

 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 BlueCross BlueShield of Tennessee at 1-800-245-7942 or visit [www.bcbst.com](http://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.healthcare.gov](http://www.healthcare.gov) or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In-network: <b>\$1,300</b> Ind/ <b>\$2,600</b> Family*. Out-of-network: <b>\$2,600</b> Ind/ <b>\$5,200</b> Family* Doesn't apply to preventive care. Copays, premiums, prescription drugs and vision care do not apply to the deductible.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. The <u>deductible</u> starts over on January 1st of each plan year. See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Preventive care services are covered at 100% and do not apply toward the deductible.	You don't have to meet the <u>deductible</u> before preventive care services are covered.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	In-network: <b>\$4,500</b> Ind/ <b>\$9,000</b> Family*. Out-of-network: <b>\$9,000</b> Ind/ <b>\$18,000</b> Family*	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, out-of-network vision services/materials, balance-billed charges, and health care this plan 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. For a list of <u>in-network providers</u> , see <a href="http://www.bcbst.com">www.bcbst.com</a> or call 1-800-245-7942.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.

\*For those employees on the four-tier structure, Family includes: Individual + Child(ren), Individual + Spouse and Family.

 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% co-insurance	40% co-insurance	-----none-----
	<u>Specialist</u> visit	20% co-insurance	40% co-insurance	-----none-----
	<u>Preventive care/screening/immunization</u>	No Charge	40% co-insurance	-----none-----
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% co-insurance	40% co-insurance	-----none-----
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	-----none-----
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs	20% \$10 min/\$100 max retail 20% \$20 min/\$200 max mail order	Reimbursed the amount the drug would've cost at an in-network pharmacy minus the retail copayment you would've paid	Plan covers up to 30 day supply (retail prescription); up to 90 day supply (mail order prescription)  Your plan uses a preferred drug list which identifies the status of covered drugs.
	Preferred brand drugs	20% \$24 min/\$100 max retail 20% \$48 min/\$200 max mail order	Reimbursed the amount the drug would've cost at an in-network pharmacy minus the retail copayment you would've paid	Some drugs may require preauthorization. If the necessary preauthorization is not obtained, the drug may not be covered.
	Non-preferred brand drugs	20% \$39 min/\$100 max retail 20% \$78 min/\$200 max mail order	Reimbursed the amount the drug would've cost at an in-network pharmacy minus the retail copayment you would've paid	You pay the difference in cost if you or the prescriber requests a brand name drug when a generic equivalent is available.  After a maintenance medication prescription is filled 3 times at retail, you will be required to pay 100% on the 4th (and subsequent) fill if not filled through mail order.
	<u>Specialty drugs</u>	Preferred: 20% \$24 min/\$100 max retail Non-preferred: 20% \$39 min/\$100 max retail <i>Note: Mail order pricing</i>	Reimbursed the amount the drug would've cost at an in-network pharmacy minus the retail copayment you would've paid	After a maintenance medication prescription is filled 3 times at retail, you will be required to pay 100% on the 4th (and subsequent) fill if not filled through mail order.

[\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbst.com](http://www.bcbst.com).]

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)	
		<i>does not apply to specialty drugs</i>		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	Prior Authorization required. Benefits may be reduced or denied if not obtained.
	Physician/surgeon fees	20% co-insurance	40% co-insurance	Prior Authorization required. Benefits may be reduced or denied if not obtained.
If you need immediate medical attention	Emergency room care	20% co-insurance	20% co-insurance	-----none-----
	<u>Emergency medical transportation</u>	20% co-insurance	20% co-insurance	-----none-----
	<u>Urgent care</u>	See Limitations & Exceptions	See Limitations & Exceptions	Urgent Care benefits are determined by place of service, such as physician's office or ER
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	Prior Authorization required. Benefits may be reduced or denied if not obtained.
	Physician/surgeon fees	20% co-insurance	40% co-insurance	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% co-insurance	40% co-insurance	-----none-----
	Inpatient services	20% co-insurance	40% co-insurance	Prior Authorization required for electro-convulsive therapy (ECT). Benefits may be reduced or denied if not obtained.
If you are pregnant	Office visits	20% co-insurance	40% co-insurance	-----none-----
	Childbirth/delivery professional services	20% co-insurance	40% co-insurance	-----none-----
	Childbirth/delivery facility services	20% co-insurance	40% co-insurance	-----none-----
If you need help recovering or have other special health needs	<u>Home health care</u>	20% co-insurance	40% co-insurance	Prior Authorization required. Benefits may be reduced or denied if not obtained.
	<u>Rehabilitation services</u>	20% co-insurance	40% co-insurance	Therapy limited to 60 visits per type per year. Cardiac/Pulmonary Rehab limited to 36 visits per year.
	<u>Habilitation services</u>	20% co-insurance	40% co-insurance	
	<u>Skilled nursing care</u>	20% co-insurance	40% co-insurance	Prior Authorization required. Benefits may be reduced or denied if not obtained.
	<u>Durable medical equipment</u>	20% co-insurance	40% co-insurance	-----none-----
	<u>Hospice services</u>	20% co-insurance	40% co-insurance	Prior Authorization required. Benefits may be reduced or denied if not obtained.

[\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbst.com](http://www.bcbst.com).]

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 your child needs dental or eye care	Children's eye exam	\$10 co-pay	40% of maximum allowable charge + 100% of any amount over MAC	-----none-----
	Children's glasses	Children under 19 have a selection of frames to choose from. Frames: \$10 co-pay Single Vision Lens: \$10 co-pay	Frames: 40% of maximum allowable charge + 100% of any amount over MAC Single Vision Lens: 40% of maximum allowable charge + 100% of any amount over MAC	-----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 <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (Children)</li> <li>Infertility treatment</li> <li>Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing</li> <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>Bariatric surgery</li> <li>Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids for adults</li> <li>Hearing aids for children under 18</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> </ul>

**Your Rights to Continue Coverage:** For employees under the plan: As a Federal governmental plan, if you lose coverage under the plan, you will not be able to continue coverage under the plan pursuant to certain laws such as COBRA. However, the plan does provide for you to be able to continue coverage for up to 3 months following the month you are no longer eligible for coverage. This temporary continuation coverage will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan.

For retirees under the plan: You only lose coverage if you cancel your coverage yourself or if your coverage is cancelled due to non-payment. If you lose coverage, you will not be eligible to enroll at a future date.

For more information on your ability to continue coverage under the plan, contact TVA Employee Benefits at 1-888-275-8094.

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:** If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, contact: BlueCross BlueShield of Tennessee at 1-800-245-7942 or [www.bcbst.com](http://www.bcbst.com).

[\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbst.com](http://www.bcbst.com).]

**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 [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 [insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [insert telephone number].]

-----*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 \$400
- Specialist [cost sharing] 20%
- 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>\$7,540</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,300
Copayments	\$0
Coinsurance	\$1,248
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,548</b>

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

- The plan's overall deductible \$400
- Specialist [cost sharing] 20%
- 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>\$5,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,300
Copayments	\$0
Coinsurance	\$680
<i>What isn't covered</i>	
Limits or exclusions	\$700
<b>The total Joe would pay is</b>	<b>\$2,680</b>

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

- The plan's overall deductible \$400
- Specialist [cost sharing] 20%
- 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>\$2,500</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,300
Copayments	\$0
Coinsurance	\$240
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,540</b>