Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
: **Highland Ventures, LTD (OPT#2)**

Coverage Period: 01/01/2024 - 12/31/2024
Coverage for: Individual or Family | **Plan Type:** PPO

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.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $7,000 person/$13,000 family Out-of-network: $14,000 person/$26,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive services, Office visits, and Emergency room visits are covered before you meet your deductible (unless specified).	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $7,700 person/$14,400 family Out-of-network: $15,400 person/$28,800 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premium, balance-billing charges, penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. This plan uses Network P. See http://www.bcbst.com/Network-P or call 1-800-565-9140 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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	$40 copay/visit deductible does not apply.	40% coinsurance	None
	Specialist visit	$60 copay/visit deductible does not apply.	40% coinsurance	Office surgery subject to deductible/coinsurance.
	Preventive care/screening/ immunization	No Charge	40% coinsurance	A1c testing will be covered at 100%. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Travel immunization not covered in office or clinic setting.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	40% coinsurance	Diagnostic testing benefits are determined by place of service, such as office or ER.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbst.com/rxp	Preferred Generic drugs / Non-Preferred Generic drugs	No Charge / $10 copay/prescription	40% coinsurance	Pharmacy Out-of-Pocket Maximum: $1,000 Individual / $3,000 Family 30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network 2 times Retail Copayment up to 90 day supply.
	Preferred brand drugs	$50 copay/prescription	40% coinsurance	Pharmacy Out-of-Pocket Maximum: $1,000 Individual / $3,000 Family 30 day supply for Retail Network; up to 90 day supply for Home Delivery or Plus90 Network 2 times Retail Copayment up to 90 day supply. When a brand drug is chosen and a generic drug equivalent is available, you will pay a penalty for the difference between the cost of the brand drug and the generic drug, plus the generic drug copayment or coinsurance.
	Non-preferred brand drugs	$100 copay/prescription	40% coinsurance	
	Preferred Specialty drugs / Non-Preferred Specialty drugs	$150 copay/prescription	Not Covered	Pharmacy Out-of-Pocket Maximum: $1,000 Individual / $3,000 Family Up to a 30 day supply. Must use a

Common Medical Event	Services You May Need	What You Will Pay In-Network Provider (You will pay the least)	 Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
				pharmacy in the Preferred Specialty Pharmacy Network.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Prior Authorization required for certain outpatient procedures. Your cost share may increase to 50% if not obtained.
If you need immediate medical attention	Emergency room care	$250 copay/visit deductible does not apply..	$250 copay/visit deductible does not apply..	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	40% coinsurance	Office surgery subject to deductible/coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay/visit deductible does not apply for office visits and 20% coinsurance other outpatient services	40% coinsurance	Prior Authorization required for electro-convulsive therapy (ECT). Your cost share may increase to 50% if not obtained.
	Inpatient services	20% coinsurance	40% coinsurance	Prior Authorization required. Your cost share may increase to 50% if not obtained.
If you are pregnant	Office visits	$40 copay/visit deductible does not apply.	40% coinsurance	None
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	This service may be covered under the Specialty Care Program. Cost Share may vary; use a Blue Distinction Center for best benefit.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	This service may be covered under the Specialty Care Program. Cost Share may vary; use a Blue Distinction Center for best benefit.
If you need help recovering or have	Home health care	20% coinsurance	40% coinsurance	Unlimited visits per year.
	Rehabilitation services	20% coinsurance	40% coinsurance	Therapy visits unlimited per annual benefit

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
other special health needs				period, except for chiropractic which is limited to 30 visits per annual benefit period.
	Habilitation services	20% coinsurance	40% coinsurance	Therapy visits unlimited per annual benefit period, except for chiropractic which is limited to 30 visits per annual benefit period.
	Skilled nursing care	20% coinsurance	40% coinsurance	Skilled nursing and rehabilitation facility limited to 60 days combined per year.
	Durable medical equipment	20% coinsurance	40% coinsurance	Prior Authorization may be required for certain durable medical equipment. Your cost share may increase to 50% if not obtained.
	Hospice services	20% coinsurance	40% coinsurance	Prior Authorization required for inpatient hospice. Your cost share may increase to 50% if not obtained.
If your 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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Hearing aids for adults
- Hearing aids for children under 18
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Chiropractic care
- Private-duty nursing

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/No].

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? [Yes/No].

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.

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	**$7,000**
Specialist copay	**$60**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$6,700
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$7,720**

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

The plan's overall deductible	**$7,000**
Specialist copay	**$60**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$1,400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	**$1,730**

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

The plan's overall deductible	**$7,000**
Specialist copay	**$60**
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$700
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,400**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Nondiscrimination Notice

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

BlueCross:

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

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

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

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

Language Access Services:

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

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

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-565-9140 (TTY:1-800-848-0298)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-565-9140 (TTY:1-800-848-0298).

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

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

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

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

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

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

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-565-9140 (TTY:1-800-848-0298) まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-565-9140 (TTY:1-800-848-0298).

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

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

-توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-565-9140 (TTY:1-800-848-0298) تماس بگیرید .

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

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

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

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

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