WOLFCHASE HONDA-NISSAN

2016-2017 Medical Plan Options

	Plan #1	Plan #2	Plan #3
Plan Name	PPO 5000/6000	PPO 3500/5000	PPO 5000/6600
Plan Type	PPO	PPO	PPO
IN-NETWORK BENEFITS:			
Provider Network	Network S	Network S	Network S
Provider Directory Website	www.bcbst.com	www.bcbst.com	www.bcbst.com
Local Hospitals	Methodist, St. Francis, LeBonheur, Regional Medical Center, St. Jude	Methodist, St. Francis, LeBonheur, Regional Medical Center, St. Jude	Methodist, St. Francis, LeBonheur, Regional Medical Center, St. Jude
Wellness	$0; *deductible waived*	$0; *deductible waived*	$0; *deductible waived*
Primary Care Office Visit	30%; *deductible waived*	30%; *deductible waived*	30%; *deductible waived*
Specialist Office Visit	30%; *deductible waived*	30%; *deductible waived*	30%; *deductible waived*
Walk In Clinics	30%; *deductible waived*	30%; *deductible waived*	30%; *deductible waived*
Diagnostic Lab, In Physician Office	30%; *deductible waived*	30%; *deductible waived*	30%; *deductible waived*
Diagnostic X-ray, In Physician Office	30%; *deductible waived*	30%; *deductible waived*	30%; *deductible waived*
24 Hour Telehealth (MDLive)	$38 co-pay; *deductible waived*	$38 co-pay; *deductible waived*	$38 co-pay; *deductible waived*
Urgent Care, Physician Charges	30%; *deductible waived*	30%; *deductible waived*	30%; *deductible waived*
Emergency Room	$250; *deductible waived*	$250; *deductible waived*	$250; *deductible waived*
Prescription Drugs:			
Generic	$8 co-pay; *deductible waived*	$8 co-pay; *deductible waived*	$10 co-pay; *deductible waived*
Preferred Brand	$40 co-pay; *deductible waived*	$40 co-pay; *deductible waived*	$75 co-pay; *deductible waived*
Non-Preferred Brand	$60 co-pay; *deductible waived*	$60 co-pay; *deductible waived*	$150 co-pay; *deductible waived*
Specialty	$120 co-pay; *deductible waived*	$120 co-pay; *deductible waived*	$300 co-pay; *deductible waived*
Complex Imaging (MRI, CAT Scans, etc.)	30%; *after deductible*	30%; *after deductible*	30%; *after deductible*
Surgery	30%; *after deductible*	30%; *after deductible*	30%; *after deductible*
In / Outpatient Hospital	30%; *after deductible*	30%; *after deductible*	30%; *after deductible*
Deductible	$5,000	$3,500	$5,000
Deductible, Maximum for Family	x2	x2	x2
BlueCross Coinsurance	70%	70%	70%
Annual Out-of-Pocket Maximum (Includes deductible, coinsurance & co-pays)	$6,000	$5,000	$6,600
Out-of-Pocket, Maximum for Family	x2	x2	x2
Benefit Year Period	Calendar Year	Calendar Year	Calendar Year
OUT-OF-NETWORK BENEFITS:	$10,000 Deductible; 50% coinsurance; $18,000 Out-of-Pocket	$7,000 Deductible; 50% coinsurance; $15,000 Out-of-Pocket	$10,000 Deductible; 50% coinsurance; $19,800 Out-of-Pocket
Weekly Employee Contributions			
Single Coverage	**$32.01**	**$40.30**	**$24.03**
Employee & Spouse Coverage	**$124.35**	**$141.75**	**$107.57**
Employee & Children Coverage	**$101.68**	**$116.85**	**$87.07**
Employee & Family Coverage	**$202.83**	**$227.99**	**$178.59**
All Payroll Deductions are before-tax via our Section 125 Cafeteria Plan			

MUST ENROLL NOW OR WAIT UNTIL OPEN ENROLLMENT (MAY 1ST) UNLESS QUALIFYING FOR SPECIAL ENROLLMENT

This is a brief overview only. Refer to your BlueCross Evidence of Coverage or the Summary of Benefits and Comparison for details.

BlueCross BlueShield of TN - Network S
Walk-In Clinics and Urgent Care Clinics
As of 04/7/16; **bcbst.com**

Walk-In Clinics

The Little Clinic (Kroger)
11630 Highway 51 S.
Atoka, TN 38004
(901) 837-5020

The Little Clinic (Kroger)
7615 US Highway 70
Memphis, TN 38133
(901) 969-1773

The Little Clinic (Kroger)
9025 Highway 64
Arlington, TN 38002
(901) 387-2998

The Little Clinic (Kroger)
11635 US Highway 70
Arlington, TN 38002
(901) 290-9270

The Little Clinic (Kroger)
1675 N Germantown Pkwy
Cordova, TN 38016
(901) 969-1405

The Little Clinic (Kroger)
3444 Plaza Ave
Memphis, TN 38111
(901) 730-4204

TakeCare Clinic (Walgreens)
43 Tabb Dr
Munford, TN 38058
(855) 925-4733

TakeCare Clinic (Walgreens)
6697 Stage Rd
Memphis, TN 38134
(855) 925-4733

TakeCare Clinic (Walgreens)
8046 Macon Rd
Cordova, TN 38018
(855) 925-4733

TakeCare Clinic (Walgreens)
1863 Union Ave
Memphis, TN 38104
(855)925-4733

TakeCare Clinic (Walgreens)
4680 Poplar Ave
Memphis, TN 38117
(855) 925-4733

TakeCare Clinic (Walgreens)
8001 Winchester Rd,
Memphis, TN 38125
(855) 925-4733

MinuteClinic (CVS Rx)
6670 Stage Rd
Memphis, TN 38134
(866) 389-2727

MinuteClinic (CVS Rx)
786 N Germantown Pkwy # TN005
Cordova, TN 38018
(866) 389-2727

TakeCare Clinic (Walgreens)
6958 Goodman Rd
Olive Branch, MS 38654
(855) 925-4733

TakeCare Clinic (Walgreens)
1501 Goodman Rd West
Horn Lake, MS 38637
(855) 925-4733

Urgent Care Clinics

Medpost Urgent Care
1520 Bonnie Lane
Cordova, TN 38016
(901) 791-9060

Methodist LeBonheur Urgent Care
8035 Club Pkwy
Cordova, TN 38016
(901) 758-6000

LeBonheur Urgent Care
8093 Club Pkwy
Cordova, TN 38016
((901) 758-6000

LeBonheur Urgent Care
50 N Dunlap Street
Memphis, TN 38103
((901) 287-6756

LeBonheur Urgent Care
848 Adams Avenue
Memphis, TN 38103
((901) 287-5437

LeBonheur Urgent Care
806 Estate Place
Memphis, TN 38120
((901) 287-4000

Methodist LeBonheur Urgent Care
8071 Winchester Road
Memphis, TN 38125
((901) 759-2030

MedPost Urgent Care
1941 S Germantown Rd, #103
Germantown, TN 38138
(901) 624-6055

BlueCross BlueShield of Tennessee

BlueHealth SOLUTIONS℠

We're Here to Help
NURSELINE

No question is too big or too small -
Call us 24 hours a day, 7 days a week.

Health questions come up at all times during the day and night. It's not easy to predict when you might get sick or injured, but with Nurseline, part of your BlueCross BlueShield of Tennessee health plan, nurses are available 24/7/365 at no cost to you.

Answers to all your medical questions are just a phone call away. Or if you prefer, connect with Nurseline via live online chat.

Advice When You Need It

No matter what the health concern - a cut finger, child's fever, possible food poisoning, skin rash and sprained ankle - an experienced, caring nurse will help you decide what kind of care you need.

Our nurses also provide support and guidance for major health care decisions.

If you are thinking about surgery or facing a major health decision, you don't have to make a decision alone. A nurse can help you make the best choice for you and your family.

PEACE OF MIND
IS JUST A
PHONE CALL
AWAY

CALL NURSELINE
1-800-818-8581
(OPTION 1)
1-888-308-7231 (TTY)

CHAT ONLINE
Log in to BlueAccess℠ on **bcbst.com** to chat with a nurse.

of Tennessee

BlueHealth SOLUTIONS

$38 MDLive Consultation Fee

THE DOCTOR IS IN ON YOUR PHONE, TABLET OR COMPUTER

MDLIVE, powered by BlueHealth Solutions, connects you with doctors 24 hours a day, 7 days a week.

Use telehealth to avoid the hassle of scheduling time with your doctor or spending hours in an ER or Urgent Care waiting room. **All you need is a telephone, smartphone, tablet or computer.***

When Should I Use Telehealth?

- When it's not an emergency
- When it's not easy to schedule with your doctor
- When you're traveling
- When you're too busy to go to your doctor's office

SAVING YOU MONEY

You pay less using telehealth than you would visiting an Urgent Care or Emergency Room.

- **Average Urgent Care visit costs $150**
- **Average Emergency Room visit costs $750**

LEARN MORE ABOUT HOW TO CONNECT TO A DOCTOR 24/7

Visit bcbst.com/blueaccess and select the My Health and Wellness tab.

Or call 888-283-6691

What Common Conditions Can Telehealth Doctors Treat?

- Allergies
- Asthma
- Bronchitis
- Cold & flu
- Ear infections
- Fever
- Infections
- Sinus infections
- Respiratory infections
- Skin infections
- Sore throat
- Sports injuries
- Urinary Tract infections
- And more**

Common Pediatric Conditions Include:***

- Cold & flu
- Constipation
- Ear infections
- Fever
- Nausea
- Pink eye
- Vomiting

*Some state exclusions apply.

** Some state laws require that a doctor can only prescribe medication in certain situations and can be subject to certain limitations. BlueCross members should have their prescriptions filled at a network pharmacy in compliance with the BlueCross drug formulary.

***Children under the age of 2 with a fever will be automatically sent to the pediatrician on call.

How Do I Use Telehealth?

You can connect with a doctor via the phone or the internet.

Registering for MDLIVE is simple. Be sure to have the primary subscriber's birthday and Social Security Number handy.

- Visit **bcbst.com/blueaccess**
- Complete and confirm your medical history (this can be completed before your consultation)
- Request a consultation
- Stand by for your doctor to contact you for your consultation

of Tennessee

1 Cameron Hill Circle | Chattanooga, TN 37402 | bcbst.com

BHS-65 (6/15)
BlueHealth Solutions
MDLIVE Employee Flier

BlueCross BlueShield of Tennessee

An Independent Licensee of the BlueCross BlueShield Association

Group Name: Wolfchase Honda-Nissan Medical Plan
Network: Blue Network S
Effective Date: 5/1/2016
Option Number: 1

PPO Benefits		
Benefit Features	**Network Providers**	**Out-of-Network Providers [2]**
Annual Deductible		
Individual	$5,000	$10,000
Family	$10,000	$20,000
Annual Out-of-Pocket Maximum Amount		
Individual	$6,000	$18,000
Family	$12,000	$36,000
Dependent Age Limit	To age 26	
4th Quarter Deductible Carryover Provision	Not Included	
Benefits for Covered Services	**Network Benefits**	**Out-of-Network Benefits [2]**
Practitioner Office Services		
Primary Care Office Visits	70%	50% after Deductible
Specialist Office Visits	70%	50% after Deductible
Office Surgery [4][5][6]	70% after Deductible	50% after Deductible
Routine Diagnostic Lab, X-Ray, & Injections	70%	50% after Deductible
Advanced Radiological Imaging [3][5][7]	70% after Deductible	50% after Deductible
Provider-Administered Specialty Drugs [12]	$120 Copay	50% after Deductible
Preventive Health Care Services		
Well Child Care (to age 6)	100%	50% after Deductible
Annual Well Woman Exam	100%	50% after Deductible
Annual Mammography Screening - age 40+	100%	50% after Deductible
Annual Cervical Cancer Screening	100%	50% after Deductible
Annual Prostate Cancer Screening - age 50+	100%	50% after Deductible
Immunizations (to age 6)	100%	50% after Deductible
Well Care Services (ages 6 and up) [14]	100%	50% after Deductible
Services Received at a Facility (includes professional and facility charges)		
Inpatient Services [3][5]	70% after Deductible	50% after Deductible
Outpatient Surgery [4][5][6]	70% after Deductible	50% after Deductible
Routine Diagnostic Services-Outpatient	70%	50% after Deductible
Advanced Radiological Imaging-Outpatient [3][5][7]	70% after Deductible	50% after Deductible
Provider-Administered Specialty Drugs [12]	70% after Deductible	50% after Deductible
Other Outpatient Services [8]	70% after Deductible	50% after Deductible
Emergency Care Services [10]	$250 Copay	$250 Copay
Emergency Care Advanced Radiological Imaging [7]	70% after Deductible	70% after Deductible
Medical Equipment		
Durable Medical Equipment	70% after Deductible	50% after Deductible
Prosthetics	70% after Deductible	50% after Deductible
Orthotic Appliances	70% after Deductible	50% after Deductible
Behavioral Health		
Inpatient: Unlimited days per calendar annual benefit period	70% after deductible	50% after Deductible
Outpatient: Unlimited days per calendar annual benefit period	70%	50% after Deductible
Therapeutic Services [9]		
Therapy (Limited to 20-36 visits per therapy type per annual benefit period)	70% after Deductible	50% after Deductible
Skilled Nursing Facility & Rehabilitation Facility Services [3][5]		
Limited to 60 days combined	70% after Deductible	50% after Deductible
Home Health Services [3]		
Limited to 60 visits per annual benefit period	70% after Deductible	50% after Deductible
Hospice Services	100%	50% after Deductible
Ambulance Service	70% after Deductible	70% after Deductible
Pharmacy		
Prescription Drugs[11][13]	$8/$40/$60 Copays	50% after Deductible
Specialty Drugs[11][12][13]	$120 Copay	Not Covered

Notes:

1. Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your Evidence of Coverage (EOC) and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the EOC will govern. For a complete list of limitations and exclusions, please refer to your EOC.
2. Out-of-network benefit payment based on BlueCross BlueShield of Tennessee maximum allowable charge. You are responsible for paying any amount exceeding the maximum allowable charge.
3. Requires prior authorization.
4. Certain Outpatient Surgeries and/or procedures may require prior authorization.
5. If prior authorization is required, when using network providers outside Tennessee and all out-of-network providers, benefits will be reduced to 40% if prior authorization is not obtained and services are medically necessary. If services are not medically necessary no benefits will be provided.
6. Surgeries include incisions, excisions, biopsies, injection treatments, fracture treatments, applications of casts and splints, sutures, and invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy and endoscopy).
7. CAT scans, PET Scans, MRIs, nuclear medicine and other similar technologies.
8. Includes services such as chemotherapy, radiation therapy, and renal dialysis.
9. Physical, speech, manipulative, and occupational therapies are limited to 20 visits per therapy type per annual benefit period. Cardiac and pulmonary rehabilitative therapies are limited to 36 visits per therapy type per annual benefit period.
10. Copay, if applicable, waived if admitted to hospital.
11. See attached rider for Pharmacy exclusions and Specialty Drug vendors.
12. Refer to www.bcbst.com for Specialty Pharmacy Drug List.
13. Copay per prescription, up to 30 day supply.
14. Services include: annual physical, childhood immunizations, recommended adult immunizations, vision and hearing screenings performed by the physician during the preventive health exam.

Preventive Health Services
Covered at 100% In-Network

In-network preventive services that are covered with no cost share include:

- Primary care services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF)
- Immunizations recommended by the Advisory Committee on Immunization Practices that have been adopted by the Centers for Disease Control and Prevention (CDC)
- Bright Futures recommendations for infants, children and adolescents that are supported by the Health Resources and Services Administration (HRSA)
- Preventive care and screening for women as provided in the guidelines supported by HRSA

The following preventive care services are covered.
Coverage of some services may depend on age and/or risk exposure.

All Members:

- One-a-year preventive health exams. More frequent preventive exams are covered for children up to age 3
- All standard immunizations adopted by the CDC
- Screening for colorectal cancer (age 50—75), high cholesterol and lipids, high blood pressure, obesity, diabetes, and depression
- Screening for HIV and certain sexually transmitted diseases, and counseling for the prevention of sexually transmitted diseases
- Screening and counseling in primary care setting for alcohol misuse and tobacco use; tobacco cessation counseling in the primary care setting will be limited to eight visits per year
- Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, obesity, coronary artery disease and congestive heart failure; limited to six visits per year

Women:

- Annual well-woman visit, including annual sexually transmitted infection (STI) counseling and annual domestic violence screening & counseling
- Cervical Cancer Screening
- Screening of pregnant women for anemia, iron deficiency, bacteriuria, hepatitis B virus, Rh factor incompatibility, gestational diabetes
- Breastfeeding support/counseling & supplies (one lactation consultant visit and manual breast pump in conjunction with each birth)
- Counseling women at high risk of breast cancer for chemoprevention, including risks and benefits
- Mammography screening at age 40 and over, and evaluation for genetic testing for BRCA breast cancer gene
- Osteoporosis screening (age 60 or older)
- HPV testing once every 3 years, beginning at age 30
- Annual HIV screening and counseling
- FDA-approved contraceptive methods and counseling
  Medical plan: Injectable or implantable hormonal contraceptives and barrier methods, sterilization for women
  Rx plan: Generic oral & injectable contraceptives, vaginal contraceptive, patch, prescription emergency contraception

Men:

- Prostate cancer screening at age 50 and older
- Abdominal aortic aneurysm screening at age 65—75 (for men who have ever smoked)

Children:

- Newborn screening for hearing, phenylketonuria (PKU), thyroid disease, sickle cell anemia, and cystic fibrosis
- Development delays and autism screening
- Iron deficiency screening
- Vision screening
- Screening for major depressive disorders

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the coverage document at www.bcbst.com or by calling 1-800-565-9140. Coverage documents are not available until after the effective date of your coverage, but you may obtain a sample at http://www.bcbst.com/samplepolicy/2016/LG . This sample may not match your benefits exactly, so you should review your coverage document once it is available.
Contributions made by you and/or your employer to health savings accounts (HSAs), flexible spending arrangements (FSAs), or health reimbursement arrangements (HRAs) may help pay your deductible or other out-of-pocket expenses.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$5,000** person/**$10,000** family Out-of-network: **$10,000** person/**$20,000** family Doesn't apply to preventive care. Copays do not apply to the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-network: **$6,000** person/**$12,000** family Out-of-network: **$18,000** person/**$36,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premium, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. This plan uses Network S. For a list of **in-network providers**, see www.bcbst.com or call 1-800-565-9140.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Important Questions	Answers	Why this Matters:
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% co-insurance	50% co-insurance	none
	Specialist visit	30% co-insurance	50% co-insurance	none
	Other practitioner office visit	30% co-insurance	50% co-insurance	Therapy visits limited to 20 per type per year. Cardiac/Pulmonary Rehab visits limited to 36 per type per year.
	Preventive care / screening / immunization	No Charge	50% co-insurance	none
If you have a test	Diagnostic test (x-ray, blood work)	30% co-insurance	50% co-insurance	none
	Imaging (CT/PET scans, MRIs)	30% co-insurance	50% co-insurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Generic drugs	$8 co-pay	50% co-insurance	30-day supply retail; up to 90 day supply home delivery or Select90 network. Co-pay per 30-day supply.
	Preferred brand drugs	$40 co-pay	50% co-insurance	30-day supply retail; up to 90 day supply home delivery or Select90 network. Co-pay per 30-day supply. When a Brand Drug is chosen and a Generic Drug equivalent is

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
www.bcbst.com.	Non-preferred brand drugs	$60 co-pay	50% co-insurance	available, Your cost share will increase by the difference between the cost of the Brand Drug and the Generic Drug.
	Self-Administered Specialty drugs	$120 co-pay at specialty pharmacy network	Not Covered	Up to a 30 day supply. Must use a pharmacy in Specialty pharmacy network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-insurance	50% co-insurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained.
	Physician/surgeon fees	30% co-insurance	50% co-insurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained.
If you need immediate medical attention	Emergency room services	$250 co-pay/visit	$250 co-pay/visit	none
	Emergency medical transportation	30% co-insurance	30% co-insurance	none
	Urgent care	See Limitations & Exceptions	See Limitations & Exceptions	Urgent Care benefits are determined by place of service, such as physician's office or ER.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-insurance	50% co-insurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
	Physician/surgeon fee	30% co-insurance	50% co-insurance	none
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30% co-insurance	50% co-insurance	Prior Authorization required for electro-convulsive therapy (ECT). Your cost share may increase to 60% if not obtained.
	Mental/Behavioral health inpatient services	30% co-insurance	50% co-insurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
	Substance use disorder outpatient services	30% co-insurance	50% co-insurance	Prior Authorization required for electro-convulsive therapy (ECT). Your cost share may increase to 60% if not obtained.
	Substance use disorder inpatient services	30% co-insurance	50% co-insurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you are pregnant	Prenatal and postnatal care	30% co-insurance	50% co-insurance	none
	Delivery and all inpatient services	30% co-insurance	50% co-insurance	none

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you need help recovering or have other special health needs	Home health care	30% co-insurance	50% co-insurance	Limited to 60 visits.
	Rehabilitation services	30% co-insurance	50% co-insurance	Therapy limited to 20 visits per type per year. Cardiac/Pulmonary Rehab limited to 36 visits per year.
	Habilitation services	30% co-insurance	50% co-insurance	
	Skilled nursing care	30% co-insurance	50% co-insurance	Skilled Nursing and Rehabilitation Facility limited to 60 days/year combined.
	Durable medical equipment	30% co-insurance	50% co-insurance	Prior Authorization may be required for certain durable medical equipment. Your cost share may increase to 60% if not obtained.
	Hospice service	No Charge	50% co-insurance	Prior Authorization required for Inpatient Hospice. Your cost share may increase to 60% if not obtained.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	none
	Glasses	Not Covered	Not Covered	none
	Dental check-up	Not Covered	Not Covered	none

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture	• Hearing aids for adults	• Routine eye care (Adult)
• Bariatric surgery	• Infertility treatment	• Routine eye care (Children)
• Cosmetic surgery	• Long-term care	• Routine foot care for non-diabetics
• Dental care (Adult)	• Private-duty nursing	• Weight loss programs
• Dental care (Children)		

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Chiropractic care	• Hearing aids for children under 18	• Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-565-9140. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- Your Plan at 1-800-565-9140 or www.bcbst.com.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.
- Consumer Insurance Services within the Tennessee Department of Commerce and Insurance at 1-800-342-4029 or visit www.tn.gov/insurance/consumerRes.shtml.

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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage <u>does meet</u> the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-800-565-9140**.
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Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-800-565-9140**.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $1,760
- **Patient pays** $5,780

Sample care costs:	
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:	
Deductibles	$5,000
Copays	$50
Co-insurance	$700
Limits or exclusions	$30
Total	**$5,780**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,700
- **Patient pays** $1,700

Sample care costs:	
Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:	
Deductibles	$0
Copays	$1,400
Co-insurance	$300
Limits or exclusions	$0
Total	**$1,700**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

BlueCross BlueShield of Tennessee

An Independent Licensee of the BlueCross BlueShield Association

Group Name: Wolfchase Honda-Nissan Medical Plan
Network: Blue Network S
Effective Date: 5/1/2016
Option Number: 2

PPO Benefits		
Benefit Features	**Network Providers**	**Out-of-Network Providers [2]**
Annual Deductible		
Individual	$3,500	$7,000
Family	$7,000	$14,000
Annual Out-of-Pocket Maximum Amount		
Individual	$5,000	$15,000
Family	$10,000	$30,000
Dependent Age Limit	To age 26	
4th Quarter Deductible Carryover Provision	Not Included	
Benefits for Covered Services	**Network Benefits**	**Out-of-Network Benefits [2]**
Practitioner Office Services		
Primary Care Office Visits	70%	50% after Deductible
Specialist Office Visits	70%	50% after Deductible
Office Surgery [4][5][6]	70% after Deductible	50% after Deductible
Routine Diagnostic Lab, X-Ray, & Injections	70%	50% after Deductible
Advanced Radiological Imaging [3][5][7]	70% after Deductible	50% after Deductible
Provider-Administered Specialty Drugs [12]	$120 Copay	50% after Deductible
Preventive Health Care Services		
Well Child Care (to age 6)	100%	50% after Deductible
Annual Well Woman Exam	100%	50% after Deductible
Annual Mammography Screening - age 40+	100%	50% after Deductible
Annual Cervical Cancer Screening	100%	50% after Deductible
Annual Prostate Cancer Screening - age 50+	100%	50% after Deductible
Immunizations (to age 6)	100%	50% after Deductible
Well Care Services (ages 6 and up) [14]	100%	50% after Deductible
Services Received at a Facility (includes professional and facility charges)		
Inpatient Services [3][5]	70% after Deductible	50% after Deductible
Outpatient Surgery [4][5][6]	70% after Deductible	50% after Deductible
Routine Diagnostic Services-Outpatient	70%	50% after Deductible
Advanced Radiological Imaging-Outpatient [3][5][7]	70% after Deductible	50% after Deductible
Provider-Administered Specialty Drugs [12]	70% after Deductible	50% after Deductible
Other Outpatient Services [8]	70% after Deductible	50% after Deductible
Emergency Care Services [10]	$250 Copay	$250 Copay
Emergency Care Advanced Radiological Imaging [7]	70% after Deductible	70% after Deductible
Medical Equipment		
Durable Medical Equipment	70% after Deductible	50% after Deductible
Prosthetics	70% after Deductible	50% after Deductible
Orthotic Appliances	70% after Deductible	50% after Deductible
Behavioral Health		
Inpatient: Unlimited days per calendar annual benefit period	70% after deductible	50% after Deductible
Outpatient: Unlimited days per calendar annual benefit period	70%	50% after Deductible
Therapeutic Services [9]		
Therapy (Limited to 20-36 visits per therapy type per annual benefit period)	70% after Deductible	50% after Deductible
Skilled Nursing Facility & Rehabilitation Facility Services [3][5]		
Limited to 60 days combined	70% after Deductible	50% after Deductible
Home Health Services [3]		
Limited to 60 visits per annual benefit period	70% after Deductible	50% after Deductible
Hospice Services	100%	50% after Deductible
Ambulance Service	70% after Deductible	70% after Deductible
Pharmacy		
Prescription Drugs[11][13]	$8/$40/$60 Copays	50% after Deductible
Specialty Drugs[11][12][13]	$120 Copay	Not Covered

Notes:

1. Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your Evidence of Coverage (EOC) and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the EOC will govern. For a complete list of limitations and exclusions, please refer to your EOC.
2. Out-of-network benefit payment based on BlueCross BlueShield of Tennessee maximum allowable charge. You are responsible for paying any amount exceeding the maximum allowable charge.
3. Requires prior authorization.
4. Certain Outpatient Surgeries and/or procedures may require prior authorization.
5. If prior authorization is required, when using network providers outside Tennessee and all out-of-network providers, benefits will be reduced to 40% if prior authorization is not obtained and services are medically necessary. If services are not medically necessary no benefits will be provided.
6. Surgeries include incisions, excisions, biopsies, injection treatments, fracture treatments, applications of casts and splints, sutures, and invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy and endoscopy).
7. CAT scans, PET Scans, MRIs, nuclear medicine and other similar technologies.
8. Includes services such as chemotherapy, radiation therapy, and renal dialysis.
9. Physical, speech, manipulative, and occupational therapies are limited to 20 visits per therapy type per annual benefit period. Cardiac and pulmonary rehabilitative therapies are limited to 36 visits per therapy type per annual benefit period.
10. Copay, if applicable, waived if admitted to hospital.
11. See attached rider for Pharmacy exclusions and Specialty Drug vendors.
12. Refer to www.bcbst.com for Specialty Pharmacy Drug List.
13. Copay per prescription, up to 30 day supply.
14. Services include: annual physical, childhood immunizations, recommended adult immunizations, vision and hearing screenings performed by the physician during the preventive health exam.

Preventive Health Services
Covered at 100% In-Network

In-network preventive services that are covered with no cost share include:

- Primary care services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF)
- Immunizations recommended by the Advisory Committee on Immunization Practices that have been adopted by the Centers for Disease Control and Prevention (CDC)
- Bright Futures recommendations for infants, children and adolescents that are supported by the Health Resources and Services Administration (HRSA)
- Preventive care and screening for women as provided in the guidelines supported by HRSA

The following preventive care services are covered.
Coverage of some services may depend on age and/or risk exposure.

All Members:

- One-a-year preventive health exams. More frequent preventive exams are covered for children up to age 3
- All standard immunizations adopted by the CDC
- Screening for colorectal cancer (age 50—75), high cholesterol and lipids, high blood pressure, obesity, diabetes, and depression
- Screening for HIV and certain sexually transmitted diseases, and counseling for the prevention of sexually transmitted diseases
- Screening and counseling in primary care setting for alcohol misuse and tobacco use; tobacco cessation counseling in the primary care setting will be limited to eight visits per year
- Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, obesity, coronary artery disease and congestive heart failure; limited to six visits per year

Women:

- Annual well-woman visit, including annual sexually transmitted infection (STI) counseling and annual domestic violence screening & counseling
- Cervical Cancer Screening
- Screening of pregnant women for anemia, iron deficiency, bacteriuria, hepatitis B virus, Rh factor incompatibility, gestational diabetes
- Breastfeeding support/counseling & supplies (one lactation consultant visit and manual breast pump in conjunction with each birth)
- Counseling women at high risk of breast cancer for chemoprevention, including risks and benefits
- Mammography screening at age 40 and over, and evaluation for genetic testing for BRCA breast cancer gene
- Osteoporosis screening (age 60 or older)
- HPV testing once every 3 years, beginning at age 30
- Annual HIV screening and counseling
- FDA-approved contraceptive methods and counseling
  Medical plan: Injectable or implantable hormonal contraceptives and barrier methods, sterilization for women
  Rx plan: Generic oral & injectable contraceptives, vaginal contraceptive, patch, prescription emergency contraception

Men:

- Prostate cancer screening at age 50 and older
- Abdominal aortic aneurysm screening at age 65—75 (for men who have ever smoked)

Children:

- Newborn screening for hearing, phenylketonuria (PKU), thyroid disease, sickle cell anemia, and cystic fibrosis
- Development delays and autism screening
- Iron deficiency screening
- Vision screening
- Screening for major depressive disorders

# of Tennessee: Wolfchase Honda-Nissan Medical (OPT#2)

Summary of Benefits & Coverage: What this Plan Covers & What it Costs

Coverage Period: 05/01/2016 - 04/30/2017
Coverage for: Individual or Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the coverage document at www.bcbst.com or by calling 1-800-565-9140. Coverage documents are not available until after the effective date of your coverage, but you may obtain a sample at http://www.bcbst.com/samplepolicy/2016/LG . This sample may not match your benefits exactly, so you should review your coverage document once it is available.
Contributions made by you and/or your employer to health savings accounts (HSAs), flexible spending arrangements (FSAs), or health reimbursement arrangements (HRAs) may help pay your deductible or other out-of-pocket expenses.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$3,500** person/**$7,000** family Out-of-network: **$7,000** person/**$14,000** family Doesn't apply to preventive care. Copays do not apply to the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-network: **$5,000** person/**$10,000** family Out-of-network: **$15,000** person/**$30,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premium, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. This plan uses Network S. For a list of **in-network providers**, see www.bcbst.com or call 1-800-565-9140.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Important Questions	Answers	Why this Matters:
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% co-insurance	50% co-insurance	none
	Specialist visit	30% co-insurance	50% co-insurance	none
	Other practitioner office visit	30% co-insurance	50% co-insurance	Therapy visits limited to 20 per type per year. Cardiac/Pulmonary Rehab visits limited to 36 per type per year.
	Preventive care / screening / immunization	No Charge	50% co-insurance	none
If you have a test	Diagnostic test (x-ray, blood work)	30% co-insurance	50% co-insurance	none
	Imaging (CT/PET scans, MRIs)	30% co-insurance	50% co-insurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Generic drugs	$8 co-pay	50% co-insurance	30-day supply retail; up to 90 day supply home delivery or Select90 network. Co-pay per 30-day supply.
	Preferred brand drugs	$40 co-pay	50% co-insurance	30-day supply retail; up to 90 day supply home delivery or Select90 network. Co-pay per 30-day supply. When a Brand Drug is chosen and a Generic Drug equivalent is

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
www.bcbst.com.	Non-preferred brand drugs	$60 co-pay	50% co-insurance	available, Your cost share will increase by the difference between the cost of the Brand Drug and the Generic Drug.
	Self-Administered Specialty drugs	$120 co-pay at specialty pharmacy network	Not Covered	Up to a 30 day supply. Must use a pharmacy in Specialty pharmacy network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-insurance	50% co-insurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained.
	Physician/surgeon fees	30% co-insurance	50% co-insurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained.
If you need immediate medical attention	Emergency room services	$250 co-pay/visit	$250 co-pay/visit	none
	Emergency medical transportation	30% co-insurance	30% co-insurance	none
	Urgent care	See Limitations & Exceptions	See Limitations & Exceptions	Urgent Care benefits are determined by place of service, such as physician's office or ER.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-insurance	50% co-insurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
	Physician/surgeon fee	30% co-insurance	50% co-insurance	none
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30% co-insurance	50% co-insurance	Prior Authorization required for electro-convulsive therapy (ECT). Your cost share may increase to 60% if not obtained.
	Mental/Behavioral health inpatient services	30% co-insurance	50% co-insurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
	Substance use disorder outpatient services	30% co-insurance	50% co-insurance	Prior Authorization required for electro-convulsive therapy (ECT). Your cost share may increase to 60% if not obtained.
	Substance use disorder inpatient services	30% co-insurance	50% co-insurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you are pregnant	Prenatal and postnatal care	30% co-insurance	50% co-insurance	none
	Delivery and all inpatient services	30% co-insurance	50% co-insurance	none

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you need help recovering or have other special health needs	Home health care	30% co-insurance	50% co-insurance	Limited to 60 visits.
	Rehabilitation services	30% co-insurance	50% co-insurance	Therapy limited to 20 visits per type per year. Cardiac/Pulmonary Rehab limited to 36 visits per year.
	Habilitation services	30% co-insurance	50% co-insurance	
	Skilled nursing care	30% co-insurance	50% co-insurance	Skilled Nursing and Rehabilitation Facility limited to 60 days/year combined.
	Durable medical equipment	30% co-insurance	50% co-insurance	Prior Authorization may be required for certain durable medical equipment. Your cost share may increase to 60% if not obtained.
	Hospice service	No Charge	50% co-insurance	Prior Authorization required for Inpatient Hospice. Your cost share may increase to 60% if not obtained.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	none
	Glasses	Not Covered	Not Covered	none
	Dental check-up	Not Covered	Not Covered	none

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture	• Hearing aids for adults	• Routine eye care (Adult)
• Bariatric surgery	• Infertility treatment	• Routine eye care (Children)
• Cosmetic surgery	• Long-term care	• Routine foot care for non-diabetics
• Dental care (Adult)	• Private-duty nursing	• Weight loss programs
• Dental care (Children)		

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Chiropractic care	• Hearing aids for children under 18	• Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **1-800-565-9140**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272** or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at **1-877-267-2323 x61565** or **www.cciio.cms.gov**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- Your Plan at **1-800-565-9140** or **www.bcbst.com**.
- The Department of Labor's Employee Benefits Security Administration at **1-866-444-3272** or **www.dol.gov/ebsa/healthreform**.
- Consumer Insurance Services within the Tennessee Department of Commerce and Insurance at **1-800-342-4029** or visit **www.tn.gov/insurance/consumerRes.shtml**.

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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-800-565-9140**.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-565-9140**.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码 1-800-565-9140**.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-800-565-9140**.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $2,860
- **Patient pays** $4,680

Sample care costs:	
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:	
Deductibles	$3,500
Copays	$50
Co-insurance	$1,100
Limits or exclusions	$30
Total	**$4,680**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,700
- **Patient pays** $1,700

Sample care costs:	
Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:	
Deductibles	$0
Copays	$1,400
Co-insurance	$300
Limits or exclusions	$0
Total	**$1,700**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

BlueCross BlueShield of Tennessee

An Independent Licensee of the BlueCross BlueShield Association

Group Name: Wolfchase Honda-Nissan Medical Plan
Network: Blue Network S
Effective Date: 5/1/2016
Option Number: 3

PPO Benefits		
Benefit Features	**Network Providers**	**Out-of-Network Providers [2]**
Annual Deductible		
Individual	$5,000	$10,000
Family	$10,000	$20,000
Annual Out-of-Pocket Maximum Amount		
Individual	$6,600	$19,800
Family	$13,200	$39,600
Dependent Age Limit	To age 26	
4th Quarter Deductible Carryover Provision	Not Included	
Benefits for Covered Services	**Network Benefits**	**Out-of-Network Benefits [2]**
Practitioner Office Services		
Primary Care Office Visits	70%	50% after Deductible
Specialist Office Visits	70%	50% after Deductible
Office Surgery [4][5][6]	70% after Deductible	50% after Deductible
Routine Diagnostic Lab, X-Ray, & Injections	70%	50% after Deductible
Advanced Radiological Imaging [3][5][7]	70% after Deductible	50% after Deductible
Provider-Administered Specialty Drugs [12]	$300 Copay	50% after Deductible
Preventive Health Care Services		
Well Child Care (to age 6)	100%	50% after Deductible
Annual Well Woman Exam	100%	50% after Deductible
Annual Mammography Screening - age 40+	100%	50% after Deductible
Annual Cervical Cancer Screening	100%	50% after Deductible
Annual Prostate Cancer Screening - age 50+	100%	50% after Deductible
Immunizations (to age 6)	100%	50% after Deductible
Well Care Services (ages 6 and up) [14]	100%	50% after Deductible
Services Received at a Facility (includes professional and facility charges)		
Inpatient Services [3][5]	70% after Deductible	50% after Deductible
Outpatient Surgery [4][5][6]	70% after Deductible	50% after Deductible
Routine Diagnostic Services-Outpatient	70%	50% after Deductible
Advanced Radiological Imaging-Outpatient [3][5][7]	70% after Deductible	50% after Deductible
Provider-Administered Specialty Drugs [12]	70% after Deductible	50% after Deductible
Other Outpatient Services [8]	70% after Deductible	50% after Deductible
Emergency Care Services [10]	$250 Copay	$250 Copay
Emergency Care Advanced Radiological Imaging [7]	70% after Deductible	70% after Deductible
Medical Equipment		
Durable Medical Equipment	70% after Deductible	50% after Deductible
Prosthetics	70% after Deductible	50% after Deductible
Orthotic Appliances	70% after Deductible	50% after Deductible
Behavioral Health		
Inpatient: Unlimited days per calendar annual benefit period	70% after deductible	50% after Deductible
Outpatient: Unlimited days per calendar annual benefit period	70%	50% after Deductible
Therapeutic Services [9]		
Therapy (Limited to 20-36 visits per therapy type per annual benefit period)	70% after Deductible	50% after Deductible
Skilled Nursing Facility & Rehabilitation Facility Services [3][5]		
Limited to 60 days combined	70% after Deductible	50% after Deductible
Home Health Services [3]		
Limited to 60 visits per annual benefit period	70% after Deductible	50% after Deductible
Hospice Services	100%	50% after Deductible
Ambulance Service	70% after Deductible	70% after Deductible
Pharmacy		
Prescription Drugs[11][13]	$10/$75/$150	50% after Deductible
Specialty Drugs[11][12][13]	$300 Copay	Not Covered

Notes:

1. Limitations and Exclusions. These pages summarize the benefits of your health care plan. Your Evidence of Coverage (EOC) and riders define the full terms and conditions in greater detail. Should any questions arise concerning benefits, the EOC will govern. For a complete list of limitations and exclusions, please refer to your EOC.
2. Out-of-network benefit payment based on BlueCross BlueShield of Tennessee maximum allowable charge. You are responsible for paying any amount exceeding the maximum allowable charge.
3. Requires prior authorization.
4. Certain Outpatient Surgeries and/or procedures may require prior authorization.
5. If prior authorization is required, when using network providers outside Tennessee and all out-of-network providers, benefits will be reduced to 40% if prior authorization is not obtained and services are medically necessary. If services are not medically necessary no benefits will be provided.
6. Surgeries include incisions, excisions, biopsies, injection treatments, fracture treatments, applications of casts and splints, sutures, and invasive diagnostic services (e.g., colonoscopy, sigmoidoscopy and endoscopy).
7. CAT scans, PET Scans, MRIs, nuclear medicine and other similar technologies.
8. Includes services such as chemotherapy, radiation therapy, and renal dialysis.
9. Physical, speech, manipulative, and occupational therapies are limited to 20 visits per therapy type per annual benefit period. Cardiac and pulmonary rehabilitative therapies are limited to 36 visits per therapy type per annual benefit period.
10. Copay, if applicable, waived if admitted to hospital.
11. See attached rider for Pharmacy exclusions and Specialty Drug vendors.
12. Refer to www.bcbst.com for Specialty Pharmacy Drug List.
13. Copay per prescription, up to 30 day supply.
14. Services include: annual physical, childhood immunizations, recommended adult immunizations, vision and hearing screenings performed by the physician during the preventive health exam.

Preventive Health Services
Covered at 100% In-Network

In-network preventive services that are covered with no cost share include:

- Primary care services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF)
- Immunizations recommended by the Advisory Committee on Immunization Practices that have been adopted by the Centers for Disease Control and Prevention (CDC)
- Bright Futures recommendations for infants, children and adolescents that are supported by the Health Resources and Services Administration (HRSA)
- Preventive care and screening for women as provided in the guidelines supported by HRSA

The following preventive care services are covered.
Coverage of some services may depend on age and/or risk exposure.

All Members:

- One-a-year preventive health exams. More frequent preventive exams are covered for children up to age 3
- All standard immunizations adopted by the CDC
- Screening for colorectal cancer (age 50—75), high cholesterol and lipids, high blood pressure, obesity, diabetes, and depression
- Screening for HIV and certain sexually transmitted diseases, and counseling for the prevention of sexually transmitted diseases
- Screening and counseling in primary care setting for alcohol misuse and tobacco use; tobacco cessation counseling in the primary care setting will be limited to eight visits per year
- Dietary counseling for adults with hyperlipidemia, hypertension, Type 2 diabetes, obesity, coronary artery disease and congestive heart failure; limited to six visits per year

Women:

- Annual well-woman visit, including annual sexually transmitted infection (STI) counseling and annual domestic violence screening & counseling
- Cervical Cancer Screening
- Screening of pregnant women for anemia, iron deficiency, bacteriuria, hepatitis B virus, Rh factor incompatibility, gestational diabetes
- Breastfeeding support/counseling & supplies (one lactation consultant visit and manual breast pump in conjunction with each birth)
- Counseling women at high risk of breast cancer for chemoprevention, including risks and benefits
- Mammography screening at age 40 and over, and evaluation for genetic testing for BRCA breast cancer gene
- Osteoporosis screening (age 60 or older)
- HPV testing once every 3 years, beginning at age 30
- Annual HIV screening and counseling
- FDA-approved contraceptive methods and counseling
  Medical plan: Injectable or implantable hormonal contraceptives and barrier methods, sterilization for women
  Rx plan: Generic oral & injectable contraceptives, vaginal contraceptive, patch, prescription emergency contraception

Men:

- Prostate cancer screening at age 50 and older
- Abdominal aortic aneurysm screening at age 65—75 (for men who have ever smoked)

Children:

- Newborn screening for hearing, phenylketonuria (PKU), thyroid disease, sickle cell anemia, and cystic fibrosis
- Development delays and autism screening
- Iron deficiency screening
- Vision screening
- Screening for major depressive disorders

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the coverage document at www.bcbst.com or by calling 1-800-565-9140. Coverage documents are not available until after the effective date of your coverage, but you may obtain a sample at http://www.bcbst.com/samplepolicy/2016/LG . This sample may not match your benefits exactly, so you should review your coverage document once it is available.
Contributions made by you and/or your employer to health savings accounts (HSAs), flexible spending arrangements (FSAs), or health reimbursement arrangements (HRAs) may help pay your deductible or other out-of-pocket expenses.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$5,000** person/**$10,000** family Out-of-network: **$10,000** person/**$20,000** family Doesn't apply to preventive care. Copays do not apply to the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-network: **$6,600** person/**$13,200** family Out-of-network: **$19,800** person/**$39,600** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premium, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. This plan uses Network S. For a list of **in-network providers**, see www.bcbst.com or call 1-800-565-9140.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

Important Questions	Answers	Why this Matters:
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% co-insurance	50% co-insurance	none
	Specialist visit	30% co-insurance	50% co-insurance	none
	Other practitioner office visit	30% co-insurance	50% co-insurance	Therapy visits limited to 20 per type per year. Cardiac/Pulmonary Rehab visits limited to 36 per type per year.
	Preventive care / screening / immunization	No Charge	50% co-insurance	none
If you have a test	Diagnostic test (x-ray, blood work)	30% co-insurance	50% co-insurance	none
	Imaging (CT/PET scans, MRIs)	30% co-insurance	50% co-insurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at	Generic drugs	$10 co-pay	50% co-insurance	30-day supply retail; up to 90 day supply home delivery or Select90 network. Co-pay per 30-day supply.
	Preferred brand drugs	$75 co-pay	50% co-insurance	30-day supply retail; up to 90 day supply home delivery or Select90 network. Co-pay per 30-day supply. When a Brand Drug is chosen and a Generic Drug equivalent is

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
www.bcbst.com.	Non-preferred brand drugs	$150 co-pay	50% co-insurance	available, Your cost share will increase by the difference between the cost of the Brand Drug and the Generic Drug.
	Self-Administered Specialty drugs	$300 co-pay at specialty pharmacy network	Not Covered	Up to a 30 day supply. Must use a pharmacy in Specialty pharmacy network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% co-insurance	50% co-insurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained.
	Physician/surgeon fees	30% co-insurance	50% co-insurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained.
If you need immediate medical attention	Emergency room services	$250 co-pay/visit	$250 co-pay/visit	none
	Emergency medical transportation	30% co-insurance	30% co-insurance	none
	Urgent care	See Limitations & Exceptions	See Limitations & Exceptions	Urgent Care benefits are determined by place of service, such as physician's office or ER.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% co-insurance	50% co-insurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
	Physician/surgeon fee	30% co-insurance	50% co-insurance	none
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	30% co-insurance	50% co-insurance	Prior Authorization required for electro-convulsive therapy (ECT). Your cost share may increase to 60% if not obtained.
	Mental/Behavioral health inpatient services	30% co-insurance	50% co-insurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
	Substance use disorder outpatient services	30% co-insurance	50% co-insurance	Prior Authorization required for electro-convulsive therapy (ECT). Your cost share may increase to 60% if not obtained.
	Substance use disorder inpatient services	30% co-insurance	50% co-insurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you are pregnant	Prenatal and postnatal care	30% co-insurance	50% co-insurance	none
	Delivery and all inpatient services	30% co-insurance	50% co-insurance	none

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you need help recovering or have other special health needs	Home health care	30% co-insurance	50% co-insurance	Limited to 60 visits.
	Rehabilitation services	30% co-insurance	50% co-insurance	Therapy limited to 20 visits per type per year. Cardiac/Pulmonary Rehab limited to 36 visits per year.
	Habilitation services	30% co-insurance	50% co-insurance	
	Skilled nursing care	30% co-insurance	50% co-insurance	Skilled Nursing and Rehabilitation Facility limited to 60 days/year combined.
	Durable medical equipment	30% co-insurance	50% co-insurance	Prior Authorization may be required for certain durable medical equipment. Your cost share may increase to 60% if not obtained.
	Hospice service	No Charge	50% co-insurance	Prior Authorization required for Inpatient Hospice. Your cost share may increase to 60% if not obtained.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	none
	Glasses	Not Covered	Not Covered	none
	Dental check-up	Not Covered	Not Covered	none

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture	• Hearing aids for adults	• Routine eye care (Adult)
• Bariatric surgery	• Infertility treatment	• Routine eye care (Children)
• Cosmetic surgery	• Long-term care	• Routine foot care for non-diabetics
• Dental care (Adult)	• Private-duty nursing	• Weight loss programs
• Dental care (Children)		

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Chiropractic care	• Hearing aids for children under 18	• Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-565-9140. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- Your Plan at 1-800-565-9140 or www.bcbst.com.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.
- Consumer Insurance Services within the Tennessee Department of Commerce and Insurance at 1-800-342-4029 or visit www.tn.gov/insurance/consumerRes.shtml.

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 Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-800-565-9140**.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-800-565-9140**.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码 1-800-565-9140**.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-800-565-9140**.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $1,750
- **Patient pays** $5,790

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$5,000
Copays	$60
Co-insurance	$700
Limits or exclusions	$30
Total	**$5,790**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,800
- **Patient pays** $2,600

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$2,300
Co-insurance	$300
Limits or exclusions	$0
Total	**$2,600**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.