

 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, go to www.ticua.org/tbc.com or call (615) 292-3535. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call Coordinated Health Care at (877) 498-6689 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	For participating <u>providers</u> : \$300 person / \$900 family For non-participating <u>providers</u> : \$600 person / \$1,800 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .]
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive care</u> , <u>primary care provider</u> , and <u>specialist</u> services are covered before you meet your <u>deductible</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 <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	For participating <u>providers</u> : \$2,000 person /\$6,000 family (<u>deductible</u> & <u>coinsurance</u>) \$6,550 person/\$13,100 family (<u>deductible</u> , <u>coinsurance</u> , <u>copays</u> , and penalty amounts) For non-participating <u>providers</u> : \$12,000 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 <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges 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 <u>network provider</u>?	Yes. See www.aetna.com/docfind/custom/mymeritain or call (800) 343-3140 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No, but you may receive greater benefits if you have a <u>referral</u> .	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
		Participating Provider (You will pay the least)	Non-Participating 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	\$20 <u>copay</u> /visit	50% <u>coinsurance</u>	<p><u>Copay</u> applies per visit regardless of what services are rendered. Includes office visits during which routine diagnostic procedures are performed. Designated <u>primary care physician</u> (PCP) and pre-notified <u>specialist</u> office visits** (This amount also applies to minor surgery performed by a PCP during an office visit. All other minor surgery procedures will be paid as shown elsewhere in the schedule of benefits.)</p> <p>You may have to pay for services that aren't <u>preventive</u>. Ask your <u>provider</u> if the services you need are <u>preventive</u>. Then check what your <u>plan</u> will pay for.</p>
	<u>Specialist</u> visit	\$20 <u>copay</u> /visit (referral from PCP) / \$30 <u>copay</u> /visit (no referral)	50% <u>coinsurance</u>	
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	No Charge	50% <u>coinsurance</u> (well child care through age 4) / Not Covered (all other <u>preventive</u>)	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge (lab)/20% <u>coinsurance</u> (x-ray)	50% <u>coinsurance</u>	For <u>out-of-network providers</u> , 20% <u>coinsurance</u> if the lab work is out of the patient's control.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$250 of the total cost of the service.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.caremark.com .	Generic drugs	\$20 <u>copay</u> (retail)/\$40 <u>copay</u> (mail order)	Not Covered	<p><u>Deductible</u> does not apply. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription); 30-day supply (<u>specialty drugs</u>). The <u>copay</u> applies per prescription. There is no charge for preventive drugs. If you stay up to date in the Chronic Conditions Program, the <u>copay</u> will be waived for generic drugs to treat chronic conditions (when available) and brand drug <u>copays</u> will be reduced by 50%.</p>
	Preferred brand drugs	\$35 <u>copay</u> (retail)/\$70 <u>copay</u> (mail order)	Not Covered	
	Non-preferred brand drugs	\$50 <u>copay</u> (retail)/\$100 <u>copay</u> (mail order)	Not Covered	
	<u>Specialty drugs</u>	Paid the same as generic, preferred and non-preferred drugs	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$250 of the total cost of the service.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u> (emergency services) / 50% <u>coinsurance</u> (non-emergency services)	<u>Out-of-network providers</u> paid at the in-network provider level of benefits for <u>emergency services</u> .
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Out-of-network providers</u> paid at the in-network provider level of benefits
	<u>Urgent care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$250 of the total cost of the service.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	-----none-----
	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$250% of the total cost of the service.
If you are pregnant	Office visits	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required for inpatient Hospital stays in excess of 48 hrs. (vaginal delivery) or 96 hrs. (C-section). If you don't get <u>preauthorization</u> , benefits could be reduced by \$250 of the total cost of the service. <u>Cost sharing</u> does not apply to <u>preventive services</u> from a participating provider. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Baby does not count toward the mother's expense; therefore the family <u>deductible</u> amount may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 50 visits per year. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$250 of the total cost of the service.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Includes physical, speech & occupational therapy. Limited to 60 visits per each type of therapy, per year. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$250 of the total cost of the service.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage limited to children under the age of 16 and limited to 60 visits per <u>plan</u> year.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 120 days per year, unless additional days are specifically <u>preauthorized</u> . <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$250 of the total cost of the service.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required for any item in excess of \$500. If you don't get <u>preauthorization</u> , benefits could be reduced by \$250 of the total cost of the service.
	<u>Hospice services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Bereavement counseling is covered if received within 3 months of death. Respite care is covered. <u>Preauthorization</u> required. If you don't get <u>preauthorization</u> , benefits could be reduced by \$250 of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered
	Children's glasses	Not Covered	Not Covered	Not Covered
	Children's dental check-up	Not Covered	Not Covered	Not Covered

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.)

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| • Acupuncture | • Glasses (Adult & Child) | • Non-emergency care when traveling outside the U.S. |
| • Cosmetic surgery | • Hearing aids | • Routine eye care (Adult & Child) |
| • Dental care (Adult & Child) | • Infertility treatment | • Routine foot care |
| | • Long-term care | |

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

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| • Bariatric surgery (for the treatment of morbid obesity only) | • Private-duty nursing | • Weight loss programs (for the treatment of morbid obesity only) |
| • Chiropractic care | | |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <https://www.dol.gov/agencies/ebsa/healthreform> or TICUA Benefit Consortium at (615) 292-3535. 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 the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <https://www.dol.gov/agencies/ebsa/healthreform> or TICUA Benefit Consortium at (615) 292-3535.

Additionally, a consumer assistance program can help you file your appeal. Contact the Tennessee Department of Commerce & Insurance at (615) 741-2241.

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 the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-378-1179.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-378-1179.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-378-1179.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-378-1179.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$300
- Primary Care Physician coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Primary care physician visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,840
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$120
Coinsurance	\$2,304
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,784

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

- The plan's overall deductible \$300
- Specialist copayment \$20
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Specialist office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,460
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$1,275
Coinsurance	\$346
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$1,976

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

- The plan's overall deductible \$300
- Specialist copayment \$20
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,010
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$60
Coinsurance	\$326
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$686