



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call Benefits Administration at 1-800-253-9981 or visit <https://www.tn.gov/partnersforhealth.html>. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or www.cciio.cms.gov or call 1-800-253-9981 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	<u>In-network/Out-of-network:</u> \$1,800/\$3,600 employee only; \$2,500/\$4,800 employee + child(ren); \$2,800/\$5,500 employee + spouse; \$3,600/\$7,200 employee + spouse + child(ren)	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. In-network preventive care screenings at outpatient facilities; in-network outpatient occupational, physical and speech therapies; other preventive care ; other outpatient services, including primary and specialist office visits, behavioral health and substance use, routine x-rays, labs, and diagnostics, reading, interpretation and results, telehealth, chiropractic and acupuncture, convenience clinics, urgent care , emergency room , and pharmacy.	This plan covers some items and services even if you haven't met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	<u>In-network/Out-of-network:</u> \$6,800/\$10,400 employee only; \$13,600/\$20,800 employee + child(ren); \$13,600/\$20,800 employee + spouse; \$13,600/\$20,800 employee + spouse + child(ren)	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	<u>Premiums</u> , balance-billing charges, health care this plan doesn't cover, and penalties for failure to obtain preauthorization or failure to follow the Dispense as Written (DAW) provisions of the prescription drug benefit.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider ?	Yes. See www.bcbst.com/members/tn_state or call 1-800-558-6213 for a list of participating BCBST network providers . See www.cigna.com/sites/stateoftn or call 1-800-997-1617 for a list of Cigna network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 copay /office visit	\$55 copay /office visit	Deductible does not apply
	Specialist visit	\$55 copay /office visit	\$80 copay /office visit	Deductible does not apply
	Preventive care/screening/immunization	No charge	\$50 copay /office visit	Deductible does not apply. You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance /test	30% coinsurance /test	Deductible does not apply. You pay a separate coinsurance for reading, interpretation and results.
	Imaging (CT/PET scans, MRIs)	30% coinsurance /test	50% coinsurance /test	You pay a separate coinsurance for reading, interpretation and results. Preauthorization is required. No Network benefits and Out-of-Network benefits reduced by half if you don't get preauthorization .

* For more information about limitations and exceptions, see the plan or policy document at <https://www.tn.gov/partnersforhealth.html>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://info.caremark.com/stateoftn</p>	Generic drugs	\$14 <u>copay/prescription</u> 30-day supply; \$14 <u>copay per prescription</u> 90-day supply of some maintenance drugs; \$28 <u>copay/prescription</u> 90-day supply of other drugs	<u>Copay/prescription</u> plus charges exceeding the <u>allowed amount</u> for 30-day supply; No benefit for 90-day supply	<p><u>Deductible</u> does not apply. Certain low-dose generic statins received in-network may be covered at no charge.</p> <p>Members do not have to pay for specific medications used to treat opioid dependency.</p> <p>90-day supply must be obtained from a Retail-90 network pharmacy or mail order.</p> <p>There is no out-of-network benefit for a 90-day supply.</p>
	Preferred brand drugs	\$60 <u>copay/prescription</u> 30-day supply; \$60 <u>copay/prescription</u> 90-day supply of some maintenance drugs; \$120 <u>copay per prescription</u> 90-day supply of other drugs	<u>Copay/prescription</u> plus charges exceeding the <u>allowed amount</u> for 30-day supply; No benefit for 90-day supply	<p>Maintenance drugs include some medications for high blood pressure, high cholesterol, coronary artery disease (CAD), congestive heart failure (CHF), depression, asthma/chronic obstructive pulmonary disease (COPD), and diabetes (oral medications, insulins, needles, test strips and lancets).</p>
	Non-preferred brand drugs	\$110 <u>copay per prescription</u> 30-day supply; \$200 <u>copay/prescription</u> 90-day supply of some maintenance drugs; \$220 <u>copay per prescription</u> 90-day supply of other drugs	<u>Copay/prescription</u> plus charges exceeding the <u>allowed amount</u> for 30-day supply; No benefit for 90-day supply	<p><u>Deductible</u> does not apply. Minimum \$50; Maximum \$150; 30-day supply limit per prescription. Prescriptions must be obtained from a CVS/caremark Specialty Network Pharmacy.</p>
	Specialty drugs	10% <u>coinsurance</u>	Not covered	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<p><u>Preauthorization</u> required. No Network benefits and Out-of-Network benefits reduced by half if you don't get <u>preauthorization</u>.</p>
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
<p>If you need immediate medical attention</p>	Emergency room care	\$200 <u>copay/visit</u>	\$200 <u>copay/visit</u>	<u>Deductible</u> and <u>coinsurance</u> may apply for services like advanced imaging – CT, MRI, etc.
	Emergency medical transportation	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Urgent care	\$55 <u>copay/visit</u>	\$80 <u>copay/visit</u>	<u>Deductible</u> does not apply.
<p>If you have a hospital stay</p>	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<p><u>Preauthorization</u> required. No network benefits and Out-of-Network benefits reduced by half if you don't get <u>preauthorization</u>.</p>
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	

* For more information about limitations and exceptions, see the plan or policy document at <https://www.tn.gov/partnersforhealth.html>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 <u>copay</u> /visit	\$55 <u>copay</u> /visit	<u>Deductible</u> does not apply. <u>Preauthorization</u> is required for psychological testing, transcranial magnetic stimulation, electroconvulsive therapy, and Applied Behavior Analysis. No Network benefits and Out-of-Network benefits reduced by half if you don't get <u>preauthorization</u> .
	Inpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required. Residential treatment, partial hospitalization/day treatment programs and intensive outpatient therapy are considered inpatient services. No Network benefits and Out-of-Network benefits reduced by half if you don't get <u>preauthorization</u> .
If you are pregnant	Office visits	\$35 <u>copay</u> /visit	\$55 <u>copay</u> /visit	Global billing for labor and delivery and routine services beyond the initial office visit. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	Home health care	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required. Part-time, intermittent home nursing care limited to 125 visits/plan year. Home health aide care limited to 30 visits per plan year. No Network benefits and Out-of-Network benefits reduced by half if you don't get <u>preauthorization</u> .
	Rehabilitation services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required for inpatient services and equipment. No Network benefits and Out-of-Network benefits reduced by half if you don't get <u>preauthorization</u> . <u>Deductible</u> does not apply to in-network, outpatient physical, occupational and speech therapies.
	Habilitation services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Skilled nursing care	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Durable medical equipment	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
Hospice services	No charge	No charge	<u>Deductible</u> does not apply. 100% covered up to the MAC even if <u>deductible</u> has not been met.	
If your child needs dental or eye care	Children's eye exam	\$55 <u>copay</u> /visit	\$80 <u>copay</u> /visit	Deductible does not apply. For illness or injury. No Routine refraction.
	Children's glasses	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to the first pair of eyeglasses following cataract surgery.
	Children's dental check-up	Not Covered	Not Covered	No coverage for dental check-ups.

* For more information about limitations and exceptions, see the plan or policy document at <https://www.tn.gov/partnersforhealth.html>.

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded.)

- Cosmetic Surgery
- Long-term care
- Routine eye care (Adult)
- Weight loss programs (all programs not approved or sponsored by the [plan](#))

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture (50 visits per plan year)
- Bariatric surgery
- Chiropractic care (50 visits per plan year)
- Dental care (Adult –extraction of impacted wisdom teeth, excision of solid-based oral tumors, accidental injury or damage to sound natural teeth and/or jaw, orthodontic treatment for facial hemiatrophy, or congenital birth defect)
- Hearing aids (every 3 years; children under 18; bone anchored hearing devices with [preauthorization](#))
- Infertility Treatment (and testing; coverage ceases if fertilization services are initiated)
- Non-emergency care when traveling outside the U.S. (when traveling for business or pleasure)
- Routine foot care (diabetics only)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Benefits Administration at 1-800-253-9981 or <https://www.tn.gov/partnersforhealth.html>. You may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: BlueCross BlueShield 1-800-558-6213, Cigna 1-800-997-1617, or Benefits Administration 1-800-253-9981. Additionally, a consumer assistance program can help you file your [appeal](#). Contact Tennessee Department of Commerce & Insurance 615-741-2241, <https://www.tn.gov/commerce/consumer-services.html>.

Does this plan provide Minimum Essential Coverage? Yes.

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

Does this plan meet the Minimum Value Standards? Yes.

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

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-866-576-0029.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-576-0029.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-576-0029.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-576-0029.

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

* For more information about limitations and exceptions, see the plan or policy document at <https://www.tn.gov/partnersforhealth.html>.

About these Coverage Examples:



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

Peg is Having a Baby

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

■ The plan's overall deductible	\$1800
■ Specialist copayment	\$55
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,800
Copayments	\$700
Coinsurance	\$3,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,560

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$1800
■ Specialist copayment	\$55
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,200
Copayments	\$1,600
Coinsurance	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$3,460

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1800
■ Specialist copayment	\$55
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$200
Coinsurance	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,700

Anti-Discrimination and Civil Rights Compliance

Benefits Administration does not support any practice that excludes participation in programs or denies the benefits of such programs on the basis of race, color, national origin, sex, age or disability in its health programs and activities. If you have a complaint regarding discrimination, please call 1-866-576-0029.

If you think you have been treated in a different way for these reasons, please mail this information to Benefits Administration:

- Your name, address and phone number. You must sign your name. (If you write for someone else, include your name, address, phone number and how you are related to that person, for instance wife, lawyer or friend.)
- The name and address of the program you think treated you in a different way.
- How, why and when you think you were treated in a different way.
- Any other key details.

Mail to: State of Tennessee, Benefits Administration, Civil Rights Compliance, Department of Finance and Administration, 19th Floor, 312 Rosa L. Parks Avenue, William R. Snodgrass Tennessee Tower, Nashville, TN 37243-1102.

Need free language help? Have a disability and need free help or an auxiliary aid or service, for instance Braille or large print? Please call 800.253.9981.

You may also contact the: U.S. Department of Health & Human Services – Region IV Office for Civil Rights, Sam Nunn Atlanta Federal Center, Suite 16T70, 61 Forsyth Street, SW, Atlanta, Georgia 30303-8909 or 1-800-368-1019 or TTY/TDD at 1-800-537-7697.

If you speak a language other than English, help in your language is available for free. This tells you how to get help in a language other than English.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-576-0029 (TTY: 1-800-848-0298).

تامدخ نإف، ةغللا ركذا ثدحتت تنك اذا: ةظوحلم -576-0029- مقدر 866
1 مقرب لصتا. ن اجملاب كل رفاوتت ةيوغللا ةدعاسملا
مكبل او مصلا فتاه -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 1-866-576-0029 (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 1-866-576-0029 (TTY:1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이
용하실 수 있습니다. 1-866-576-0029 (TTY: 1-800-848-0298) 번으로
전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous
proposés gratuitement. Appelez le 1-866-576-0029 (ATS : 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1-866-576-0029 (TTY:1-800-848-0298) まで、
お電話にてご連絡ください

Ni songen mwohmw ohte, komw pahn sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie [Lokaiahn Pohnpei] komw kalangan oh ntingidieng ni lokaiahn Pohnpei. Call 1-866-576-0029 (TTY: 1- 800-848-0298).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶቻችን በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-866-576-0029 (መስማት ለተሳናቸው: 1-800-848-0298)።

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-576-0029 (TTY: 1- 800-848-0298).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નન:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-576-0029 (TTY: 1-800-848-0298)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wikanang walang bayad. Tumawag sa 1-866-576-0029 (TTY: 1-800-848-0298).

ध्यान द: य द आप हदी बोलते ह तो आपके लिए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-866-576-0029 (TTY: 1-800-848-0298) पर कॉल कर।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-576-0029 (телетайп: 1-800-848-0298).

زبانى سھڻالتك ن ٻڌ، مى گ ن ناگونداسى زبان ٻه اڱر: ناوچ ه نى م راهم (TTY: 1-800-848-0298) 866-576-0029 ٻرا ٻرا بامش ٻن اڱ صورت ٻا گ ٻر ٻر ٻر اس ٻا ٻا شد