

SUMMARY OF BENEFITS - CIGNA CHOICE FUND



Metropolitan Government of Nashville and Davidson County Pensioners

Health Reimbursement Account

Your employer has established a health reimbursement account that you can use to pay for eligible out-of-pocket expenses during the plan year.

Employer Contribution	Employee	Family
Pensioners WITHOUT Medicare Parts A & B	\$1,100	\$2,200
Pensioners WITH Medicare Parts A & B	\$0	\$0

Annual deductibles and maximums	In-network	Out-of-network
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Lifetime maximum	Unlimited per individual	
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Pre-Existing Condition Limitation (PCL)	Does Not Apply	Does Not Apply
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Coinsurance	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
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Maximum Reimbursable Charge <ul style="list-style-type: none"> Determined based on the lesser of: <ul style="list-style-type: none"> the health care professional's normal charge for a similar service; or a percentile of the amount charged by health care professionals in the geographic area where the service is received. Out-of-network services are subject to a plan year deductible and maximum reimbursable charge limitations. 	N/A	50 th Percentile
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Plan year deductible <ul style="list-style-type: none"> The amount you pay for out-of-network services counts towards both your in-network and out-of-network deductibles. All family members contribute towards the family deductible. The plan cannot pay an individual's claims until the total family deductible has been met, even if he or she has met the individual deductible. This plan includes a combined Medical/Rx deductible. Out-of-network pharmacy deductible accumulates to the in-network pharmacy deductible. Mail order pharmacy costs contribute to the deductible. 	Individual Share \$450 Family Share \$900	Individual Share \$450 Family Share \$900
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Plan year out-of-pocket maximum <ul style="list-style-type: none"> The amount you pay for out-of-network services counts towards both your in-network and out-of-network out-of-pocket maximums. Mental health and substance abuse services count towards your out-of-pocket maximum. This plan includes a combined Medical/Rx out-of-pocket maximum. Out-of-network pharmacy out-of-pocket expenses accumulates to the in-network pharmacy out-of-pocket maximum. Mail order pharmacy costs contribute to the out-of-pocket maximum. 	Individual Share \$1,150 Family Share \$2,300	Individual Share \$5,000 Family Share \$10,000
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Benefits	In-network	Out-of-network
Physician services		
Office visit <ul style="list-style-type: none"> Primary care physician and specialist office visits 	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
Physician services (hospital) <ul style="list-style-type: none"> In hospital visits and consultations Inpatient services Outpatient services 	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
Surgery (in a physician's office)	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
Preventive care		
Preventive care <ul style="list-style-type: none"> Includes well-baby, well-child, well-woman and adult preventive care Immunizations are included at no charge. Lab and x-ray billed outside the doctor's office do not count towards the plan year maximum. Unlimited plan year maximum 	No charge	You pay 30% Plan pays 70% after the deductible is met
Mammogram, PSA, Pap Smear <ul style="list-style-type: none"> Preventive care related mammogram charges do not accumulate to the plan's Preventive Care dollar maximum, regardless of place of service. Preventive care related PSA and PAP Smear charges, when billed by the physician's office, will be subject to the plan's Preventive Care dollar maximum. Preventive care related PSA and PAP Smear charges, when billed by an independent diagnostic facility or outpatient hospital, do not accumulate to the plan's Preventive Care dollar maximum. 	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the deductible is met
Inpatient hospital facility services		
Semi-private room and board and other non-physician services <ul style="list-style-type: none"> Inpatient room and board, pharmacy, x-ray, lab, operating room, surgery, etc. 	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
Inpatient Professional Services <ul style="list-style-type: none"> For services performed by surgeons, radiologists, pathologists and anesthesiologists 	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
Multiple surgical reduction <ul style="list-style-type: none"> Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery. 	Included	Included

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Benefits	In-network	Out-of-network
Outpatient services		
Outpatient surgery (facility charges)	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
Outpatient Professional Services <ul style="list-style-type: none"> For services performed by surgeons, radiologists, pathologists and anesthesiologists 	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
Physical, occupational, cognitive and speech therapy <ul style="list-style-type: none"> Limited to Unlimited days per plan year for all therapies combined Includes physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation and cognitive therapy 	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
Cardiac rehabilitation <ul style="list-style-type: none"> Limited to 36 days per plan year 	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
Chiropractic services <ul style="list-style-type: none"> \$2,000 plan year maximum 	You pay 30% Plan pays 70% after the deductible is met	You pay 50% Plan pays 50% after the deductible is met
Lab and X-ray		
Lab and X-ray <ul style="list-style-type: none"> Physician’s office Outpatient hospital facility Emergency room Independent X-ray and/or lab facility Independent X-ray and/or lab facility as part of an emergency room visit 	See place of service costs	See place of service costs
Advanced radiological imaging <ul style="list-style-type: none"> MRI, MRA, CAT Scan, PET Scan, etc. Inpatient hospital facility, outpatient hospital facility, emergency room, urgent care facility or physician’s office 	See place of service costs	See place of service costs
Emergency and urgent care services		
Hospital emergency room <ul style="list-style-type: none"> Includes radiology, pathology and physician charges Out-of-network services are covered at the in-network rate. 	You pay 10% Plan pays 90% after the deductible is met	
Ambulance <ul style="list-style-type: none"> Out-of-network services are covered at the in-network rate only if it is a true emergency. If not a true emergency, the out-of-network rate is charged. 	You pay 10% Plan pays 90% after the deductible is met	
Urgent care services <ul style="list-style-type: none"> Out-of-network services are covered at the in-network rate. 	You pay 10% Plan pays 90% after the deductible is met	

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Benefits	In-network	Out-of-network
Other health care facilities		
Skilled nursing facility, rehabilitation hospital and other facilities <ul style="list-style-type: none"> 100 days per plan year 	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
Home health care <ul style="list-style-type: none"> Unlimited days per plan year 	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
Hospice <ul style="list-style-type: none"> Inpatient services Outpatient services 	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
Other health care services		
Durable medical equipment <ul style="list-style-type: none"> Unlimited plan year maximum 	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
External prosthetic appliances (EPA) <ul style="list-style-type: none"> Unlimited plan year maximum 	You pay 10% Plan pays 90% after deductible is met	You pay 30% Plan pays 70% after deductible is met
TMJ – Non-Surgical: Case by case basis: Always excludes appliances and orthodontic treatment <ul style="list-style-type: none"> Doctor’s Office Inpatient Facility Outpatient Facility Physician’s Services \$2,000 maximum per calendar year \$4,000 lifetime maximum 	You pay 30% Plan pays 70% After deductible is met	You pay 50% Plan pays 50% after deductible is met
Infertility <ul style="list-style-type: none"> Coverage will be provided for the treatment of the underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness. 	Not Covered	Not Covered
Family planning <ul style="list-style-type: none"> Inpatient hospital facility Outpatient facility Physician services Surgical services such as tubal ligation or vasectomy are covered (excluding reversals). Includes contraceptive devices Does not contribute to the preventive care maximum 	Cost and reimbursement vary based on the facility in which it is performed	Not Covered
Mental health and substance abuse services		
Please note the following regarding Mental Health (MH) and Substance Abuse (SA) benefit administration: <ul style="list-style-type: none"> Substance Abuse includes Alcohol and Drug Abuse services. Transition of Care benefits are provided for a 90-day time period. 		

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Benefits	In-network	Out-of-network
<p>Inpatient mental health services</p> <ul style="list-style-type: none"> • Unlimited days per plan year • Mental health services are paid at 100% after you reach your out-of-pocket maximum. 	<p>You pay 10% Plan pays 90% after the medical plan deductible is met</p>	<p>You pay 30% Plan pays 70% after the medical plan deductible is met</p>
<p>Outpatient mental health services</p> <ul style="list-style-type: none"> • Unlimited visits per plan year • Mental health services are paid at 100% after you reach your out-of-pocket maximum. • This includes group therapy mental health, and intensive outpatient mental health 	<p>You pay 10% Plan pays 90% after the medical plan deductible is met</p>	<p>You pay 30% Plan pays 70% after the medical plan deductible is met</p>
<p>Inpatient substance abuse services</p> <ul style="list-style-type: none"> • Unlimited days per plan year • Substance abuse services are paid at 100% after you reach your out-of-pocket maximum. 	<p>You pay 10% Plan pays 90% after the medical plan deductible is met</p>	<p>You pay 30% Plan pays 70% after the medical plan deductible is met</p>
<p>Outpatient substance abuse services</p> <ul style="list-style-type: none"> • Unlimited visits per plan year • Substance abuse services are paid at 100% after you reach your out-of-pocket maximum. • This includes intensive outpatient substance abuse 	<p>You pay 10% Plan pays 90% after the medical plan deductible is met</p>	<p>You pay 30% Plan pays 70% after the medical plan deductible is met</p>
Prescription Drugs		
<p>CIGNA Pharmacy three-tier coinsurance plan</p> <ul style="list-style-type: none"> • No mandatory generics • Self administered injectable– excludes infertility drugs • Includes Oral Contraceptives • Lifestyle drugs – limited to sexual dysfunction • Prescription diet drugs included • Prescription smoking cessation drugs included 	<p>Retail (34 day supply) <u>You pay:</u> Generic 10% Preferred brand 30% Non-Preferred Brand 30%</p> <p>Home Delivery (102 Day supply) <u>You pay:</u> Generic 10% Preferred brand 30% Non-Preferred Brand 30%</p>	<p>You pay 30% Plan pays 70%</p> <p>Home Delivery covered in-network only.</p>
<p>Vision care</p>	<p>Not covered</p>	



Definitions

Deductible – The amount you need to pay before your plan starts paying benefits.

Coinsurance – After you’ve reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called coinsurance.

Out-of-pocket – The amount you need to pay each year before your plan starts paying benefits (may or may not include your deductible).

Place of service – Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.

Exclusions

What’s Not Covered (*not all-inclusive*):

Your plan provides coverage for most medically necessary services. Examples of things your plan does not cover, unless required by law, include (but aren’t limited to):

- Services provided through government programs
- Services that aren’t medically necessary
- Experimental, investigational or unproven services
- Services for an injury or illness that occurs while working for pay or profit including services covered by Worker’s Compensation benefits
- Cosmetic services
- Dental care, unless due to accidental injury to sound natural teeth
- Infertility Services
- Reversal of sterilization procedures
- Genetic screenings
- Non-prescription and anti-obesity drugs
- Custodial and other non-skilled services
- Weight loss programs
- Hearing aids
- Acupuncture
- Travel immunizations
- Telephone, email and internet consultations in the absence of a specific benefit
- Eyeglass lenses and frames, contact lenses and surgical vision correction

These are only the highlights

This summary outlines the highlights of your plan. For a complete list of both covered and not-covered services, including benefits required by your state, see your employer’s insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.

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