
 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, contact Metro Human Resources at 1-615-862-6640. 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 <http://www.dol.gov/ebsa/healthreform> or call 1-866-444-EBSA to request a copy.

| Important Questions   | Answers  | Why This Matters:  |
|---|--|--|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | <u>Network</u> providers: \$0/single, \$0/employee + child(ren), and \$0/family.<br><u>Out-of-network</u> providers: \$200/single and \$600/employee + child(ren) and \$600/family. Doesn't apply to preventive care. Copays do not apply to deductible. | 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> .   |
| <b>Are there services covered before you meet your <a href="#">deductible</a>?</b>    | Yes. All <u>network</u> services are covered before you meet your deductible. <u>Deductible</u> doesn't apply to preventive care.  | 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 <u>out-of-network</u> services, there are no services covered until you meet your <u>deductible</u> .  |
| <b>Are there other <a href="#">deductibles</a> for specific services?</b>             | No.  | You don't have to meet <u>deductibles</u> for specific services.   |
| <b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b> | Yes. <u>Network</u> providers \$1,000/ single and \$2,000/employee + child(ren), and \$2,000/ family. For <u>out-of-network</u> providers: \$5,000/single and \$10,000/employee + child(ren), and \$10,000/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.  |
| <b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>               | <u>Copayment</u> , <u>premium</u> , <u>balance-billed</u> charges, and health care this <u>plan</u> doesn't cover.   | Even though you pay for these expenses, they don't count toward the <u>out-of-pocket limit</u> .   |
| <b>Will you pay less if you use a <a href="#">network provider</a>?</b>               | Yes. See <a href="http://www.bcbst.com/members/metro-gov/">www.bcbst.com/members/metro-gov/</a> or call 1-800-367-7790 for a list of <u>network providers</u> .  | This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> network. 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. |
| <b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>    | 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  |
|---|--|---|--|---|
|   |  | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)   |   |
| <b>If you visit a health care <a href="#">provider's</a> office or clinic</b>   | Primary care visit to treat an injury or illness       | \$20 <a href="#">copayment</a> and 20% <a href="#">coinsurance</a>  | \$20 <a href="#">copayment</a> and 40% <a href="#">coinsurance</a>                                   | ---None---  |
|   | <a href="#">Specialist</a> visit                       | \$30 <a href="#">copayment</a> and 20% <a href="#">coinsurance</a>  | \$30 <a href="#">copayment</a> and 40% <a href="#">coinsurance</a>                                   | ---None---  |
|   | <a href="#">Preventive care/screening/immunization</a> | Age 7 and older: 100% up to \$750 then 20% <a href="#">coinsurance</a> .<br>Age 6 and younger: 20% <a href="#">coinsurance</a> .<br>Immunizations - all ages: 20% <a href="#">coinsurance</a> | 40% <a href="#">coinsurance</a>  | Colonoscopies, mammograms, PSA test and pap exams are not part of preventive or screening services and your share of the cost of these <a href="#">network</a> services will be 20% <a href="#">coinsurance</a> and copay and 40% <a href="#">coinsurance</a> and <a href="#">copayment</a> for <a href="#">out-of-network</a> services. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. |
| <b>If you have a test</b>   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>  | Not subject to the <a href="#">deductible</a> .   |
|   | Imaging (CT/PET scans, MRIs)                           | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>  | <a href="#">Prior Authorization</a> required for certain procedures.  |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.bcbst.com/members/metro-gov/">www.bcbst.com/members/metro-gov/</a> . | Generic drugs  | \$10 <a href="#">copayment</a> (retail and mail order)  | \$10 <a href="#">copayment</a> plus difference in billed charge and <a href="#">allowed amount</a> . | Covers up to a 34-day supply (retail prescription); 35 to 102-day supply (mail order prescription). Copayment per 34-day supply.  |
|   | Brand drugs  | \$30 <a href="#">copayment</a> (retail and mail order)  | \$30 <a href="#">copayment</a> plus difference in billed charge and <a href="#">allowed amount</a> . | If an <a href="#">out-of-network</a> pharmacy is used, the member must pay all expenses up front and file a claim with BCBST to be reimbursed.  |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center)         | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>  | <a href="#">Prior Authorization</a> required for certain outpatient procedures.   |
|   | Physician/surgeon fees                                 | 20% <a href="#">coinsurance</a>   | 40% <a href="#">coinsurance</a>  |   |

[\* For more information about limitations and exceptions, see the plan or policy document at <http://www.nashville.gov/Human-Resources/>]

| Common Medical Event  | Services You May Need                            | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information                                    |
|---|--|--|--|---|
|   |  | Network Provider<br>(You will pay the least)                       | Out-of-Network Provider<br>(You will pay the most)                 |   |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$100 <u>copayment</u> and 20% <u>coinsurance</u>                  | \$100 <u>copayment</u> and 40% <u>coinsurance</u>                  | ---None---  |
|   | <a href="#">Emergency medical transportation</a> | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>   | ---None---  |
|   | <a href="#">Urgent care</a>                      | \$20 <u>copayment</u> and 20% <u>coinsurance</u>                   | \$20 <u>copayment</u> and 40% <u>coinsurance</u>                   | ---None---  |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>   | ---None---  |
|   | Physician/surgeon fees                           | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>   | ---None---  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$20 <u>copayment</u> and 20% <u>coinsurance</u>                   | \$20 <u>copayment</u> and 40% <u>coinsurance</u>                   | <u>Prior Authorization</u> required for electro-convulsive therapy (ECT).                 |
|   | Inpatient services                               | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>   | <u>Prior Authorization</u> required.  |
| If you are pregnant   | Office visits                                    | \$20 <u>copayment</u> for initial visit and 20% <u>coinsurance</u> | \$20 <u>copayment</u> for initial visit and 40% <u>coinsurance</u> | ---None---  |
|   | Childbirth/delivery professional services        | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>   | ---None---  |
|   | Childbirth/delivery facility services            | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>   | ---None---  |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                 | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>   | ---None---  |
|   | <a href="#">Rehabilitation services</a>          | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>   | ---None---  |
|   | <a href="#">Habilitation services</a>            | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>   | ---None---  |
|   | <a href="#">Skilled nursing care</a>             | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>   | Coverage is limited to 100 days annual max following a 3 day hospital stay.               |
|   | <a href="#">Durable medical equipment</a>        | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>   | <u>Prior Authorization</u> may be required for certain <u>durable medical equipment</u> . |
|   | <a href="#">Hospice services</a>                 | 20% <u>coinsurance</u>   | 40% <u>coinsurance</u>   | <u>Prior Authorization</u> required for inpatient hospice.                                |
| If your child needs dental or eye care                                    | Children's eye exam                              | Not covered  | Not covered  | ---None---  |
|   | Children's glasses                               |  |  |   |
|   | Children's dental check-up                       |  |  |   |

[\* For more information about limitations and exceptions, see the plan or policy document at <http://www.nashville.gov/Human-Resources>.]

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

### 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"><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Routine eye care (Adult)</li></ul> | <ul style="list-style-type: none"><li>• Chiropractic care</li><li>• Hearing aids for children under 18</li><li>• Routine eye care (Children)</li></ul> | <ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private-duty nursing</li></ul> |
|--|--|---|

**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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](http://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: Metro Human Resources at 615-862-6640 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your [appeal](#). Contact Tennessee Department of Commerce & Insurance at 500 James Robertson Parkway, Davy Crockett Tower, 4th floor, Nashville, TN 37243-0565, (615) 741-2241 or <http://www.tn.gov/commerce/section/consumer-services>.

**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](#).

————— *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](#) \$0
- [Specialist](#) [*cost sharing*] \$30
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| Deductibles                       | \$0          |
| Copayments                        | \$70         |
| Coinsurance                       | \$900        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$10         |
| <b>The total Peg would pay is</b> | <b>\$980</b> |

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [*cost sharing*] \$30
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,400</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| Deductibles                       | \$0          |
| Copayments                        | \$800        |
| Coinsurance                       | \$100        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$30         |
| <b>The total Joe would pay is</b> | <b>\$950</b> |

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [*cost sharing*] \$30
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,900</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| Deductibles                       | \$0          |
| Copayments                        | \$300        |
| Coinsurance                       | \$300        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$600</b> |