab limited to 36 visits per type per year. |
| | Habilitation services | 20% co-insurance | 40% co-insurance | |
| | Skilled nursing care | 20% co-insurance | 40% co-insurance | Skilled Nursing and Rehabilitation Facility limited to 60 days/year combined. |
| | Durable medical equipment | 20% co-insurance | 40% co-insurance | Prior Authorization may be required for certain durable medical equipment. |
| | Hospice service | No Charge | 40% co-insurance | Prior Authorization required for Inpatient Hospice. |
| If your child needs dental or eye care | Eye exam | Not Covered | Not Covered | —————none————— |
| | Glasses | Not Covered | Not Covered | —————none————— |
| | Dental check-up | Not Covered | Not Covered | —————none————— |

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**.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Hearing aids for adults
- Infertility treatment
- Long-term care
- Prescription Drugs
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Children)
- Routine foot care for non-diabetics
- 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.)

- Chiropractic care
- Hearing aids for children under 18
- Non-emergency care when traveling outside the U.S.

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 **1-800-565-9140**. 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:

- Your Plan at **1-800-565-9140** or www.bcbst.com.
- The Department of Labor's Employee Benefits Security Administration at **1-866-444-3272** or www.dol.gov/ebsa/healthreform.

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.



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.

- Amount owed to providers: \$7,540
- Plan pays \$5,280
- Patient pays \$2,260

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 | \$1000 |
| Copays | \$0 |
| Co-insurance | \$1,260 |
| Limits or exclusions | \$0 |
| Total | \$2,260 |

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,920
- Patient pays \$1,480

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 | \$1000 |
| Copays | \$0 |
| Co-insurance | \$480 |
| Limits or exclusions | \$0 |
| Total | \$1,480 |

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 **co-insurance** 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 **co-insurance**. 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 1-800-565-9140 or visit us at www.bcbst.com.

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/pdf/SBCUniformGlossary.pdf or call 1-800-565-9140 to request a copy.

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>.

Questions: Call 1-800-565-9140 or visit us at www.bcbst.com.

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/pdf/SBCUniformGlossary.pdf or call 1-800-565-9140 to request a copy.

Language Access Services:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-565-9140 (TTY: 1-800-848-0298).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-565-9140 (رقم هاتف الصم والبكم: 1-800-848-0298).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-565-9140 (TTY:1-800-848-0298)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-565-9140 (TTY:1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-565-9140 (TTY: 1-800-848-0298) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-565-9140 (ATS : 1-800-848-0298).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຍຄ່າ, ຄມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-565-9140 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም አርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-800-565-9140 (መስማት ለተሳናቸው: 1-800-848-0298).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-565-9140 (TTY: 1-800-848-0298).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-565-9140 (TTY:1-800-848-0298)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-565-9140 (TTY:1-800-848-0298) まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-565-9140 (TTY:1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-565-9140 (TTY:1-800-848-0298) पर कॉल करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-565-9140 (телетайп: 1-800-848-0298).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-565-9140 (TTY:1-800-848-0298) تماس بگیرید.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-565-9140 (TTY: 1-800-848-0298).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-565-9140 (TTY: 1-800-848-0298).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-565-9140 (TTY: 1-800-848-0298).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-565-9140 (TTY: 1-800-848-0298).

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé',t'áá jiik'eh, éí ná hóló, kójjí' hódíłnih 1-800-565-9140 (TTY: 1-800-848-0298).

Questions: Call **1-800-565-9140** or visit us at **www.bcbst.com**.

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/pdf/SBCUniformGlossary.pdf** or call **1-800-565-9140** to request a copy.