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.. 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 or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: **$550** Ind / **$1,100** Family*. Out- of-network: **$1,100** Ind / **$2,200** Family* Doesn't apply to preventive care. Copays, premiums, prescription drugs and vision care do not apply to the deductible.	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 care services are covered at 100% and do not apply toward the deductible.	You don't have to meet the deductible before preventive care services are covered. 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, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	For network providers $3,250 individual / $6,500 family; for out- of-network providers $6,500 individual / $13,000 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?	Premiums, balance-billing charges, amount of reduced or denied benefit for failure to obtain preauthorization for services, 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 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

Important Questions	Answers	Why This Matters:
		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 don't need a referral to see a specialist.	You can see the specialist 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: 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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-insurance	30% co-insurance	None
	Specialist visit	20% co-insurance	30% co-insurance	None
	Preventive care/screening/ Immunization	No Charge	No Charge	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% co-insurance	30% co-insurance	None
	Imaging (CT/PET scans, MRIs)	20% co-insurance	30% co-insurance	Prior Authorization required. Benefits may be reduced or denied if not obtained.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	$10 30-day or less / $20 90-day	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 o participating Smart90 retail pharmacy). Your plan uses a preferred drug list which identifies the status of covered drugs. Some drugs may require preauthorization. If the necessary preauthorization is not obtained,
	Preferred brand drugs	$30 30-day or less / $60 90-day	Reimbursed the amount the drug would've cost at an in-network pharmacy minus the retail copayment you would've paid	

[* For more information about limitations and exceptions, see the plan or policy document at 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)	
	Non-preferred brand drugs	$50 30-day or less / $100 90-day	Reimbursed the amount the drug would've cost at an in-network pharmacy minus the retail copayment you would've paid	the drug may not be covered. 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 or through a participating Smart90 retail pharmacy).
	Specialty drugs	Preferred: $30 retail Non-preferred: $50 retail *Note: Mail order pricing does not apply to specialty drugs*	Reimbursed the amount the drug would've cost at an in-network pharmacy minus the retail copayment you would've paid	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	30% co-insurance	Preauthorization is required. Benefits may be reduced or denied if not obtained.
	Physician/surgeon fees	20% co-insurance	30% co-insurance	None
If you need immediate medical attention	Emergency room care	20% co-insurance	20% co-insurance	None
	Emergency medical transportation	20% co-insurance	20% co-insurance	
	Urgent care	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% coinsurance	30% co-insurance	Preauthorization is required. Benefits may be reduced or denied if not obtained.
	Physician/surgeon fees	20% coinsurance	30% co-insurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% co-insurance	30% co-insurance	None
	Inpatient services	20% co-insurance	30% co-insurance	Preauthorization is required for certain outpatient procedures.
If you are pregnant	Office visits	20% coinsurance	30% co-insurance	None
	Childbirth/delivery professional services	20% coinsurance	30% co-insurance	

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)	
	Childbirth/delivery facility services	20% coinsurance	30% co-insurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% co-insurance	Prior Authorization required. Benefits may be reduced or denied if not obtained.
	Rehabilitation services	20% coinsurance	30% co-insurance	Therapy limited to 60 visits per type per year. Cardiac/Pulmonary Rehab limited to 36 visits per year.
	Habilitation services	20% coinsurance	30% co-insurance	
	Skilled nursing care	20% coinsurance	30% co-insurance	Prior Authorization required. Benefits may be reduced or denied if not obtained.
	Durable medical equipment	20% coinsurance	30% co-insurance	Prior Authorization may be required.
	Hospice services	20% coinsurance	30% co-insurance	Prior Authorization required. Benefits may be reduced or denied if not obtained.
If your child needs dental or eye care	Children's eye exam	$10 co-pay	40% of maximum allowable charge (MAC)+ 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 / $130 allowance, 20% discount on amount over $130 Single Vision Lens: $10 co-pay	Frames: 40% of MAC + 100% of any amount over MAC Single Vision Lens: 40% of MAC + 100% of any amount over MAC	
	Children's dental check-up	Not Covered	Not Covered	

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)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care for non-diabetics
- Weight loss programs

[* For more information about limitations and exceptions, see the plan or policy document at www.bcbst.com.]

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Chiropractic care	• Infertility treatment
• Bariatric surgery	• Hearing aids (Adult and Children)	

[* For more information about limitations and exceptions, see the plan or policy document at www.bcbst.com.]

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 of 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's People First Solution Center at 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 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 on how 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 BlueShield of Tennessee at 1-800-245-7942 or www.bcbst.com.

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Does this plan provide Minimum Essential Coverage? Yes.
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 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 1-800-245-7942.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-245-7942.

Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-800-245-7942.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-245-7942.

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	$550
Specialist coinsurance	20%
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	$550
Copayments	$0
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$3,020**

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

The plan's overall deductible	$550
Specialist coinsurance	20%
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	$550
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$400
The total Joe would pay is	**$1,750**

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

The plan's overall deductible	$550
Specialist coinsurance	20%
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	$550
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$960**

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