



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:
What is the overall deductible?	<u>Network</u> providers: \$0/single, \$0/employee + child(ren), and \$0/family. <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 plan begins to pay. If you have other family members on the plan , 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. All <u>network</u> services are covered before you meet your deductible. <u>Deductible</u> doesn't apply to preventive care.	This plan 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> .
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?	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 plan , 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>Copayment</u> , <u>premium</u> , <u>balance-billed</u> charges, and health care this plan doesn't cover.	Even though you pay for 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. See www.bcbst.com/members/metro-gov/ 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 plan's 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 plan 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 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
		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	\$20 <u>copayment</u> and 20% <u>coinsurance</u>	\$20 <u>copayment</u> and 40% <u>coinsurance</u>	---None---
	<u>Specialist</u> visit	\$30 <u>copayment</u> and 20% <u>coinsurance</u>	\$30 <u>copayment</u> and 40% <u>coinsurance</u>	---None---
	<u>Preventive care/screening/immunization</u>	Age 7 and older: 100% up to \$750 then 20% <u>coinsurance</u> . Age 6 and younger: 20% <u>coinsurance</u> . Immunizations - all ages: 20% <u>coinsurance</u>	40% <u>coinsurance</u>	Colonoscopies, mammograms, PSA test and pap exams are not part of preventive or screening services and your share of the cost of these <u>network</u> services will be 20% <u>coinsurance</u> and copay and 40% <u>coinsurance</u> and <u>copayment</u> for <u>out-of-network</u> services. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Not subject to the <u>deductible</u> .
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required for certain procedures.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.bcbst.com/members/metro-gov/ .	Generic drugs	\$10 <u>copayment</u> (retail and mail order)	\$10 <u>copayment</u> plus difference in billed charge and <u>allowed amount</u> .	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 <u>copayment</u> (retail and mail order)	\$30 <u>copayment</u> plus difference in billed charge and <u>allowed amount</u> .	If an <u>out-of-network</u> pharmacy is used, the member must pay all expenses up front and file a claim with BCBST to be reimbursed.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> required for certain outpatient procedures.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
Common	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important

Medical Event		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information
If you need immediate medical attention	Emergency room care	\$100 <u>copayment</u> and 20% <u>coinsurance</u>	\$100 <u>copayment</u> and 40% <u>coinsurance</u>	---None---
	Emergency medical transportation	20% <u>coinsurance</u>	40% <u>coinsurance</u>	---None---
	Urgent care	\$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	Home health care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	---None---
	Rehabilitation services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	---None---
	Habilitation services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	---None---
	Skilled nursing care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Coverage is limited to 100 days annual max following a 3 day hospital stay.
	Durable medical equipment	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior Authorization</u> may be required for certain durable medical equipment.
	Hospice services	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			

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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|--------------------------|---------------------------|---------------------------------------|
| • Cosmetic surgery | • Infertility treatment | • Routine foot care for non-diabetics |
| • Dental care (Adult) | • Long-term care | • Weight loss programs |
| • Dental care (Children) | • Hearing aids for adults | |

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

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|----------------------------|--------------------------------------|--|
| • Acupuncture | • Chiropractic care | • Non-emergency care when traveling outside the U.S. |
| • Bariatric surgery | • Hearing aids for children under 18 | • Private-duty nursing |
| • Routine eye care (Adult) | • Routine eye care (Children) | |

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. 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: 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.

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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$70
Coinsurance	\$900
What isn't covered	
Limits or exclusions	\$10
The total Peg would pay is	\$980

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*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$800
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$30
The total Joe would pay is	\$950

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*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$600

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.