

## **Cigna High Deductible Health Plan with HSA (Health Savings Account)**

- **Health Savings Account Annual Contribution from Edgecombe County Government - \$750**

A Health Savings Account combines traditional medical coverage with a savings account and investment options. You can make tax-free contributions to the savings account up to federal limits.

For 2017-2018, your annual contribution is limited to **\$3,400 for individuals** and **\$6,750 for families**. Limits for future years will be set by the IRS.

If you are age 55 or older, and not enrolled in Medicare, you may make an additional contribution for up to \$1,000 to your HSA in 2017-2018 and later years until you are age 65. Please consult with your tax advisor for further information.

Maximum contributions are based upon maintaining enrollment in a qualified HSA medical plan on the 1st of the month for 12 months of the contract year. For enrollment less than 12 months, you may not be eligible for the maximum contribution. Please consult your tax advisor.

HSA dollars can be used to reimburse yourself for qualified healthcare expenses incurred by you, your spouse or eligible dependents. Qualified expenses include **medical, dental and vision expenses as defined under Section 213(d) of the tax code and include expenses that are not covered by your HSA qualified medical plan**. Qualified dependents are children, siblings, parents and others who are considered an exemption under Section 152 of the tax code.

The plan deductible is the portion of covered medical and pharmacy expenses that you pay before your plan will begin to cover healthcare expenses. Only covered services count toward the plan deductible. Once your plan deductible has been met, your plan begins providing coverage for eligible services as described in the policy. All covered expenses (including those expenses applied to the plan deductible) benefit from negotiated discounts with participating providers and pharmacies.


Any dollars remaining in your savings account at the end of the year carry over to the next year. If you change employers or retire, you may take any dollars in your savings account with you.

You can choose how you pay for medical expenses that are submitted through your qualified HSA medical plan:

- You may pay for medical expenses on a claim-by-claim basis using the debit card that comes with your HSA.
- You may choose to cover your expenses using your own personal funds. This allows you to save your HSA dollars for future years.

 <p>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 <a href="http://www.cigna.com/sp">www.cigna.com/sp</a>. 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 <a href="https://www.healthcare.gov/sbc-glossary">https://www.healthcare.gov/sbc-glossary</a> or call 1-800-Cigna24 to request a copy.</p>		<p><b>Why This Matters:</b></p>
<p><b>Important Questions</b></p>	<p><b>Answers</b></p>	
<p>What is the overall deductible?</p>	<p>For in-network providers: <b>\$2,000</b>/individual or <b>\$4,000</b>/family                      For out-of-network providers: <b>\$4,000</b>/individual or <b>\$8,000</b>/family                      Combined medical/behavioral and pharmacy deductible                      Deductible per individual applies when the employee is the only individual covered under the plan.</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 policy, the overall family deductible must be met before the plan begins to pay.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. In-network preventive care &amp; immunizations are covered before you meet your deductible.</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. 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</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 <b>\$4,000</b>/individual or <b>\$6,000</b>/family                      For out-of-network providers <b>\$8,000</b>/individual or <b>\$12,000</b>/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, the overall family out-of-pocket limit must be met.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>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>

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See <a href="http://www.myCigna.com">www.myCigna.com</a> or call 1-800-Cigna24 for a list of network providers.	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 <u>health care provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u> /visit	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u> /visit	40% <u>coinsurance</u>	None
	Preventive care/ <u>screening</u> /immunization	No charge/visit** No charge/ <u>screening</u> ** No charge/ <u>immunizations</u> ** ** <u>Deductible</u> does not apply	Not covered/visit 40% <u>coinsurance</u> / <u>screening</u> Not covered/ <u>immunizations</u>	None None None None You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

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)	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a></p>	Generic drugs (Tier 1)	20% <a href="#">coinsurance/prescription (retail)</a> , 20% <a href="#">coinsurance/prescription (home delivery)</a>	Not covered	<p>Coverage is limited up to a 34-day supply (retail) and a 90-day supply (home delivery).</p> <p>Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.</p>
	Preferred brand drugs (Tier 2)	20% <a href="#">coinsurance/prescription (retail)</a> , 20% <a href="#">coinsurance/prescription (home delivery)</a>	Not covered	
	Non-preferred brand drugs (Tier 3)	20% <a href="#">coinsurance/prescription (retail)</a> , 20% <a href="#">coinsurance/prescription (home delivery)</a>	Not covered	
<p><b>If you have outpatient surgery</b></p>	Specialty drugs (Tier 4)	20% <a href="#">coinsurance/prescription (retail)</a> , 20% <a href="#">coinsurance/prescription (home delivery)</a>	Not covered	<p>Coverage is limited up to a 34-day supply (retail) and a 90-day supply (home delivery) for self-administered injectables.</p> <p>Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.</p>
	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Emergency room care	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	Emergency medical transportation	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
<p><b>If you need immediate medical attention</b></p>	Urgent care	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	None
	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	50% penalty for no precertification.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	50% penalty for no precertification.

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 need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance/office visit 20% coinsurance/all other services	40% coinsurance/office visit 40% coinsurance/all other services	None
	Inpatient services	20% coinsurance	40% coinsurance	50% penalty for no precertification.
	Office visits	20% coinsurance	40% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy.
If you are pregnant	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	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).
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
	Home health care	20% coinsurance	40% coinsurance	16 hour maximum per day
If you need help recovering or have other special health needs	Rehabilitation services	20% coinsurance/PCP visit	40% coinsurance	Coverage is limited to annual max of: 60 days for Rehabilitation and Chiropractic care services; 36 days for Cardiac rehab services
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% coinsurance	40% coinsurance	50% penalty for no precertification. Coverage is limited to 60 days annual max.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance/inpatient; 20% coinsurance/outpatient services	40% coinsurance/inpatient; 40% coinsurance/outpatient services	50% penalty for failure to precertify inpatient hospice services.
	Children's eye exam	\$25 copay/exam	Reimbursement allowance: Up to \$45/exam	Coverage is limited to one exam every 12 months
If your child needs dental or eye care	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.)**

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)**

- Bariatric Surgery (in-network only)
- Chiropractic care (combined with Rehabilitation Services)
- Eye care (Children)
- Hearing aids (Children)
- Routine eye care (Adult)

**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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.ccoio.cms.gov](http://www.ccoio.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](http://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 questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. Contact the program for this plan's situs state: Health Insurance Smart NC at 855-408-1212. However, for information regarding your own state's consumer assistance program refer to [www.healthcare.gov](http://www.healthcare.gov).

**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 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 \$2,000
- Specialist copayment \$0
- 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 \$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Peg would pay is</b>	<b>\$4,010</b>

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

- The plan's overall deductible \$2,000
- Specialist copayment \$0
- 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 \$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$200
<b>The total Joe would pay is</b>	<b>\$4,200</b>

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

- The plan's overall deductible \$2,000
- Specialist copayment \$0
- 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 \$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,900
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

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

**Plan Name:** OAP HDHP 2017 **Ben Ver:** 9**Plan ID:** 5807131