Coverage Period: 08/01/2024 - 07/31/2025
Coverage for: Individual or Family | Plan Type: HDHP

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 1-800-565-9140 (TTY: 1-800-848-0299) or visit us at www.bcbst.com. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at <u>www.cciio.cms.gov</u> or call 1-800-565-9140 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: \$3,300 person/\$6,600 family Out-of-network: \$6,400 person/\$12,800 family	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> .
Are there services covered before you meet your deductible?	Yes. <u>Deductible</u> doesn't apply to <u>preventive care</u> .	This <u>plan</u> covers some items and services even if you haven't yet 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</u> services 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 <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In-network: \$5,000 person/\$10,000 family Out-of-network: \$15,000 person/\$27,000 family	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.
What is not included in the <u>out-of-pocket limit?</u>	Premium, balance-billing charges, penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. This <u>plan</u> uses Network P. See http://www.bcbst.com/Network-P or call 1-800-565-9140 for a list of <u>in-network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

Common		What You \	Will Pay	Limitations, Exceptions, & Other	
Medical Event Services You May Need		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information	
	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	Teladoc Health: 20% coinsurance	
	Specialist visit	20% coinsurance	40% coinsurance	None	
If you visit a health care <u>provider's</u> office or clinic	Preventive care/screening/ immunization	No Charge	40% coinsurance	A1c testing will be covered at 100%. 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. Travel immunization not covered in office or clinic setting.	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None	
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.	
If you need drugs to treat your illness or	Preferred Generic drugs / Non- Preferred Generic drugs	20% coinsurance	40% <u>coinsurance</u>	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network \$3/\$25/\$50 copayment per 30 day supply for generic/preferred brand/non-preferred brand drugs on Preventive Drug List.	
condition	Preferred brand drugs	20% coinsurance	40% coinsurance	30 day supply for Retail Network; up to 90	
More information about prescription drug coverage is available at www.bcbst.com/rxp	Non-preferred brand drugs	20% coinsurance	40% coinsurance	day supply for Home Delivery or Plus90 Network \$3/\$25/\$50 copayment per 30 day supply for generic/preferred brand/non-preferred brand drugs on Preventive Drug List.	
	Preferred Specialty drugs / Non-Preferred Specialty drugs	20% coinsurance	Not Covered	Up to a 30 day supply. Must use a pharmacy in the Preferred Specialty Pharmacy Network.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained.	

Common		What You Will Pay		Limitations, Exceptions, & Other Important Information	
Medical Event	nt Services You May Need <u>In-Network Provider</u> Out-of-Network Provider (You will pay the least) (You will pay the most)		Out-of-Network Provider (You will pay the most)		
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained.	
	Emergency room care	20% coinsurance	20% coinsurance	None	
If you need immediate medical attention	Emergency medical transportation	20% coinsurance	20% coinsurance	None	
	<u>Urgent care</u>	20% coinsurance	40% coinsurance	None	
If you have a hospital	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.	
stay	Physician/surgeon fees	20% coinsurance	40% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.	
If you need mental health, behavioral	Outpatient services	20% coinsurance	40% coinsurance	Prior Authorization required for electro- convulsive therapy (ECT). Your cost share may increase to 50% if not obtained.	
health, or substance abuse services Inpatient services		20% coinsurance	40% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.	
	Office visits	20% coinsurance	40% coinsurance	Teladoc Health: 20% coinsurance	
If you are pregnant	Childbirth/delivery professional services	20% coinsurance	40% <u>coinsurance</u>	This service may be covered under the Specialty Care Program. Cost Share may vary; use a Blue Distinction Center for best benefit.	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	This service may be covered under the Specialty Care Program. Cost Share may vary; use a Blue Distinction Center for best benefit.	
	Home health care	20% coinsurance	40% coinsurance	Unlimited visits per year.	
If you need help	Rehabilitation services	20% coinsurance	40% coinsurance	Therapy limited to 60 visits combined per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.	
recovering or have other special health needs	Habilitation services	20% coinsurance	40% coinsurance	Therapy limited to 60 visits combined per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.	
necus	Skilled nursing care	20% coinsurance	40% coinsurance	Skilled nursing and rehabilitation facility limited to 60 days combined per year.	
	Durable medical equipment	20% coinsurance	40% coinsurance	Prior Authorization may be required for certain <u>durable medical equipment</u> . Your	

Common		What You \	Will Pay	Limitations, Exceptions, & Other
Medical Event	Services You May Need		Out-of-Network Provider (You will pay the most)	Important Information
				cost share may increase to 50% if not obtained.
	Hospice services	20% coinsurance	40% coinsurance	Prior Authorization required for inpatient hospice. Your cost share may increase to 50% if not obtained.
If your shild poods	Children's eye exam	Not Covered	Not Covered	None
If your child needs dental or eye care	Children's glasses	Not Covered	Not Covered	None
dental of eye care	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Se	Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)				
•	Bariatric surgery	•	Infertility treatment	•	Routine eye care (Adult)
•	Cosmetic surgery	•	Long-term care	•	Routine eye care (Children)
•	Dental care (Adult)	•	Non-emergency care when traveling outside the	•	Routine foot care for non-diabetics
•	Dental care (Children)		U.S.	•	Weight loss programs
•	Hearing aids for adults	•	Private-duty nursing		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
Acupuncture	 Chiropractic care 	 Hearing aids for children under 18

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:

- For plans subject to ERISA, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental plans, the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- For church plans, the State Division of Benefits Administration at 1-866-576-0029.
- BlueCross at 1-800-565-9140 or www.bcbst.com, or contact your plan administrator.

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 <u>Grievance</u> and <u>Appeals</u> <u>Rights:</u> There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact:

- BlueCross at 1-800-565-9140 or www.bcbst.com, or your plan administrator.
- For plans subject to ERISA, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- The State Division of Benefits Administration at 1-866-576-0029.

Additionally, a consumer assistance program can help you file your appeal. Contact the Tennessee Department of Commerce and Insurance (TDCI) at 1-800-342-4029, https://sbs-tn.naic.org/Lion-Web/servlet/org.naic.sbs.ext.onlineComplaint.OnlineComplaintCtrl?spanishVersion=N, or email them at CIS.Complaints@state.tn.us. You may also write them at 500 James Robertson Pkwy, Davy Crockett Tower, 6th Floor, Nashville, TN 37243.

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 <u>plan</u> meet <u>Minimum Value Standards</u>? 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.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$3,200
Specialist coinsurance	20%
■ 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

In this example, Peg would pay:

Cost Sharing				
Deductibles	\$3,200			
<u>Copayments</u>	\$10			
Coinsurance	\$1,800			
What isn't covered				
Limits or exclusions	\$20			
The total Peg would pay is	\$5,020			

Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$3,200
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (*including disease education*)

<u>Diagnostic tests</u> (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

Total Example Cost	\$5,600

In this example, Joe would pay:

Cost Sharing			
<u>Deductibles</u>	\$1,200		
Copayments	\$500		
Coinsurance	\$0		
What isn't covered			
Limits or exclusions	\$30		
The total Joe would pay is	\$1,730		

Mia's Simple Fracture

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

■ The plan's overall deductible	\$3,200
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

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

Cost Sharing		
<u>Deductibles</u>	\$2,800	
<u>Copayments</u>	\$0	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$2,800	

Nondiscrimination Notice

BlueCross BlueShield of Tennessee (BlueCross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

BlueCross:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- Provides free language services to people whose primary language is not English, such as: (1) qualified interpreters and (2) written information in other languages.

If you need these services, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711).

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance ("Nondiscrimination Grievance"). For help with preparing and submitting your Nondiscrimination Grievance, contact a consumer advisor at the number on the back of your Member ID card or call 1-800-565-9140 (TTY: 1-800-848-0298 or 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Compliance Coordinator; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination OfficeGM@bcbst.com (email).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Access Services:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-565-9140 (TTY: 1-800-848-0298).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-9140-565-800 (رقم هاتف الصم والبكم: 8-800-848-0298

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 1-800-565-9140 (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. Goi số 1-800-565-9140 (TTY:1-800-848-0298).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-565-9140 (TTY: 1-800-848-0298) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-565-9140 (ATS : 1-800-848-0298).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-565-9140 (TTY: 1-800-848-0298).

ማስታወሻ: የሚናንሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-565-9140 *(መ*ስማት ለተሳናቸው: 1-800-848-0298).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-565-9140 (TTY: 1-800-848-0298).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-565-9140 (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。1-800-565-9140 (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 wika nang walang bayad. Tumawag sa 1-800-565-9140 (TTY:1-800-848-0298).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-565-9140 (TTY:1-800-848-0298) पर कॉल करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-565-9140 (телетайп: 1-800-848-0298).

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

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-565-9140 (TTY: 1-800-848-0298).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-565-9140 (TTY: 1-800-848-0298).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-565-9140 (TTY: 1-800-848-0298).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti.Chiamare il numero 1-800-565-9140 (TTY: 1-800-848-0298).

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-800-565-9140 (TTY: 1-800-848-0298).