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 and out-of-network providers: $1,550/single, $3,100/employee + child(ren), and $3,100/family. Doesn't apply to preventive care. Your deductible is lowered by funds your employer provides to your HRA account. Your employer will contribute up to: $1,100/single, $2,200/employee + child(ren), and $2,200 family which reduces your share of the deductible. Your 2019 account will be prorated if your insurance becomes effective after April 2019. If you are a pensioner and have Medicare Parts A and B, your employer will not make a contribution to your HRA account.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered service after you meet the deductible. If you receive an employer contribution to your HRA account, it effectively reduces the overall amount of the deductible described here so your share of the deductible is $450/single and $900/employee + child(ren) and $900/family. Any dollars in the account are used first to pay for medical and pharmacy expenses before your share of the deductible is due. Once the account is exhausted, your share of the deductible must be met before you enter the coinsurance phase. If at the end of the year, you have any funds remaining in your HRA account, the balance will roll over to the next plan year thereby lowering your deductible the next plan year.
Are there services covered before you meet your deductible?	Yes. Network preventive care and immunizations.	This plan covers some items and services even if you haven't yet met the deductible amount. But coinsurance may apply.
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 $2,250/single, $4,500 employee + child(ren), and $4,500/ family. For out-of-network providers: $6,100/single and $12,200/employee + child(ren), and $12,200/family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	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.

(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)

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.mycigna.com or call 1-800-244-6224 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.

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	10% coinsurance	30% coinsurance	---None---
	Specialist visit	10% coinsurance	30% coinsurance	Acupuncture coverage is limited to $1,000 annual max.
	Preventive care/screening/ immunization	No charge; deductible does not apply	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	---None---
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	---None---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.mycigna.com.	Generic drugs	10% coinsurance	30% coinsurance	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail and home delivery) for Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.
	Brand drugs (preferred brand and non-preferred brand drugs)	30% coinsurance	30% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	---None---
	Physician/surgeon fees	10% coinsurance	30% coinsurance	---None---
If you need immediate medical attention	Emergency room care	10% coinsurance	30% coinsurance	---None---
	Emergency medical	10% coinsurance	30% coinsurance	---None---

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

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)	
	transportation			
	Urgent care	10% coinsurance	30% coinsurance	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	50% penalty for no pre-authorization on out-of-network stays
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	---None---
	Inpatient services	10% coinsurance	30% coinsurance	Pre-authorization required; 50% penalty for no pre-authorization on out-of-network stays
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Depending on the type of services, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	16 hour maximum per day
	Rehabilitation services	10% coinsurance	30% coinsurance	---None---
	Habilitation services	10% coinsurance	30% coinsurance	---None---
	Skilled nursing care	10% coinsurance	30% coinsurance	50% penalty for no pre-authorization. Coverage is limited to 100 days annual max.
	Durable medical equipment	10% coinsurance	30% coinsurance	---None---
	Hospice services	10% coinsurance	30% coinsurance	50% penalty for failure to pre-authorize inpatient hospice services.
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.)

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye Care (Children)
- Hearing aids for adults
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Acupuncture (20 days)
- Bariatric surgery (network only Surgeon charges lifetime max $10,000)
- Chiropractic care

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 or policy document at http://www.nashville.gov/Human-Resources.]

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	$1,550.
Specialist *[cost sharing]*	10%
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,550
Copayments	$0
Coinsurance	$700
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$2,260**

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

The plan's overall deductible	$1,550,
Specialist *[cost sharing]*	10%
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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	$1,550
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$2,250**

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

The plan's overall deductible	$1,550
Specialist *[cost sharing]*	10%
Hospital (facility) *[cost sharing]*	10%
Other *[cost sharing]*	10%

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	$1,550
Copayments	$0
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,590**

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