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?	Network providers: $0/single, $0/employee + child(ren), and $0/family. Out-of-network 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 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. All network services are covered before you meet your deductible. Deductible doesn't apply to preventive care.	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 out-of-network services, there are no services covered until you meet your deductible.
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?	Yes. Network providers $1,000/ single and $2,000/employee + child(ren), and $2,000/ family. For out-of-network providers: $5,000/single and $10,000/employee + child(ren), and $10,000/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?	Copayment, premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay for these expenses, they don't count toward the out-of-pocket limit.
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 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.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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 provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment and 20% coinsurance	$20 copayment and 40% coinsurance	---None---
	Specialist visit	$30 copayment and 20% coinsurance	$30 copayment and 40% coinsurance	---None---
	Preventive care/screening/ immunization	Age 7 and older: 100% up to $750 then 20% coinsurance. Age 6 and younger: 20% coinsurance. Immunizations - all ages: 20% coinsurance	40% coinsurance	Colonoscopies, mammograms, PSA test and pap exams are not part of preventive or screening services and your share of the cost of these network services will be 20% coinsurance and copay and 40% coinsurance and copayment for out-of-network services. 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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Not subject to the deductible.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Prior Authorization required for certain procedures.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbst.com/members/metro-gov/.	Generic drugs	$10 copayment (retail and mail order)	$10 copayment plus difference in billed charge and allowed amount.	Covers up to a 34-day supply (retail prescription); 35 to 102-day supply (mail order prescription). Copayment per 34-day supply. If an out-of-network pharmacy is used, the member must pay all expenses up front and file a claim with BCBST to be reimbursed.
	Brand drugs	$30 copayment (retail and mail order)	$30 copayment plus difference in billed charge and allowed amount.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Prior Authorization required for certain outpatient procedures.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
Common	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important

[* For more information about limitations and exceptions, see the plan document at hr.nashville.gov.]

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 copayment and 20% coinsurance	$100 copayment and 40% coinsurance	---None---
	Emergency medical transportation	20% coinsurance	40% coinsurance	---None---
	Urgent care	$20 copayment and 20% coinsurance	$20 copayment and 40% coinsurance	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	---None---
	Physician/surgeon fees	20% coinsurance	40% coinsurance	---None---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copayment and 20% coinsurance	$20 copayment and 40% coinsurance	Prior Authorization required for electro-convulsive therapy (ECT).
	Inpatient services	20% coinsurance	40% coinsurance	Prior Authorization required.
If you are pregnant	Office visits	$20 copayment for initial visit and 20% coinsurance	$20 copayment for initial visit and 40% coinsurance	---None---
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	---None---
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	---None---
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	---None---
	Rehabilitation services	20% coinsurance	40% coinsurance	---None---
	Habilitation services	20% coinsurance	40% coinsurance	---None---
	Skilled nursing care	20% coinsurance	40% coinsurance	Coverage is limited to 100 days annual max following a 3 day hospital stay.
	Durable medical equipment	20% coinsurance	40% coinsurance	Prior Authorization may be required for certain durable medical equipment.
	Hospice services	20% coinsurance	40% coinsurance	Prior Authorization 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 document at hr.nashville.gov.]

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.)

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Infertility treatment
- Long-term care
- Hearing aids for adults
- 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.)

- Acupuncture
- Bariatric surgery
- Routine eye care (Adult)
- Chiropractic care
- Hearing aids for children under 18
- Routine eye care (Children)
- Non-emergency care when traveling outside the U.S.
- 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: 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 you 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.

[* For more information about limitations and exceptions, see the plan document at hr.nashville.gov.]

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**

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**

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**

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.