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 www.tn.gov/finance/section/fa-benefits. 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 www.dol.gov/ebsa/healthreform 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?	In-network/Out-of-network: $500/$1,000 employee only; $750/$1,500 employee + child(ren); $1,000/$2,000 employee + spouse; $1,250/$2,500 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. Preventive Care; Outpatient Services including primary and specialist office visits, behavioral health and substance abuse, routine x-rays, labs, and diagnostics, telehealth, and chiropractic; Pharmacy; Convenience Clinic and Urgent Care; and Emergency Room	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.healthare.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?	In-network/Out-of-network: $3,600/$4,000 employee only; $5,400/$6,000 employee + child(ren); $7,200/$8,000 employee + spouse; $9,000/$10,000 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?	Premiums, 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	$25 copay/office visit	$45 copay/office visit	Deductible does not apply
	Specialist visit	$45 copay/office visit	$70 copay/office visit	Deductible does not apply
	Preventive care/screening/ immunization	No charge	$45 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)	10% coinsurance/test	10% coinsurance/test	Deductible does not apply. You pay a separate coinsurance for reading, interpretation and results.
	Imaging (CT/PET scans, MRIs)	10% coinsurance/test	40% 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 www.tn.gov/finance/section/fa-benefits.

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 drugs to treat your illness or condition More information about prescription drug coverage is available at http://info.caremark.com/stateoftn	Generic drugs	$7 copay/prescription 30-day supply; $7 copay/prescription 90-day supply of some maintenance drugs; $14 copay/prescription 90-day supply of other drugs	Copay/prescription plus charges exceeding the allowed amount for 30-day supply; No benefit for 90-day supply	Deductible 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. 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). Certain low-dose generic statins received in-network may be covered at no charge.
	Preferred brand drugs	$40 copay/prescription 30-day supply; $40 copay/prescription 90-day supply of some maintenance drugs; $80 copay per prescription 90-day supply of other drugs	Copay/prescription plus charges exceeding the allowed amount for 30-day supply; No benefit for 90-day supply	
	Non-preferred brand drugs	$90 copay/prescription 30-day supply; $160 copay/prescription 90-day supply of some maintenance drugs; $180 copay/prescription 90-day supply of other drugs	Copay/prescription plus charges exceeding the allowed amount for 30-day supply; No benefit for 90-day supply	
	Specialty drugs	10% coinsurance	Not covered	Deductible does not apply. Minimum $50; Maximum $150; 30-day supply limit per prescription. Prescriptions must be obtained from a CVS/caremark Specialty Network Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	Preauthorization required. No Network benefits and Out-of-Network benefits reduced by half if you don't get preauthorization.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	Deductible and coinsurance may apply for services like advanced imaging – CT, MRI, etc.
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	$45 copay/visit	$70 copay/visit	Deductible does not apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	Preauthorization required. No network benefits and Out-of-Network benefits reduced by half if you don't get preauthorization.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	

[* For more information about limitations and exceptions, see the plan or policy document at www.tn.gov/finance/section/fa-benefits.

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	$25 copay/visit	$45 copay/visit	Deductible does not apply. Preauthorization is required for psychological testing, transcranial magnetic stimulation, electro-convulsive treatment, extended outpatient treatment visits, and Applied Behavior Analysis. No Network benefits and Out-of-Network benefits reduced by half if you don't get preauthorization.
	Inpatient services	10% coinsurance	40% coinsurance	Preauthorization 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 preauthorization.
If you are pregnant	Office visits	$25 copay/visit	$45 copay/visit	Global billing for labor and delivery and routine services beyond the initial office visit. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	Preauthorization 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 preauthorization.
	Rehabilitation services	10% coinsurance	40% coinsurance	Preauthorization may be required for inpatient services and more expensive equipment. No Network benefits and Out-of-Network benefits reduced by half if you don't get preauthorization.
	Habilitation services	10% coinsurance	40% coinsurance	
	Skilled nursing care	10% coinsurance	40% coinsurance	
	Durable medical equipment	10% coinsurance	40% coinsurance	
	Hospice services	No charge	No charge	Deductible does not apply. 100% covered up to the MAC even if deductible has not been met.
If your child needs dental or eye care	Children's eye exam	$45 copay/visit	$70 copay/visit	Deductible does not apply. For illness or injury. No Routine refraction.
	Children's glasses	10% coinsurance	40% coinsurance	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 www.tn.gov/finance/section/fa-benefits.

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
- 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 (anesthetic for surgery)
- Bariatric surgery
- Chiropractic care
- Dental care (Adult –extraction of impacted wisdom teeth, excision of solid-based oral tumors, accidental injury, orthodontic treatment for facial hemiatrophy, or congenital birth defect)
- Hearing aids (every 3 years; children under 18)
- 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 www.tn.gov/finance/section/fa-benefits. 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, www.tn.gov/commerce/section/consumer-services.

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, kwiijigo 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 www.tn.gov/finance/section/fa-benefits.

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	$500
Specialist copayment	$45
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$12,840

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$500
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,060

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist copayment	$45
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$7,460

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$1,030
Coinsurance	$190
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,780

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist copayment	$45
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$2,010

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$140
Coinsurance	$160
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$800

The plan would be responsible for the other costs of these EXAMPLE covered services.

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 orfriend.)
- The name and address of the program you think treated you in a differentway.
- How, why and when you think you were treated in a differentway.
- 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).

866 (رقم -576-0029- ملحوظة: إذا كنت تتحدث ذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1 -800-848-0298).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-576-0029 (TTY:1-800-848-0298)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành chobạn. Gọi số 1-866-576-0029 (TTY:1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 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 sont proposés gratuitement. Appelez le 1-866-576-0029 (ATS : 1-800-848-0298).

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 ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለውቁጥር ይደውሉ 1-866-576-0029 (ሞስማት 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 નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-866-576-0029 (TTY:1-800-848-0298)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます1-866-576-0029（TTY:1-800-848-0298）まで、お電話にてご連絡ください

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa 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).

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