



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 deductible ?	<u>In-network/Out-of-network:</u> \$1,300/\$2,600 employee only; \$1,950/\$3,900 employee + child(ren); \$2,600/\$5,200 employee + spouse; \$3,250/\$6,500 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 plan begins to pay. If you have other family members on the plan , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible ?	Yes. <u>In-network preventive care screenings</u> at outpatient facilities; <u>In-network</u> outpatient occupational, physical, speech and applied behavior analysis therapies; other in-network <u>preventive care</u> ; other outpatient services, including <u>primary</u> and <u>specialist</u> office visits, behavioral health and substance use, routine x-rays, labs, and diagnostics, reading, interpretation and results, telehealth, chiropractic and acupuncture, convenience clinics, <u>urgent care</u> , and pharmacy.	This plan covers some items and services even if you haven't met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan ?	Separate Limits for <u>In-network Specialty drugs</u> / Other <u>In-network</u> / and <u>Out-of-network</u> : \$2,400/ \$4,400/ \$8,800 employee only; \$3,600/ \$6,600/ \$13,200 employee + child(ren); \$4,800/ \$8,800/ \$17,600 employee + spouse; \$6,000/ \$11,000/ \$22,000 employee + spouse + child(ren)	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit ?	<u>Premiums</u> , <u>balance-billing</u> charges (unless prohibited), health care this plan 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 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.

What You Will Pay				
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 copay /visit	\$50 copay /visit	Deductible does not apply
	Specialist visit	\$50 copay /visit	\$75 copay /visit	Deductible does not apply
	Preventive care/screening/immunization	No charge	\$50 copay /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)	20% coinsurance	20% coinsurance	Deductible does not apply. You pay a separate coinsurance for reading, interpretation and results.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	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 .

What You Will Pay				
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://info.caremark.com/stateoftn	Generic drugs	\$14 <u>copay/prescription</u> 30-day supply; \$14 <u>copay/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	<u>Deductible</u> does not apply. 90-day supply must be obtained from a Retail-90 network pharmacy or mail order. There is no out-of-network benefit for a 90-day supply.
	Preferred brand drugs	\$50 <u>copay/prescription</u> 30-day supply; \$50 <u>copay/prescription</u> 90-day supply of some maintenance drugs; \$100 <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	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.
	Non-preferred brand drugs	\$100 <u>copay per prescription</u> 30-day supply; \$180 <u>copay/prescription</u> 90-day supply of some maintenance drugs; \$200 <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	Certain low-dose generic statins received in-network may be covered at no charge. Members do not have to pay for specific medications used to treat opioid dependency.
	Obesity drugs Specialty drugs	25% <u>coinsurance</u> 30% <u>coinsurance</u>	Not covered	<u>Deductible</u> does not apply. 30-day supply limit per <u>prescription</u>. <u>Specialty drugs</u> must be obtained from a Network Specialty Pharmacy.

What You Will Pay				
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other 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	Emergency room care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Deductible</u> and <u>coinsurance</u> will apply for services like advanced imaging – CT, MRI, etc.
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Urgent care	\$50 <u>copay</u> /visit	\$75 <u>copay</u> /visit	<u>Deductible</u> does not apply.
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	\$30 <u>copay</u> /visit	\$50 <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	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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	\$30 <u>copay</u> /visit	\$50 <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	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	Home health care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> 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 <u>preauthorization</u> . 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
	Rehabilitation services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Habilitation services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Skilled nursing care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Durable medical equipment	20% <u>coinsurance</u>	40% <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	Not covered	Not covered	No routine care or services
	Children's glasses	Not covered	Not covered	No routine care or services
	Children's dental check-up	Not Covered	Not Covered	No routine care or services

Excluded Services & Other Covered Services:

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

- Cosmetic Surgery
- Routine eye care (vision impairment screenings and exams for medical injury or disease are not excluded)
- Long-term care
- Weight loss programs (all programs not approved or sponsored by the plan)

[* For more information about limitations and exceptions, see the [plan](#) or policy document at www.tn.gov/partnersforhealth.]

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 (must go through plan's specific COE program)
- Chiropractic care (50 visits per plan year)
- Dental care (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, facility and related medical services when hospitalization for dental services is determined to be medically necessary, certain eligible expenses for TMJ)
- 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. 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 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.

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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	\$1,300
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,300
Copayments	\$10
Coinsurance	\$2300

What isn't covered	
Limits or exclusions	\$60

The total Peg would pay is	\$3,670
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Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$1,300
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$800
Copayments	\$700
Coinsurance	\$20

What isn't covered	
Limits or exclusions	\$20

The total Joe would pay is	\$1,540
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Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,300
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	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*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,300
Copayments	\$200
Coinsurance	\$200

What isn't covered	
Limits or exclusions	\$0

The total Mia would pay is	\$1,700
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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 think you have been denied services or treated differently for these reasons, you may submit a complaint to the Tennessee Department of Finance and Administration Civil Rights Coordinator at FA.CivilRights@tn.gov. Please include the following information in your email:

- Your name, address and phone number. You must provide 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.

Email to FA.CivilRights@tn.gov or Mail to:
State of Tennessee, Department of Finance and Administration, Civil Rights Coordinator, 312 Rosa L. Parks Avenue, William R. Snodgrass Tennessee Tower, 19th Floor, Nashville, TN 37243

F&A Policy No.36. Non-Discrimination Policy and Complaint procedure may be found on the F&A Policies webpage at www.tn.gov/finance/looking-for/policies/.

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. Do you speak a language other than English, and need free language help? Do you 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 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 on the F&A Policies webpage at www.tn.gov/finance/looking-for/policies/.

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, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາພຣີດມ່ວນມີຢູ່. 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 સુચન: 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 بگیری.