



DbA Shrine Services
139 Fox Rd. Ste. 105
Knoxville, TN 37922-3472
Ph: (865) 588-9698
Fx: (865) 584-8370

October 17, 2018

TO: All Employees

FROM: Tracy Sherrill Henderlight

RE: Your Health Coverage Options

This document and all attachments are being provided to inform employees of your health insurance options. For the plan year 12/1/2018 through 11/30/2019 the employer-sponsored health coverage is with Blue Cross Blue Shield of Tennessee (BCBST). There are two plan offerings including a Gold plan and a Silver plan. A benefit summary for both plans is attached, and a Summary of Benefits and Coverage for each is available upon request.

Employee-sponsored coverage is available to all full-time employees who are employees who work a minimum of 30 hours per week for 121 days or more per year. Employees who meet these criteria are eligible to enroll in the medical plan after 30 days of employment. Once enrolled, coverage begins on the 1st day of the month following the 30th day of employment. If enrollment is waived at that time, employees and dependents can enroll during the open enrollment period which is Dec. 1 through Dec. 31 each year.

Etsell, Inc. will pay ½ of the premium toward an employee's individual monthly health care premium. Based on the company's contribution, following is a breakdown of the portion of the premium the employee will pay depending on the plan chosen.

<u>Individual Medical Coverage</u>	<u>Monthly Premium Paid By Employee</u>	<u>Your WEEKLY Pre-tax Payroll Deduction</u>
Silver Plan	\$284.45	\$68.27
Gold Plan	\$294.24	\$70.62

For employees outside the state of Tennessee, you need to make sure your provider accepts BlueCard PPO coverage in order to be considered an in-network provider for either plan.

The premiums above do **NOT** reflect charges for dental, vision or any supplemental plans. If you choose to enroll in additional plans, those premiums would be in addition to the medical premiums listed above. Please also note that premiums listed are for Individual Medical coverage only. If an employee chooses to include dependent coverage, the employee is responsible to pay 100% of the difference up to the cost of the dependent coverage in addition to the amounts listed above. Etsell, Inc. reserves the right to pay an additional portion of premiums depending on length of employment, management positions or other factors.

Etsell, Inc. also offers a Health Savings Account (HSA) option which allows insurance subscribers to make pre-tax contributions to a Health Savings Account that the employee can use toward the medical deductible, copays or certain medical supplies. For the calendar year 2019 employees can contribute to the HSA through tax-free payroll deductions in any amount up to a maximum of \$3500 for the year for individuals under the age of 55 and a maximum of \$4500 for individuals 55 and older. The maximum annual contribution for families is \$7000 per year if covered employee is under the age of 55 / \$8000 if covered employee is 55 or older. If an employee chooses to contribute to their own HSA, please notify OpCenter immediately upon enrollment for sign-up instructions.

For Medicare-eligible subscribers, the prescription drug coverage available under the company's group medical plan has been reviewed and found to be a NON-creditable plan. This basically means that due to the group plan deductible, Medicare Part D will on average provide better prescription drug coverage than the group plan. Medicare-eligible subscribers should review their own individual circumstances to determine their need to enroll in Medicare Part D. Additional information regarding Medicare can be found at www.medicare.gov.

Depending on the percentage of income it costs an employee to pay for their portion of the company plan premium, employees also have the option to seek insurance coverage through the Marketplace. The Marketplace will be managed by each state or by the federal government depending on the state the employee resides in. Visit www.Healthcare.gov for more information on eligibility, enrollment, available coverage and premiums available through the Marketplace. If an employee purchases a qualified health plan through the Marketplace, the employee loses the employer contribution to any employer-sponsored health plans.

All individuals are required to have minimum essential coverage, and individuals without the required coverage may pay a penalty assessed via tax return.

Please call Julie Spangler with any questions regarding the Blue Cross Blue Shield of Tennessee plan offerings or if you have any enrollment or premium questions.

Thank you,
Tracy Sherrill Henderlight
Etsell, Inc.



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact _____.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Etsell, Inc.		4. Employer Identification Number (EIN) available upon request	
5. Employer address 139 Fox Rd, Ste 105		6. Employer phone number 865-588-9698	
7. City Knoxville	8. State TN	9. ZIP code 37922	
10. Who can we contact about employee health coverage at this job? Julie Spangler or Tracy Henderlight			
11. Phone number (if different from above)		12. Email address jspangler@shrineservices.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

All employees. Eligible employees are:

Some employees. Eligible employees are:

Full-time employees who have worked at least 30 days. Employees are considered full-time if they work a minimum of 30 hours per week for at least 121 days per year.

- With respect to dependents:

We do offer coverage. Eligible dependents are:

- A spouse of a covered employed.
- Dependent child(ren) of a covered employee up to the age of 26.
- * An employee must have coverage on themselves in order to get

We do not offer coverage. coverage on dependents.

If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

Yes (Go to question 15) No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ 284.45

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year? Info above is for the plan year


Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly


* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

 **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 www.cciio.cms.gov or call 1-800-565-9140 to request a copy. 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/2018/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: \$6,000 person/\$12,000 family Out-of-network: \$12,000 person/\$24,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Deductible</u> doesn't apply to <u>preventive care</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	In-network: \$6,000 person/\$12,000 family Out-of-network: \$18,000 person/\$36,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premium</u> , <u>balance-billing</u> charges, penalties, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. This <u>plan</u> uses Network P. See www.bcbst.com/NetPP or call 1-800-565-9140 for a list of <u>in-network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	No charge, after <u>deductible</u>	20% <u>coinsurance</u>	None
	<u>Specialist</u> visit	No charge, after <u>deductible</u>	20% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	20% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge, after <u>deductible</u>	20% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	No charge, after <u>deductible</u>	20% <u>coinsurance</u>	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.bcbst.com/rxpp	Generic drugs	No charge, after <u>deductible</u>	20% <u>coinsurance</u>	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network. \$10/\$35/\$60 <u>copayment</u> per 30 day supply for generic/preferred brand/non-preferred brand drugs on Preventive Drug List.
	Preferred brand drugs	No charge, after <u>deductible</u>	20% <u>coinsurance</u>	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network. \$10/\$35/\$60 <u>copayment</u> per 30 day supply for generic/preferred brand/non-preferred brand drugs on Preventive Drug List.
	Non-preferred brand drugs	No charge, after <u>deductible</u>	20% <u>coinsurance</u>	30 day supply for generic/preferred brand/non-preferred brand drugs on Preventive Drug List.
	<u>Specialty drugs</u>	No charge, after <u>deductible</u> at Specialty Pharmacy Network	Not Covered	Up to a 30 day supply. Must use a pharmacy in the Specialty Pharmacy Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge, after <u>deductible</u>	20% <u>coinsurance</u>	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained.
	Physician/surgeon fees	No charge, after <u>deductible</u>	20% <u>coinsurance</u>	Prior Authorization required for certain

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)	
				outpatient procedures. Your cost share may increase to 50% if not obtained.
If you need immediate medical attention	<u>Emergency room care</u>	No charge, after <u>deductible</u>	No charge, after <u>deductible</u>	None
	<u>Emergency medical transportation</u>	No charge, after <u>deductible</u>	No charge, after <u>deductible</u>	None
	<u>Urgent care</u>	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)	No charge, after <u>deductible</u>	20% <u>coinsurance</u>	Prior Authorization required. Your cost share may increase to 50% if not obtained.
	Physician/surgeon fees	No charge, after <u>deductible</u>	20% <u>coinsurance</u>	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge, after <u>deductible</u>	20% <u>coinsurance</u>	Prior Authorization required for electroconvulsive therapy (ECT). Your cost share may increase to 50% if not obtained.
	Inpatient services	No charge, after <u>deductible</u>	20% <u>coinsurance</u>	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you are pregnant	Office visits	No charge, after <u>deductible</u>	20% <u>coinsurance</u>	None
	Childbirth/delivery professional services	No charge, after <u>deductible</u>	20% <u>coinsurance</u>	None
	Childbirth/delivery facility services	No charge, after <u>deductible</u>	20% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge, after <u>deductible</u>	20% <u>coinsurance</u>	Limited to 60 visits per year.
	<u>Rehabilitation services</u>	No charge, after <u>deductible</u>	20% <u>coinsurance</u>	Therapy limited to 20 visits per type per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	<u>Habilitation services</u>	No charge, after <u>deductible</u>	20% <u>coinsurance</u>	Therapy limited to 20 visits per type per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	<u>Skilled nursing care</u>	No charge, after <u>deductible</u>	20% <u>coinsurance</u>	Skilled nursing and rehabilitation facility limited to 60 days combined per year.
	<u>Durable medical equipment</u>	No charge, after <u>deductible</u>	20% <u>coinsurance</u>	Prior Authorization may be required for certain <u>durable medical equipment</u> . Your cost share may increase to 50% if not obtained.

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)	
	Hospice services	No charge, after deductible	20% 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

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
<ul style="list-style-type: none"> Acupuncture Bariatric surgery Cosmetic surgery Dental care (Adult) Dental care (Children) 	<ul style="list-style-type: none"> Hearing aids for adults Infertility treatment Long-term care Private-duty nursing 	<ul style="list-style-type: none"> Routine eye care (Adult) Routine eye care (Children) Routine foot care for non-diabetics Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> Chiropractic care 	<ul style="list-style-type: none"> Hearing aids for children under 18 	<ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S.

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-tn.naic.org/Lion-Web/servlet/org.naic.sbs.ext.onlineComplaint.OnlineComplaintCtrl?spanishVersion=N>, or email them at CIS.Complaints@state.tn.us. You may also write them at 500 James Robertson Pkwy, Davy Crockett Tower, 6th Floor, Nashville, TN 37243.


Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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.

 **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 www.cciio.cms.gov or call 1-800-565-9140 to request a copy. 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/2018/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: \$3,000 person/\$6,000 family Out-of-network: \$6,000 person/\$12,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Deductible</u> doesn't apply to <u>preventive care</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	In-network: \$4,000 person/\$8,000 family Out-of-network: \$12,000 person/\$24,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Premium</u> , <u>balance-billing</u> charges, penalties, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. This <u>plan</u> uses Network S. See www.bcbst.com/NetSP or call 1-800-565-9140 for a list of <u>in-network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Specialist</u> visit	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	50% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	50% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Imaging</u> (CT/PET scans, MRIs)	50% <u>coinsurance</u>	50% <u>coinsurance</u>	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 www.bcbst.com/rxpp	Generic drugs	50% <u>coinsurance</u>	50% <u>coinsurance</u>	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network. \$10/\$35/\$60 <u>copayment</u> per 30 day supply for generic/preferred brand/non-preferred brand drugs on Preventive Drug List.
	Preferred brand drugs	50% <u>coinsurance</u>	50% <u>coinsurance</u>	30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network. \$10/\$35/\$60 <u>copayment</u> per 30 day supply for generic/preferred brand/non-preferred brand drugs on Preventive Drug List.
	Non-preferred brand drugs	50% <u>coinsurance</u>	50% <u>coinsurance</u>	30 day supply for generic/preferred brand/non-preferred brand drugs on Preventive Drug List.
	<u>Specialty drugs</u>	50% <u>coinsurance</u> at Specialty Pharmacy Network	Not Covered	Up to a 30 day supply. Must use a pharmacy in the Specialty Pharmacy Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 60% if not obtained.
	Physician/surgeon fees	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior Authorization required for certain

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)	
				outpatient procedures. Your cost share may increase to 60% if not obtained.
If you need immediate medical attention	<u>Emergency room care</u>	50% coinsurance	50% coinsurance	None
	<u>Emergency medical transportation</u>	50% coinsurance	50% coinsurance	None
	<u>Urgent care</u>	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)	50% coinsurance	50% coinsurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
	Physician/surgeon fees	50% coinsurance	50% coinsurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	50% coinsurance	50% coinsurance	Prior Authorization required for electroconvulsive therapy (ECT). Your cost share may increase to 60% if not obtained.
	Inpatient services	50% coinsurance	50% coinsurance	Prior Authorization required. Your cost share may increase to 60% if not obtained.
If you are pregnant	Office visits	50% coinsurance	50% coinsurance	None
	Childbirth/delivery professional services	50% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	50% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	<u>Home health care</u>	50% coinsurance	50% coinsurance	Limited to 60 visits per year.
	<u>Rehabilitation services</u>	50% coinsurance	50% coinsurance	Therapy limited to 20 visits per type per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	<u>Habilitation services</u>	50% coinsurance	50% coinsurance	Therapy limited to 20 visits per type per year. Cardiac/Pulmonary rehab limited to 36 visits per type per year.
	<u>Skilled nursing care</u>	50% coinsurance	50% coinsurance	Skilled nursing and rehabilitation facility limited to 60 days combined per year.
	<u>Durable medical equipment</u>	50% coinsurance	50% coinsurance	Prior Authorization may be required for certain <u>durable medical equipment</u> . Your cost share may increase to 60% if not obtained.

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)	
	Hospice services	50% coinsurance	50% coinsurance	Prior Authorization required for inpatient hospice. Your cost share may increase to 60% 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

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|---|--|--|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult) • Dental care (Children) | <ul style="list-style-type: none"> • Hearing aids for adults • Infertility treatment • Long-term care • Private-duty nursing | <ul style="list-style-type: none"> • Routine eye care (Adult) • Routine eye care (Children) • Routine foot care for non-diabetics • Weight loss programs |
|---|--|--|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- | | | |
|---|--|--|
| <ul style="list-style-type: none"> • Chiropractic care | <ul style="list-style-type: none"> • Hearing aids for children under 18 | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. |
|---|--|--|

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-tn.naic.org/Lion-Web/servlet/org.naic.sbs.ext.onlineComplaint.OnlineComplaintCtrl?spanishVersion=N>, or email them at CIS.Complaints@state.tn.us. You may also write them at 500 James Robertson Pkwy, Davy Crockett Tower, 6th Floor, Nashville, TN 37243.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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.

Nondiscrimination Notice

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

BlueCross:

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

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

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

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

