




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:
<p>What is the overall deductible?</p>	<p><u>In-network/Out-of-network</u>: \$1,300/\$1,500 employee only; \$1,950/\$3,900 employee + child(ren); \$2,600/\$5,200 employee + spouse; \$3,250/\$6,500 employee + spouse + child(ren)</p>	<p>Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u>, 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>.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>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.</p>	<p>This <u>plan</u> 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 <u>plan</u> 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/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p><u>In-network/Out-of-network</u>: \$4,400/\$8,800 employee only; \$6,600/\$13,200 employee + child(ren); \$8,800/\$17,600 employee + spouse; \$11,000/\$22,000 employee + spouse + child(ren)</p>	<p>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 <u>plan</u>, 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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p><u>Premiums</u>, <u>balance-billing</u> charges, health care this <u>plan</u> 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.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>

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 /test	20% coinsurance /test	Deductible does not apply. You pay a separate coinsurance for reading, interpretation and results.
	Imaging (CT/PET scans, MRIs)	20% 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/partnersforhealth.]

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
<p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://info.caremark.com/stateoftn</p>	Generic drugs	\$14 <u>copay/prescription</u> 30-day supply; \$14 <u>copay/prescription</u> 90-day supply of some maintenance drugs; \$28 <u>copay/prescription</u> 90-day supply of other drugs	<u>copay/prescription</u> plus charges exceeding the <u>allowed amount</u> for 30-day supply; No benefit for 90- day supply	<p><u>Deductible</u> does not apply.</p> <p>90-day supply must be obtained from a Retail-90 network pharmacy or mail order.</p> <p>There is no out-of-network benefit for a 90- day supply.</p> <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> <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><u>Deductible</u> does not apply. 30-day supply limit per <u>prescription</u>. <u>Prescriptions</u> must be obtained from a CVS/caremark Specialty Network Pharmacy.</p> <p>Tier 1 generics – Min \$100; Max \$200 Tier 2 all brands – Min \$200; Max \$400</p>
	Preferred brand drugs	\$50 <u>copay/prescription</u> 30-day supply; \$50 <u>copay/prescription</u> 90- day supply of some maintenance drugs; \$100 copay per <u>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	
	Non-preferred brand drugs	\$100 copay per <u>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	
	Specialty drugs	Tier 1 - generics 20% <u>coinsurance</u> Tier 2 - all brands 30% <u>coinsurance</u>	Not covered	

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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> .

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

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. Part-time, intermittent home nursing care limited to 125 visits/plan year. Home health aide care limited to 30 visits per plan year. No Network benefits and Out-of-Network benefits reduced by half if you don't get <u>preauthorization</u> .
	Rehabilitation services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> may be required for inpatient services and equipment. No Network benefits and Out-of-Network benefits reduced by half if you don't get <u>preauthorization</u> . <u>Deductible</u> does not apply to in-network, outpatient occupational, physical, speech and applied behavior analysis therapies.
	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	\$50 <u>copay</u> /visit	\$75 <u>copay</u> /visit	<u>Deductible</u> does not apply. 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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)	
<ul style="list-style-type: none"> • Cosmetic Surgery • Long-term care 	<ul style="list-style-type: none"> • Routine eye care (Adult) • 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
- 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 (and testing; coverage ceases if fertilization services are initiated)
- Non-emergency care when traveling outside the U.S. (when traveling for business or pleasure)
- Private-duty nursing
- 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, Benefits Administration 1-800-253-9981 or or Tennessee Department of Commerce & Insurance 615-741-2241, <https://www.tn.gov/commerce/consumer-services.html>.

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 [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码[insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].]

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 [plan's](#) overall [deductible](#) \$1,700
- [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	\$1,700
Copayments	\$0
Coinsurance	\$1,100
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,860

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1,700
- [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	\$1,200
Copayments	\$1,270
Coinsurance	\$330
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$2,860

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,700
- [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	\$1,110
Copayments	\$150
Coinsurance	\$330
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,590

1,000

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 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, Civil Rights Coordinator, Department of Finance and Administration, Office of General Counsel 20th Floor, 312 Rosa L. Parks Avenue, William R. Snodgrass Tennessee Tower, Nashville, TN 37243.

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 615-532-9617.

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 **OR** U. S. Office for Civil Rights, Office of Justice Programs, U. S. Department of Justice, 810 7th Street, NW, Washington, DC 20531 **OR** Tennessee Human Rights Commission, 312 Rosa Parks Avenue, 23rd Floor, William R. Snodgrass Tennessee Tower, Nashville, TN 37243.

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).

رقم 1-866-576-0029- ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك (866 بالمجان. اتصل برقم هاتف الصم والبكم: 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 cho bạn. 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 አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በገጽ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-866-576-0029 (ማስማት ለተሰናዥው: 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 િન:શુદ્ધ 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).

◆ान दः य द आप हदी बोलते ह तो आपके िलए मु◆ म भाषा सहायता सेवाएं उपल◆ 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 بہ زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما 0029-576-866 (TTY: 1-800-848-0298) فراہم می باشد. یا تماس بگیرید.