

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Metropolitan Government of Nashville and Davidson County:
PPO Plan (Open Access Plus Network)

Coverage Period: 01/01/2025 - 12/31/2025
Coverage for: Individual/Individual + Family | Plan Type: OAP



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, go online at www.cigna.com/sp. 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 <https://www.healthcare.gov/sbc-glossary> or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>For in-network providers: \$0/individual or \$0/family For out-of-network providers: \$200/individual or \$600/family</p>	<p>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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. Out-of-network prescription drugs, out-of-network emergency room visits.</p>	<p>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>For in-network providers: \$1,000/individual or \$2,000/family For out-of-network providers: \$5,000/individual or \$10,000/family Combined medical/behavioral and pharmacy out-of-pocket limit</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Medical copayments, penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.cigna.com or call 1-800-Cigna24 for a list of network providers.</p>	<p>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.</p>

Important Questions	Answers	Why This Matters:
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
		In-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 copay , plus 20% coinsurance /visit	\$20 copay , plus 40% coinsurance /visit	None
	Specialist visit	\$30 copay , plus 20% coinsurance /visit	\$30 copay , plus 40% coinsurance /visit	None
	Preventive care/ screening/ immunization	20% coinsurance No charge (up to \$750), then 20% coinsurance	40% coinsurance 40% coinsurance	Coverage birth through age 6 Coverage age 7 and older 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	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.cigna.com	Generic drugs (Tier 1)	\$10 copay /prescription (retail 34 days), \$20 copay /prescription (retail & home delivery 102 days)	\$10 copay /prescription (retail); Not covered (home delivery) Deductible does not apply	Coverage is limited up to a 102-day supply (retail and home delivery); up to a 34-day supply (retail and home delivery) for Specialty drugs .
	Preferred brand drugs (Tier 2)	\$30 copay /prescription (retail 34 days), \$60 copay /prescription (retail & home delivery 102 days)	\$30 copay /prescription (retail); Not covered (home delivery) Deductible does not apply	Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Non-preferred brand drugs (Tier 3)	\$30 copay /prescription (retail 34 days), \$60 copay /prescription (retail & home delivery 102 days)	\$30 copay /prescription (retail); Not covered (home delivery) Deductible does not apply	For drugs in the Cigna Patient Assurance Program you may pay less than the noted retail or home delivery cost share amounts.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	\$100 copay /visit, plus 20% coinsurance	\$100 copay /visit, plus 20% coinsurance Deductible does not apply	Per visit copay is waived if admitted. Out-of-network services are paid at the in-network cost share.
	Emergency medical transportation	20% coinsurance	20% coinsurance Deductible does not apply	Out-of-network air ambulance services are paid at the in-network cost share and deductible .
	Urgent care	\$20 copay /visit, plus 20% coinsurance	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 copay , plus 20% coinsurance /office visit 20% coinsurance /all other services	\$20 copay , plus 40% coinsurance /office visit 40% coinsurance /all other services	Includes medical services for MH/SA diagnoses.
	Inpatient services	20% coinsurance	40% coinsurance	Includes medical services for MH/SA diagnoses.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services . Depending on the type of services, a copayment , coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	16 hour maximum per day
	Rehabilitation services	20% coinsurance /PCP visit	40% coinsurance /PCP visit	Coverage is limited to annual max of: 20 days for Chiropractic care services.
		20% coinsurance / Specialist visit	40% coinsurance / Specialist visit	
		50% coinsurance /visit for Chiropractic care services	50% coinsurance /visit for Chiropractic care services	
	Habilitation services	20% coinsurance /PCP visit	40% coinsurance /PCP visit	Services are covered when Medically Necessary to treat a mental health condition (e.g. autism) or a congenital abnormality.
		20% coinsurance / Specialist visit	40% coinsurance / Specialist visit	
	Skilled nursing care	20% coinsurance	20% coinsurance	Coverage is limited to 100 days annual max.
Durable medical equipment	20% coinsurance	40% coinsurance	None	
Hospice services	20% coinsurance /inpatient services 20% coinsurance /outpatient services	40% coinsurance /inpatient services 40% coinsurance /outpatient services	None	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	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 [excluded services](#).)

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- 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 (\$1,000 annual maximum)
- Bariatric Surgery (in-network only)
- Chiropractic care (20 days)
- Hearing aids (2 devices (1 per ear) per 3 Years, through age 17)
- Hearing aids (\$2,000 max, up to 2 devices, per 36 months, age 18 and over)

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: Cigna at 1-800-Cigna24, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: Cigna Customer service at 1-800-Cigna24. Additionally, a consumer assistance program can help you file your [appeal](#). Contact: Tennessee Department of Commerce & Insurance at (615) 741-2218.

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 1-800-244-6224.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-244-6224.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-244-6224.

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 copayment](#) \$30
- 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$20
Coinsurance	\$1,000
What isn't covered	
Limits or exclusions	\$20
The total Peg would pay is	\$1,020

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 copayment](#) \$30
- 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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$700
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$40
The total Joe would pay is	\$940

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$30
- 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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$500
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$800

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

Discrimination is against the law.

Medical coverage

Cigna Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna Healthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna Healthcare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.



If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna Healthcare

Nondiscrimination Complaint Coordinator
P.O. Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at <https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

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Proficiency of Language Assistance Services

English - ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna Healthcare customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish - ATENCION: Hay servicios de asistencia de idiomas, sin cargo, a su disposici6n. Si es un cliente actual de Cigna Healthcare, llame al numero que figura en el reverso de su tarjeta de identificaci6n. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese - *i±* : ft{F -a:T:mf&i.f..Jtm{#: fU@ ° ftm- Cigna Healthcare E!'jfj!f] p, § fff@.:El'j ID -tc lfifEl'j51,'c\$° 1ili p\$'Jli ffl 1.800.244.6224 **lufi!*l** : **ti** 711) °

Vietnamese - XIN LU'U Y: Quy vi dU'Q'C clip dich v1,1 trq giup v ngon ngfr mien phi. Danh cho khach hang hi\$ n ti cua Cigna Healthcare, vui long goi s6 a m it sau the Hoi vien. Cac trll'ang hQ'p khac xin goi s6 1.800.244.6224 (TTY: Quay s6 711).

Korean-?£1: **Oj** .A. -S-o "l -f:lq., <2:l0j ::x::1 }..-il::lA E.£ Ol-S-o -? £/ Lig. -ri:H Cigna Healthcare 7 ::i: \::J J l'i ID :1 c OJI £/ 2 .2..£ '2:1stoH?{J"l2.. 7IE q -f:lq.011 1.800.244.6224 (TTY: qo1 711) 9£ 2 OH?{J.A.l2..

Tagalog - PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna Healthcare, tagawan ang numero sa likuran ng iyong ID card.0 kaya, tumawag sa 1.800.244.6224 (TTY: l-dial ang 711).

Russian - BHv1MAHv1E: BaM MoryT npeAOCTaBVITb 6ecn.naTHble ycnynr neneBoP,a. Ec.nvi Bbl y)(e y4acTByeTe B n.naHe Cigna Healthcare, no3BOHVITe no HOMepy, yKa3aHHOMY Ha o6paTHOVI CTOpOHe Bawevi VIA8HTVIQ)VIKal..VIOHHOVI KapTO4KVI y4aCTHVIKa n.naHa. Ec.nvi Bbl He s:IBmleTeCb y4aCTHVIKOM OAHOrO VI3 HaWVIX n.naHOB, no3BOHVITe no HOMepy 1.800.244.6224 (TTY: 711).

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French Creole - ATANSYON: Gen sevis ed nan lang ki disponib gratis pou ou. Pou kliyan Cigna Healthcare yo, rele nimewo ki deye kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French - ATTENTION: Des services d'aide linguistique vous sont proposes gratuitement. Si vous etes un client actuel de Cigna Healthcare, veuillez appeler le numero indique au verso de votre carte d'identite. Sinon, veuillez appeler le numero 1.800.244.6224 (ATS: composez le numero 711).

Portuguese - ATENCAO: Tern ao seu dispor servic;;os de assistencia linguistica, totalmente gratuitos. Para clientes Cigna Healthcare atuais, ligue para o numero que se encontra no verso do seu cartao de identificac;;ao. Caso contrario, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish - UWAGA: w celu skorzystania z dost pnej, bezpfatnej pomocy j zykowej, obecni klienci firmy Cigna Healthcare mogg dzwonic pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese - 51 \$: E3;,\$:ifi i3 :h '8-, Oj :/i-t:t- t::':Z c'fIjffil, 'tctaf *9 o l :r±O)Cigna HealthcareO);s:g::m ;;t IDtJ- F mjO) i3ffi *'c', ;;)s i3ti::Tc'il (tc. l,'o i"O){(h0)15tt, 1.800.244.6224 (TTY: 711) *'c', s i3ti::Tc'il (tc. l,'a

Italian - ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Peri clienti Cigna Healthcare attuali, chiamare ii numero sul retro della tessera di identificazione. In caso contrario, chiamare ii numero 1.800.244.6224 (utenti TTY: chiamare ii numero 711).

German - ACHTUNG: Die Leistungen der Sprachunterstutzung stehen Ihnen kostenlos zur VerfOGung. Wenn Sie gegenwartiger Cigna Healthcare-Kunde sind, rufen Sie bitte die Nummer auf der Ruckseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wahlen Sie 711).

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