

City Of Knoxville Health Plan: Medical Only \$500 Network S and P Coverage Period: Beginning on or after 01/01/2015

Summary of Coverage: What this Plan Covers & What it Costs

Coverage for: Individual or Family | Plan Type: PPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete medical terms in the policy or plan document at www.bcbst.com or by calling 1-800-565-9140; and prescription drug at www.cityofknoxvillerox.com or by calling 1-800-797-9791.

Contributions made by you and/or your employer to 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. Co-pays 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 (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. The Medical limit is -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, pre-certification penalty amounts, balance-billed charges, 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 – BCBST Network S or P. 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 can see the specialist you choose without permission from this plan.

Medical Questions: Call 1-800-565-9140 or visit www.bcbst.com. Pharmacy Questions: Call 1-800-797-9791 or visit www.optumrx.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.cciio.cms.gov or www.dol.gov/ebsa/healthreform 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 5. See your policy or plan document for additional information about excluded services .

- 
- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care or prescription drugs, 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 encourages 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 are limited to 30 per type per year. Chiropractic services are limited to 20 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.
If you need drugs to treat your illness or condition	Level 1 Drugs 30 Day Retail 90 Day Retail 90 Day Mail Order	<u>Full Drug List</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 <u>prescription drug coverage</u> is available at www.optumrx.com .	Level 2 Drugs 30 Day Retail 90 Day Retail 90 Day Mail Order	<u>Full Drug List</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>Full Drug List</u> \$30.00 \$75.00 \$60.00	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>Full Drug List</u> \$60.00 \$150.00 \$120.00	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>Full Drug List</u> \$100.00 Not Available	Not Covered	The Deductible does not apply. Co-Co-pay applies per prescription.
	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	Prior Authorization required for certain outpatient procedures.
If you have outpatient surgery	Physician/surgeon fees	20% co-insurance	40% co-insurance	Prior Authorization required for certain outpatient procedures.
If you need immediate medical attention	Emergency room services	\$150 co-pay	\$150 co-pay	—————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.
	Physician/surgeon fee	20% co-insurance	40% co-insurance	—————none—————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance	40% co-insurance	—————none—————
	Mental/Behavioral health inpatient services	20% co-insurance	40% co-insurance	Prior Authorization required.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
	Substance use disorder outpatient services	20% co-insurance	40% co-insurance	—————none—————
	Substance use disorder inpatient services	20% co-insurance	40% co-insurance	Prior Authorization required.
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 visits limited to 30 per type per year. Chiropractic services are limited to 20 per year. Cardiac/Pulmonary Rehab visits limited to 36 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	—————none—————
	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—————

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-800-565-9140**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-565-9140**.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **1-800-565-9140**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' **1-800-565-9140**.

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
- 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.)

- Bariatric surgery
- 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 laws 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.

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.**

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.

—————*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 \$5,635
- Patient pays \$1,905

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions – 9 preventive generic	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$500
Co-pays	\$45
Co-insurance	\$1,360
Limits or exclusions	\$0
Total	\$1,905

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,400
- Patient pays \$1,000

Sample care costs:

Prescriptions – 24 generic preventive	\$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
Co-pays	\$120
Co-insurance	\$380
Limits or exclusions	\$0
Total	\$1,000

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**, **co-payments**, 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 **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket

Questions: Call 1-800-565-9140 or visit us at www.bcbst.com. **Pharmacy Questions:** Call 1-800-797-9791 or visit www.optumrx.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.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-800-565-9140 to request a copy.



This is only a summary. If you want more detail about your coverage and costs, you can get the complete medical terms in the policy or plan document at www.bcbst.com or by calling **1-800-565-9140**; and prescription drug at www.cityofknoxvillerox.com or by calling 1-800-797-9791.

Contributions made by you and/or your employer to 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. Co-pays 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 (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. The Medical limit is - 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, pre-certification penalty amounts, balance-billed charges, 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 – BCBST Network S or P. 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 can see the specialist you choose without permission from this plan.

Medical Questions: Call **1-800-565-9140** or visit www.bcbst.com. **Pharmacy Questions:** Call **1-800-797-9791** or visit www.optumrx.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.cciio.cms.gov or www.dol.gov/ebsa/healthreform 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 5. See your policy or plan document for additional information about excluded services .



- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care or prescription drugs, 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 encourages 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. Chiropractic services are limited to 20 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.
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 <u>prescription drug coverage</u> 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	40% co-insurance	Prior Authorization required for certain outpatient procedures.
	Physician/surgeon fees	20% co-insurance	40% co-insurance	40% co-insurance	Prior Authorization required for certain outpatient procedures.
If you need immediate medical attention	Emergency room services	\$150 co-pay	\$150 co-pay	\$150 co-pay	—————none—————
	Emergency medical transportation	20% co-insurance	20% co-insurance	20% co-insurance	—————none—————
	Urgent care	See Limitations & Exceptions	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	40% co-insurance	Prior Authorization required.
	Physician/surgeon fee	20% co-insurance	40% co-insurance	40% co-insurance	—————none—————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance	40% co-insurance	40% co-insurance	—————none—————
	Mental/Behavioral health inpatient services	20% co-insurance	40% co-insurance	40% co-insurance	Prior Authorization required.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
	Substance use disorder outpatient services	20% co-insurance	40% co-insurance	—————none—————
	Substance use disorder inpatient services	20% co-insurance	40% co-insurance	Prior Authorization required.
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 visits limited to 30 per type per year. Chiropractic services are limited to 20 per year. Cardiac/Pulmonary Rehab visits limited to 36 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	—————none—————
	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—————

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-800-565-9140**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-565-9140**.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **1-800-565-9140**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' **1-800-565-9140**.

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
- 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.)

- Bariatric surgery
- 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 laws 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.

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.**

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.

—————*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 – 9 preventive generic	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$500
Co-pays	\$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** \$4,520
- **Patient pays** \$880

Sample care costs:

Prescriptions – 24 generic preventive	\$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
Co-pays	\$0
Co-insurance	\$380
Limits or exclusions	\$0
Total	\$880

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**, **co-payments**, 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 **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as 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. **Pharmacy Questions:** Call 1-800-797-9791 or visit www.optumrx.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.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-800-565-9140 to request a copy.

City Of Knoxville Health Plan: Medical Only \$1000 Network S and P Coverage Period: Beginning on or after 01/01/2015

Summary of Coverage: What this Plan Covers & What it Costs

Coverage for: Individual or Family | Plan Type: PPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete medical terms in the policy or plan document at www.bcbst.com or by calling 1-800-565-9140; and prescription drug at www.cityofknoxvillerox.com or by calling 1-800-797-9791.

Contributions made by you and/or your employer to 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 deductible?	In-network: \$1,000 person/ \$2,000 family Out-of-network: \$2,000 person/ \$4,000 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 (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. The Medical limit is - 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 out-of-pocket limit?	Premium, pre-certification penalty amounts, balance-billed charges, 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 network of providers?	Yes – BCBST Network S or P. 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 specialist?	No.	You can see the specialist you choose without permission from this plan.

Medical Questions: Call 1-800-565-9140 or visit www.bcbst.com. **Pharmacy Questions:** Call 1-800-797-9791 or visit www.optumrx.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.cciio.cms.gov or www.dol.gov/ebsa/healthreform 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 5. 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 or prescription drugs, 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 encourages 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. Chiropractic services are limited to 20 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.
If you need drugs to treat your illness or condition	Level 1 Drugs 30 Day Retail 90 Day Retail 90 Day Mail Order	<u>Full Drug List</u> \$5.00 \$12.50 \$10.00	Not Covered	The Deductible does not apply. Copay 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 <u>prescription drug coverage</u> is available at www.optumrx.com .	Level 2 Drugs 30 Day Retail 90 Day Retail 90 Day Mail Order	<u>Full Drug List</u> \$10.00 \$25.00 \$20.00	Not Covered	The Deductible does not apply. Copay applies per prescription.
	Level 3 Drugs 30 Day Retail 90 Day Retail 90 Day Mail Order	<u>Full Drug List</u> \$30.00 \$75.00 \$60.00	Not Covered	The Deductible does not apply. Copay applies per prescription.
	Level 4 Drugs 30 Day Retail 90 Day Retail 90 Day Mail Order	<u>Full Drug List</u> \$60.00 \$150.00 \$120.00	Not Covered	The Deductible does not apply. Copay applies per prescription.
	Level 5 Drugs - Self-Administered Specialty 30 Day Retail 90 Day Retail and Mail	<u>Full Drug List</u> \$100.00 Not Available	Not Covered	The Deductible does not apply. Copay 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.
	Physician/surgeon fees	20% co-insurance	40% co-insurance	Prior Authorization required for certain outpatient procedures.
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.
	Physician/surgeon fee	20% co-insurance	40% co-insurance	—————none—————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance	40% co-insurance	—————none—————
	Mental/Behavioral health inpatient services	20% co-insurance	40% co-insurance	Prior Authorization required.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
	Substance use disorder outpatient services	20% co-insurance	40% co-insurance	—————none—————
	Substance use disorder inpatient services	20% co-insurance	40% co-insurance	Prior Authorization required.
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 visits limited to 30 per type per year. Chiropractic services are limited to 20 per year. Cardiac/Pulmonary Rehab visits limited to 36 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	—————none—————
	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—————

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-800-565-9140**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-565-9140**.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **1-800-565-9140**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' **1-800-565-9140**.

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
- 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.)

- Bariatric surgery
- 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 laws 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.

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.**

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.

—————*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 \$5,145
- Patient pays \$2,305

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions – 9 preventive generic	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$1,000
Copays	\$45
Co-insurance	\$1,260
Limits or exclusions	\$0
Total	\$2,305

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,000
- Patient pays \$1,400

Sample care costs:

Prescriptions – 24 generic preventive	\$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	\$1,000
Copays	\$120
Co-insurance	\$280
Limits or exclusions	\$0
Total	\$1,400

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 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. **Pharmacy Questions:** Call 1-800-797-9791 or visit www.optumrx.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.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-800-565-9140 to request a copy.



This is only a summary. If you want more detail about your coverage and costs, you can get the complete medical terms in the policy or plan document at www.bcbst.com or by calling 1-800-565-9140; and prescription drug at www.cityofknoxvillerox.com or by calling 1-800-797-9791.

Contributions made by you and/or your employer to 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 deductible?	In-network: \$1,000 person/ \$2,000 family Out-of-network: \$2,000 person/ \$4,000 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 (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. The Medical limit is - 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 out-of-pocket limit?	Premium, pre-certification penalty amounts, balance-billed charges, 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 network of providers?	Yes – BCBST Network S or P. 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 specialist?	No.	You can see the specialist you choose without permission from this plan.

Medical Questions: Call 1-800-565-9140 or visit www.bcbst.com. **Pharmacy Questions:** Call 1-800-797-9791 or visit www.optumrx.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.cciio.cms.gov or www.dol.gov/ebsa/healthreform 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 5. 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 or prescription drugs, 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 encourages 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. Chiropractic services are limited to 20 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.
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. Copay 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 <u>prescription drug coverage</u> is available at www.optumrx.com .	Level 2 Drugs	<u>Preventive</u>	<u>All Other</u>	Not Covered	The Deductible does not apply. Copay applies per prescription.
	30 Day Retail	\$5.00	\$10.00		
	90 Day Retail	\$12.50	\$25.00		
	90 Day Mail Order	\$10.00	\$20.00		
	Level 3 Drugs	<u>Preventive</u>	<u>All Other</u>	Not Covered	The Deductible does not apply. Copay applies per prescription.
	30 Day Retail	\$10.00	\$20.00		
	90 Day Retail	\$25.00	\$50.00		
	90 Day Mail Order	\$20.00	\$40.00		
	Level 4 Drugs	<u>Preventive</u>	<u>All Other</u>	Not Covered	The Deductible does not apply. Copay applies per prescription.
	30 Day Retail	\$20.00	\$40.00		
	90 Day Retail	\$50.00	\$100.00		
	90 Day Mail Order	\$40.00	\$80.00		
	Level 5 Drugs - Self-Administered Specialty	<u>Preventive</u>	<u>All Other</u>	Not Covered	The Deductible does not apply. Copay applies per prescription.
	30 Day Retail	\$40.00	\$80.00		
	90 Day Retail and Mail	Not available	Not available		
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.
	Physician/surgeon fees	20% co-insurance		40% co-insurance	Prior Authorization required for certain outpatient procedures.
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.
	Physician/surgeon fee	20% co-insurance		40% co-insurance	—————none—————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance		40% co-insurance	—————none—————
	Mental/Behavioral health inpatient services	20% co-insurance		40% co-insurance	Prior Authorization required.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
	Substance use disorder outpatient services	20% co-insurance	40% co-insurance	—————none—————
	Substance use disorder inpatient services	20% co-insurance	40% co-insurance	Prior Authorization required.
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 visits limited to 30 per type per year. Chiro limited to 20 per year. Cardiac/Pulmonary Rehab visits limited to 36 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	—————none—————
	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—————

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-800-565-9140**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-565-9140**.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **1-800-565-9140**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' **1-800-565-9140**.

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
- 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.)

- Bariatric surgery
- 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 laws 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.

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.**

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.

—————*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 – 9 preventive generic	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$1,000
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 \$4,120
- Patient pays \$1,280

Sample care costs:

Prescriptions – 24 preventive generic	\$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	\$1,000
Copays	\$0
Co-insurance	\$280
Limits or exclusions	\$0
Total	\$1,280

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 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. **Pharmacy Questions:** Call 1-800-797-9791 or visit www.optumrx.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.cciio.cms.gov or www.dol.gov/ebsa/healthreform or call 1-800-565-9140 to request a copy.