



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>. 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 call 1-800-253-9981 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                                                                                                                      | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | <u>In-network/Out-of-network:</u><br>\$1,700/\$3,400 employee only;<br>\$3,400/\$6,800 employee + child(ren);<br>\$3,400/\$6,800 employee + spouse;<br>\$3,400/\$6,800 employee + spouse + child(ren)                                                                                                                        | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <a href="#">plan</a> begins to pay.                                                                                                                                                                                                            |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | <b>Yes.</b> In-network preventive care screenings at outpatient facilities; other in-network preventive care; 90-day supply maintenance drugs; certain low-dose generic statin drugs received in-network; and specific medications for the treatment of opioid dependency                                                    | This <a href="#">plan</a> covers some items and services even if you haven't met the <u>deductible</u> amount. But a <u>coinsurance</u> may apply. For example, this <a href="#">plan</a> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| Are there other <a href="#">deductibles</a> for specific services?              | <b>No.</b>                                                                                                                                                                                                                                                                                                                   | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | Separate Limits for <u>In-network Specialty drugs</u> / Other <u>In-network</u> / and <u>Out-of-network</u> :<br>\$2,400/ \$2,800/ \$5,600 employee only;<br>\$4,800/ \$5,600/ \$11,200 employee + child(ren);<br>\$4,800/ \$5,600/ \$11,200 employee + spouse;<br>\$4,800/ \$5,600/ \$11,200 employee + spouse + child(ren) | The <u>out-of-pocket</u> limit is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , the overall family <u>out-of-pocket limit</u> must be met.                                                                                                                                                                                                                                                                                          |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <u>Premiums</u> , <u>balance-billing</u> charges, health care this <a href="#">plan</a> doesn't cover, and penalties for failure to obtain <u>preauthorization</u> or failure to follow the Dispense as Written (DAW) provisions of the <u>prescription</u> drug benefit.                                                    | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                 |

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

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

| What You Will Pay                                                      |                                                         |                                              |                                                       |                                                                                                                                                                                                                                                                        |
|------------------------------------------------------------------------|---------------------------------------------------------|----------------------------------------------|-------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Common Medical Event                                                   | Services You May Need                                   | Network Provider<br>(You will pay the least) | Out-of-Network<br>Provider<br>(You will pay the most) | Limitations, Exceptions, & Other<br>Important Information                                                                                                                                                                                                              |
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness        | 20% <a href="#">coinsurance</a> /visit       | 40% <a href="#">coinsurance</a> /visit                | None                                                                                                                                                                                                                                                                   |
|                                                                        | <a href="#">Specialist</a> visit                        | 20% <a href="#">coinsurance</a> /visit       | 40% <a href="#">coinsurance</a> /visit                | None                                                                                                                                                                                                                                                                   |
|                                                                        | <a href="#">Preventive care/screening</a> /immunization | No charge                                    | 40% <a href="#">coinsurance</a> /visit                | <a href="#">Deductible</a> does not apply. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. |
| If you have a test                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)     | 20% <a href="#">coinsurance</a> /test        | 40% <a href="#">coinsurance</a> /test                 | You pay a separate <a href="#">coinsurance</a> for reading, interpretation and results.                                                                                                                                                                                |
|                                                                        | Imaging (CT/PET scans, MRIs)                            | 20% <a href="#">coinsurance</a> /test        | 40% <a href="#">coinsurance</a> /test                 | You pay a separate <a href="#">coinsurance</a> for reading, interpretation and results. <a href="#">Preauthorization</a> is required. No Network benefits, and Out-of-Network benefits reduced by half if you don't get <a href="#">preauthorization</a> .             |

| What You Will Pay                                                                                                                                                                                                                                                                |                                                             |                                                                                                                                                         |                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Common Medical Event                                                                                                                                                                                                                                                             | Services You May Need                                       | Network Provider<br>(You will pay the least)                                                                                                            | Out-of-Network<br>Provider<br>(You will pay the most)                                                           | Limitations, Exceptions, & Other<br>Important Information                                                                                                                                                                                                                                                                                                     |
| <p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <a href="http://info.caremark.com/stateoftn">prescription drug coverage</a> is available at <a href="http://info.caremark.com/stateoftn">http://info.caremark.com/stateoftn</a></p> | Generic drugs                                               | 20% <u>coinsurance</u> per prescription 30-day supply or 90-day supply; 10% <u>coinsurance</u> per prescription 90-day supply of some maintenance drugs | 40% <u>coinsurance</u> plus amount exceeding the allowed amount for 30-day supply; No benefit for 90-day supply | <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                                       | 20% <u>coinsurance</u> per prescription 30-day supply or 90-day supply; 10% <u>coinsurance</u> per prescription 90-day supply of some maintenance drugs | 40% <u>coinsurance</u> plus amount exceeding the allowed amount 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, osteoporosis, asthma/chronic obstructive pulmonary disease (COPD), and diabetes (oral medications, insulins, needles, test strips and lancets). Does not include any specialty drugs.</p> |
|                                                                                                                                                                                                                                                                                  | Non-preferred brand drugs                                   | 20% <u>coinsurance</u> per prescription 30-day supply or 90-day supply; 10% <u>coinsurance</u> per prescription 90-day supply of some maintenance drugs | 40% <u>coinsurance</u> plus amount exceeding the allowed amount for 30-day supply; No benefit for 90-day supply | <p><u>Deductible</u> does not apply to 90-day supply maintenance drugs.</p> <p>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>Obesity drugs</p> <p><a href="#">Specialty drugs</a></p> | <p>25% <u>coinsurance</u></p> <p>30% <u>coinsurance</u></p>                                                                                             | Not covered                                                                                                     | <p>30-day supply limit per <u>prescription</u>.</p> <p><u>Specialty drugs</u> must be obtained from a Network Specialty Pharmacy.</p>                                                                                                                                                                                                                         |

| What You Will Pay                                                         |                                                  |                                              |                                                       |                                                                                                                                                                                                                                                                                           |
|---------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Common Medical Event                                                      | Services You May Need                            | Network Provider<br>(You will pay the least) | Out-of-Network<br>Provider<br>(You will pay the most) | Limitations, Exceptions, & Other<br>Important Information                                                                                                                                                                                                                                 |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | 20% <u>coinsurance</u>                       | 40% <u>coinsurance</u>                                | <u>Preauthorization</u> required. No Network benefits and Out-of-Network benefits reduced by half if you don't get <u>preauthorization</u> .                                                                                                                                              |
|                                                                           | Physician/surgeon fees                           | 20% <u>coinsurance</u>                       | 40% <u>coinsurance</u>                                |                                                                                                                                                                                                                                                                                           |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | 20% <u>coinsurance</u>                       | 40% <u>coinsurance</u>                                | <u>Deductible</u> and <u>coinsurance</u> will apply for services like advanced imaging – CT, MRI, etc.                                                                                                                                                                                    |
|                                                                           | <a href="#">Emergency medical transportation</a> | 20% <u>coinsurance</u>                       | 50% <u>coinsurance</u>                                | None                                                                                                                                                                                                                                                                                      |
|                                                                           | <a href="#">Urgent care</a>                      | 20% <u>coinsurance</u> /visit                | 40% <u>coinsurance</u> /visit                         | <u>None</u>                                                                                                                                                                                                                                                                               |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 20% <u>coinsurance</u>                       | 40% <u>coinsurance</u>                                | <u>Preauthorization</u> required. No network benefits and Out-of-Network benefits reduced by half if you don't get <u>preauthorization</u> .                                                                                                                                              |
|                                                                           | Physician/surgeon fees                           | 20% <u>coinsurance</u>                       | 40% <u>coinsurance</u>                                | <u>Preauthorization</u> required. No Network benefits and Out-of-Network benefits reduced by half if you don't get <u>preauthorization</u> .                                                                                                                                              |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | 20% <u>coinsurance</u> /visit                | 40% <u>coinsurance</u> /visit                         | <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                               | 20% <u>coinsurance</u>                       | 40% <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> . |

| What You Will Pay                                              |                                           |                                              |                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|----------------------------------------------------------------|-------------------------------------------|----------------------------------------------|-------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Common Medical Event                                           | Services You May Need                     | Network Provider<br>(You will pay the least) | Out-of-Network<br>Provider<br>(You will pay the most) | Limitations, Exceptions, & Other<br>Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| If you are pregnant                                            | Office visits                             | 20% <u>coinsurance</u> /visit                | 40% <u>coinsurance</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 | 20% <u>coinsurance</u>                       | 40% <u>coinsurance</u>                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                | Childbirth/delivery facility services     | 20% <u>coinsurance</u>                       | 40% <u>coinsurance</u>                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | 20% <u>coinsurance</u>                       | 40% <u>coinsurance</u>                                | Preauthorization required for home health Care, Skilled nursing care, inpatient services and some equipment. No Network benefits and Out-of-Network benefits reduced by half if you don't get preauthorization. Home nursing care limited to 125 visits/plan year. Home health aide care limited to 30 visits/ plan year. Skilled nursing facility care limited to 100 days/plan year. <u>Deductible</u> does not apply to in-network, outpatient occupational, physical, speech and applied behavior analysis therapies. |
|                                                                | <a href="#">Rehabilitation services</a>   | 20% <u>coinsurance</u>                       | 40% <u>coinsurance</u>                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                | <a href="#">Habilitation services</a>     | 20% <u>coinsurance</u>                       | 40% <u>coinsurance</u>                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                | <a href="#">Skilled nursing care</a>      | 20% <u>coinsurance</u>                       | 40% <u>coinsurance</u>                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                | <a href="#">Durable medical equipment</a> | 20% <u>coinsurance</u>                       | 40% <u>coinsurance</u>                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                | <a href="#">Hospice services</a>          | <u>deductible</u> only                       | <u>deductible</u> only                                | 100% covered up to the MAC after <u>deductible</u> has been met.                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| If your child needs dental or eye care                         | Children's eye exam                       | 20% <u>coinsurance</u> /visit                | 40% <u>coinsurance</u> /visit                         | For illness or injury. No Routine refraction.                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                | Children's glasses                        | 20% <u>coinsurance</u>                       | 40% <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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

#### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |                                                                                                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Cosmetic Surgery</li> <li>Long-term care</li> </ul>                                                                                                        | <ul style="list-style-type: none"> <li>Routine eye care (Adult)</li> <li>Weight loss programs (all programs not approved or sponsored by the plan)</li> </ul> |

**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 aid devices with [preauthorization](#))
- Infertility treatment (testing and medically necessary services for correction of underlying causes; no services or supplies intended to create pregnancy)
- Non-emergency care when traveling outside the U.S. (for business or pleasure; out-of-network benefits apply)
- Private-duty nursing (included with Home Health Care)
- 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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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](http://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 on how 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.

**Does this plan provide Minimum Essential Coverage? Yes.**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet 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.]

[Arabic (Árabe): Para obtener ayuda en árabe, llame al 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.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



## 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,700 |
| ■ <a href="#">Specialist coinsurance</a>                        | 20%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 20%     |

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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$1,700 |
| <a href="#">Copayments</a>  | \$0     |
| <a href="#">Coinsurance</a> | \$1,100 |

| What isn't covered   |      |
|----------------------|------|
| Limits or exclusions | \$60 |

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Peg would pay is</b> | <b>\$2,860</b> |
|-----------------------------------|----------------|

### Managing Joe's Type 2 Diabetes

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,700 |
| ■ <a href="#">Specialist coinsurance</a>                        | 20%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 20%     |

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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$1,700 |
| <a href="#">Copayments</a>  | \$0     |
| <a href="#">Coinsurance</a> | \$1,100 |

| What isn't covered   |      |
|----------------------|------|
| Limits or exclusions | \$60 |

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Joe would pay is</b> | <b>\$2,860</b> |
|-----------------------------------|----------------|

### Mia's Simple Fracture

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,700 |
| ■ <a href="#">Specialist coinsurance</a>                        | 20%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 20%     |
| ■ Other <a href="#">coinsurance</a>                             | 20%     |

This EXAMPLE event includes services like:

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

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$1,540 |
| <a href="#">Copayments</a>  | \$0     |
| <a href="#">Coinsurance</a> | \$390   |

| What isn't covered   |     |
|----------------------|-----|
| Limits or exclusions | \$0 |

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Mia would pay is</b> | <b>\$1,930</b> |
|-----------------------------------|----------------|

1,000

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

## Anti-Discrimination Compliance and Civil Rights Complaint Procedures

Benefits Administration does not support any practice that excludes participation in its health programs or activities or denies the benefits of such programs on the basis of race, color, national origin, sex, age or disability. If you have a complaint regarding discrimination, please call 615-532-9617.

If you think you have been treated in a different way for these reasons, please mail this information to the Civil Rights Coordinator for the Department of Finance and 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 Coordinator, Department of Finance and Administration, Office of General Counsel, 19th Floor, 312 Rosa L. Parks Avenue, William R. Snodgrass Tennessee Tower, Nashville, TN 37243 or email [FA.CivilRights@tn.gov](mailto:FA.CivilRights@tn.gov).

F & A Policy No. 36. Non-Discrimination Policy and Complaint procedure may be found at the following link: [Policy 36 - 10.24.2024 pdf](#).

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  
1-800-368-1019 or TTY/TDD at 1-800-537-7697
- U. S. Office for Civil Rights Office of Justice Programs  
U. S. Department of Justice  
810 7th Street, NW Washington, DC 20531
- Tennessee Office of Attorney General and Reporter  
Civil Rights Enforcement Division  
P.O. Box 20207  
Nashville, TN 37202

Language/Communication Assistance. Need free language help? Have a disability and need free help or an auxiliary aid or service, for instance Braille or large print? Please request assistance by emailing [benefits.assistance@tn.gov](mailto:benefits.assistance@tn.gov) and [FA.CivilRights@tn.gov](mailto:FA.CivilRights@tn.gov) or calling 800-253-9981. If you think you have been denied free language or communications assistance, please call 615-532-9617

for the F&A Civil Rights Coordinator or follow the F & A complaint procedures in F & A Policy No. 36. Non-Discrimination Policy and Complaint Procedure which is available at the following link: [Policy 36 - 10.24.2024 pdf](#).

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

**Arabic** ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك (رقم هاتف الصم والبكم: 1-866-576-0029-1 اتصل برقم 1-800-848-0298).

**Chinese** 注意：如果您會說中文，則提供免費的語言協助服務。請致電 1-866-576-0029（電傳打字機：1-800-848-0298）。

**Vietnamese** CHÚ Ý: Nếu bạn nói tiếng Việt, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn. Gọi 1-866-576-0029 (TTY: 1-800-848-0298).

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

**French** ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-576-0029 (ATS : 1800-848-0298).

**Laotian** ຂໍຄວນລະວັງ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາພຣີດມັນມີຢູ່. ໂທ1-866-576-0029 (TTY: 1-800-848-0298).

**Amharic** ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-866-576-0029 (መስማት ለተሳናቸው: 1-800-848-0298).

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

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

**Japanese** 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

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

**Hindi** ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-576-0029 (TTY: 1800-848-0298) पर कॉल करें।

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

**Persian** توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان تماس 1-866-576-0029 (TTY: 1-800-848-0298) برای شما فراهم می باشد. با بگیرید.