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 1-800-565-9140 (TTY: 1-800-848-0299) or visit us at www.bcbst.com. 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 1-800-565-9140 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $400 person/$800 family Out-of-network: $1,000 person/$2,000 family	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 services, Office visits, and Emergency room visits are covered before you meet your deductible (unless specified).	This plan covers some items and services even if you haven't yet 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.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. $200 individual/$400 family Pharmacy only Deductible. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-network: $5,100 person/$10,200 family Out-of-network: $13,200 person/$26,400 family	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?	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.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See http://www.bcbst.com/Network-S or call 1-800-565-9140 for a list of in-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.

*For more information about limitations and exceptions, see the plan or policy document at www.bcbst.com/samplepolicy/2027/LG.pdf.

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
		In-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	$30 copay/visit deductible does not apply.	40% coinsurance	Teladoc Health: $30 copay
	Specialist visit	$45 copay/visit deductible does not apply.	40% coinsurance	Office surgery subject to office visit copay.
	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)	No Charge	40% coinsurance	Diagnostic testing benefits are determined by place of service, such as office or ER. Copay applies if filed with an office visit.
	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 condition	Preferred Generic drugs / Non-Preferred Generic drugs	$10 copay/prescription after pharmacy deductible	20% coinsurance	30 day supply for Retail Network; 2.5x copay up to 90 day supply for Home Delivery or Plus90 Network for Non-Preventive drugs. $10/$35/$60 copay per 30 day supply and $25/$87.50/$150 copay per 90 day supply for Preventive drugs – deductible does not apply. Out-of-Network Preventive drugs are not covered.
	Preferred brand drugs	$35 copay/prescription after pharmacy deductible	20% coinsurance	
	Non-preferred brand drugs	$60 copay/prescription after pharmacy deductible	20% coinsurance	

*For more information about limitations and exceptions, see the plan or policy document at www.bcbst.com/samplepolicy/2027/LG.pdf.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
More information about **prescription drug coverage** is available at www.bcbst.com/rxp or contact us at 800-565-9140	Preferred Specialty drugs / Non-Preferred Specialty drugs	20% coinsurance after deductible	Not Covered	Up to a 30 day supply. Must use a pharmacy in the Specialty Pharmacy Network. Up to $400 maximum.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay/visit deductible does not apply.	40% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained. *See Prior Authorization section.
	Physician/surgeon fees	No Charge	40% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained. *See Prior Authorization section.
If you need immediate medical attention	Emergency room care	$200 copay/visit deductible does not apply.	$200 copay/visit deductible does not apply.	None
	Emergency medical transportation	$200 copay/deductible does not apply.	$200 copay/deductible does not apply.	None
	Urgent care	$75 copay/visit deductible does not apply.	40% coinsurance	Office surgery subject to office visit copay.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay/visit deductible does not apply.	$300 copay/admission then 40% coinsurance after deductible.	Prior Authorization required. Your cost share may increase to 50% if not obtained.
	Physician/surgeon fees	No Charge	40% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.

*For more information about limitations and exceptions, see the plan or policy document at www.bcbst.com/samplepolicy/2027/LG.pdf.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	$30 copay/visit deductible does not apply for office visits.	40% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained. *See Prior Authorization section.
	Inpatient services	$100 copay/admission deductible does not apply.	$300 copay/admission then 40% coinsurance after deductible.	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you are pregnant	Office visits	$30 copay/visit deductible does not apply.	40% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	$100 copay/visit deductible does not apply.	$300 copay/admission then 40% coinsurance after deductible.	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Unlimited
	Rehabilitation services	$45 copay/visit deductible does not apply.	40% coinsurance	Therapy visits include acupuncture, chiropractic, physical, speech and occupational - limited to 60 visits combined per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	Habilitation services	$45 copay/ visit deductible does not apply.	40% coinsurance	Therapy visits include acupuncture, chiropractic, physical, speech and occupational - limited to 60 visits combined per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	Skilled nursing care	$100 copay/admission deductible does not apply.	$300 copay/admission then 40% coinsurance after deductible.	Skilled nursing and rehabilitation facility limited to 120 days combined per year.
	Durable medical equipment	20% coinsurance	40% coinsurance	Prior Authorization may be required for certain durable medical equipment. Your cost share may increase to 50% if not obtained. *See Prior Authorization section.

*For more information about limitations and exceptions, see the plan or policy document at www.bcbst.com/samplepolicy/2027/LG.pdf.

	Hospice services	Inpatient: $100 copay/ admission deductible does not apply - Outpatient: 20% coinsurance.	Inpatient: $300 copay/admission then 40% coinsurance after deductible Outpatient: 40% coinsurance.	Prior Authorization required for inpatient hospice. Your cost share may increase to 50% if not obtained.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

*For more information about limitations and exceptions, see the plan or policy document at www.bcbst.com/samplepolicy/2027/LG.pdf.

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.)		
• Bariatric surgery	• Infertility treatment – limited to the diagnosis and treatment of underlying medical conditions	• Routine eye care (Adult)
• Cosmetic surgery	• Long-term care	• Routine eye care (Children)
• Dental care (Adult)	• Non-emergency care when traveling outside the U.S.	• Routine foot care for non-diabetics
• Dental care (Children)		• Weight loss programs
• Hearing aids for adults		• Home childbirth delivery

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Private-duty nursing	• Hearing aids for children under 18 limited to 1 hearing aid per ear every 3 years
• Chiropractic care		

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 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 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.naic.org/solar-web/pages/public/onlineComplaintForm/onlineComplaintForm.jsf?state=tn&dswid=-8432, 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**.

*For more information about limitations and exceptions, see the plan or policy document at www.bcbst.com/samplepolicy/2027/LG.pdf.

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 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.

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.bcbst.com/samplepolicy/2027/LG.pdf.

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	$400
Specialist copay	$45
Hospital (facility) copay	$100
Other copay	$100

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	$400
Copayments	$400
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$1,820**

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

The plan's overall deductible	$400
Specialist copay	$45
Hospital (facility) copay	$100
Other copay	$100

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$400
Copayments	$245
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$1,875**

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

The plan's overall deductible	$400
Specialist copay	$45
Hospital (facility) copay	$100
Other copay	$100

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$245
Coinsurance	$480
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,125**

***This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services"?**
The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services:

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 less favorably because of race, color, national origin, age, disability or sex.

BlueCross:

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

If you need these reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact a consumer advisor at the number on the back of your Member ID card or call 1-600-565-9140 (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 Grievance; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscriminalion_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 al https://ocrportal.hhs.gov/ocr/portalllobby.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/officelfile/index.html.

You can contact BlueCross's Nondiscrimination Coordinator at 423-535-1010 (TTY: 1-800-848-0298 or 711); Nondiscrimination_ Coordinator{;M@bcbst.com (email); or Corporate Compliance, 1 Cameron Hill Circle, 1.4, Chattanooga, TN 37402.

This notice is available at BlueCross's website: bcbst.com.

BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association.

BlueCross BlueShield of Tennessee is a Qualified Health Plan Issuer in the Health Insurance Marketplace.

[1] Consistent with Iha scope of sex discrimination described al 45 CFR 92.101(a)(2))

ATTENTION: If you speak English, free language assistance services and appropriate auxiliary aids and services are available to you. Please call the Member Service number on the back of your Member ID card or 1-800-565-9140 (TTY: 1-800-848-0298).

ATENCION: Si habla espaiiol, tiane a su disposici6n servicios gratuitos de asistencia con el idioma, asi como ayudas y servicios auxiliares adecuados. Llama al numero de Servicio de atenci6n a miembros que figura en el reverso de su tarjeta de identificaci6n de miembro o al 1-800-565-9140 (TTY: 1-800-848-0298).

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ATTENTION : Si vous parlez franyais, des services gratuits d'assistance linguistique et des aides et services auxiliaires appropriSs sont a votre disposition. Veuillez appeler le numero du Service adherents indique au dos de votre carte d'assure adherent ou le 1-800-565-9140 (TTY/ATS: 1-800-848-0298).

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ACHTUNG: Wenn Sia Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste und geeignete Hilfsmillel und Dienstleislungen zur Verfugung. Bille nufen Sie die Nummer des Mitgliederdienstes auf der Ruckseite Ihrer Mitglieds-ID-Karte oder 1-800-565-9140 (TTY: 1-800-848-0298) an.

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PANSININ: Kung kayo ay nagsasalita ng Tagalog, magagamit para sa inyo ang libreng mga serbisyong tulong sa wika at kaukulang mga karagdagang tulong at mga serbisyo. Mangyaring tawagan ang numaro ng Serbisyo sa Miyembro na nasa likod ng inyong Kard ng ID ng Miyembro o sa 1-800-565-9140 (TTY: 1-800-848-0298).

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ATANSYON: Si w pale Kreyol Ayisyen, genyen sevis asislans gratis pou lang ansanm ak ad pou sevis oksilye apwopriye k ap disponib pou ou. Tanpri rele nimewo S0vis Manm ki sou do kat ID Manm ou an oswa 1-800-565-9140 (TTY: 1-800-848-0298).

UWAGA: Osoby poslugujqce si,,; j,,;,zykiem polskim mog<1bezp!atnie skorzystac z pomocy j□zykowej oraz rozwi□zal1 i ustug pomocniczych. Prosimy zadzwoniC pod numer dzialu obslugi ubezpieczonych podany na odwrocie karty identyfikacyjnej czlonka lub numer 1-800-565-9140 (TTY: 1-800-848-0298).

ATENCAO: Se voca lala Portuguss, servi<;os gratuitos de assist0ncia lingu fstica e recursos e servi□os auxiliares apropriados estao disponiveis para voce. Ligue para o nllmero de telefone do servi□o de Atendimento ao Membro informado no verso de seu cartao de identifica<;;ao de membro ou para 1-800-565-9140 (TTY: 1-800-848-0298).

ATTENZIONE: se parla italiano, sono disponibili per Lei servizi gratuiti di assistenza linguistica nonch€1 aiuti e servizi ausiliari adeguati. Chiami ii numero del Servizio per i membri riportato sul retro della Sua scheda identificativa del membro oppure ii numero 1-800-565-9140 (TTY: 1-800-848-0298).

BAA'aKOHWIINIDZIN: Dine bizaad bee yanilti'go, t'aa ji ik'eh saad bee aka'ana'awo' bee aka'anida'awo'i d66 t'aadoole'e bina hii' beeadahodoonilfgif dine bich'i' anidahazt'i'i bee bika'aanida'awo'i na dah61¢. T'aa sh66di Bil Ha'dit'ehi Bika'ana'awo' Bil Ha'dit'ehi ID naaltsoos nitl'izf bine'd□f binamboo bee hodiilnih doodago 1-800-565-9140 (TTY: 1-800-848-0298).

WICHDICH: Wann du Deitsch schwatzscht un brauchschl Hilf fer communicat-e kenne mer dich helfe unni as es dich ennich eppes koschde zellt. Mir kenne differnti Sadde Schprooch-Hilf beigriege aa fer nix. Ruf der Member Service Number uff die hinnerschl Seit vun dei Member ID Card uff odder 1-800-565-9140 (TTY: 1-800-848-0298).

FAASILASILAGA: Alai e le tautala i le faa-Samoa. o loo avanoa mo oe auaunaga fesoasoani mo gagana e aunoa ma se totogi faapea ma fesoasoani fa'aopo'opo ma auaunaga talafeagai. Faamolemole vala'au le numera o le Member Service (Auaunaga mo Tagata Auai) o lo'o i tua o lau pepa ID o le Member (Tagata Auai) po o le 1-800-565-9140 (TTY: 1-800-848-0298).

GAKIULA: Gare iga go kapelal Faluwasch, ye toore paliuwal yamem bwe tepangug rel gamatefal lane kapetal Faluwasch. Fale peshem kol yegili nampal Member Service ila yelog liugul tagurul Member ID kard la yam gare 1-800-565-9140 (TTY: 1-800-848-0298).

ATENSION: Guaha setbisio siha para hagu yanggan fifino' CHamoru hao, dibatde na setbision inayudon fumino' CHamoru yan propriu na inasisten tr3stes yan setbisio siha. Put fabot agang i numiron Setbision Membro gi santatlen i katla-mu Member ID pat 1-800-565-9140 (TTY: 1-800-848-0298).