# HSA OAP: Village Podiatry Centers

Coverage Period: 08/01/2013 - 07/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Individual + Family | Plan Type: OAP

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myCigna.com or by calling 1-866-494-2111

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall deductible? | For in-network providers $3,000 person / $6,000 family; For out-of-network providers $6,000 person / $12,000 family.<br>Does not apply to in-network preventive care.<br>Co-payments don't count toward the deductible. | 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 services after you meet the deductible. |
| 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. |
| Is there an out-of-pocket limit on my expenses? | Yes. For in-network providers $6,000 person / $12,000 family; For out-of-network providers $12,000 person / $24,000 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 the covered services. This limit helps you plan for health care expenses. |
| What is not included in the out-of-pocket limit? | Premium, balance-billed charges, penalties for no pre-authorization, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| Is there an overall annual limit on what the plan pays? | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| Does this plan use a network of providers? | Yes. For a list of participating providers, see www.myCigna.com or call 1-866-494-2111. | If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers. |
| Do I 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. |
| Are there services this plan doesn't cover? | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services. |

- Co-payments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-insurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your co-insurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charge is $1,500 for an overnight stay and allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use in-network providers by charging you lower deductibles, co-payments and co-insurance amounts.

| Common Medical Event | Services You May Need | Your Cost if you use an | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-Network Provider | Out-of-Network Provider | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | 20% co-insurance | 50% co-insurance | ----------none---------- |
| | Specialist visit | 20% co-insurance | 50% co-insurance | ----------none---------- |
| | Other practitioner office visit | 20% co-insurance for chiropractor | 50% co-insurance for chiropractor | Coverage is limited to 12 visits annual max for chiropractor |
| | Preventive care/screening/ immunization | No charge | Not Covered | ----------none---------- |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% co-insurance for office visit, 20% co-insurance outpatient | 50% co-insurance | ----------none---------- |
| | Imaging (CT/PET scans, MRIs) | 20% co-insurance during an office visit or at an outpatient facility | 50% co-insurance | ----------none---------- |
| If you need drugs to treat your illness or condition<br><br>More information about prescription drug coverage is at www.myCigna.com | Generic drugs | 20% co-insurance (retail and home delivery) | Not Covered | Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (home delivery) |
| | Preferred brand drugs | 20% co-insurance (retail and home delivery) | Not Covered | Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (home delivery) |
| | Non-preferred brand drugs | 20% co-insurance (retail and home delivery) | Not Covered | Coverage is limited up to a 30-day supply (retail) and up to a 90-day supply (home delivery) |

| Common Medical Event | Services You May Need | Your Cost if you use an | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-Network Provider | Out-of-Network Provider | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% co-insurance | 50% co-insurance | ----------none---------- |
| | Physician/surgeon fees | 20% co-insurance | 50% co-insurance | ----------none---------- |
| If you need immediate medical attention | Emergency room services | 20% co-insurance | 20% co-insurance | ----------none---------- |
| | Emergency medical transportation | 20% co-insurance | 20% co-insurance | ----------none---------- |
| | Urgent care | 20% co-insurance | 50% co-insurance | ----------none---------- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% co-insurance | 50% co-insurance | ----------none---------- |
| | Physician/surgeon fee | 20% co-insurance | 50% co-insurance | ----------none---------- |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | 20% co-insurance | 50% co-insurance | ----------none---------- |
| | Mental/Behavioral health inpatient services | 20% co-insurance | 50% co-insurance | ----------none---------- |
| | Substance use disorder outpatient services | 20% co-insurance | 50% co-insurance | ----------none---------- |
| | Substance use disorder inpatient services | 20% co-insurance | 50% co-insurance | ----------none---------- |
| If you are pregnant | Prenatal and postnatal care | 20% co-insurance | 50% co-insurance | ----------none---------- |
| | Delivery and all inpatient services | 20% co-insurance | 50% co-insurance | ----------none---------- |

| Common Medical Event | Services You May Need | Your Cost if you use an | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-Network Provider | Out-of-Network Provider | |
| If you have a recovery or other special health need | Home health care | 20% co-insurance | 50% co-insurance | Coverage is limited to 40 visits annual max |
| | Rehabilitation services | 20% co-insurance for Physical and Speech, Hearing & Occupational Therapy | 50% co-insurance for Physical and Speech, Hearing & Occupational Therapy | Coverage is limited to an annual max of 20 visits for Physical Therapy and 20 visits for Speech, Hearing, & Occupational Therapy |
| | Habilitation services | Not Covered | Not Covered | ----------none---------- |
| | Skilled nursing care | 20% co-insurance | 50% co-insurance | Coverage is limited to 30 days annual max |
| | Durable medical equipment | 20% co-insurance | 50% co-insurance | ----------none---------- |
| | Hospice service | 20% co-insurance | 50% co-insurance | ----------none---------- |
| If your child needs dental or eye care | Eye exam | Not Covered | | ----------none---------- |
| | Glasses | Not Covered | | ----------none---------- |
| | Dental check-up | Not Covered | Not Covered | ----------none---------- |

## Excluded Services & Other Covered Services

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine eye care (Children)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care

## Your Rights to Continue Coverage

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-494-2111. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-866-494-2111. 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. Additionally, a consumer assistance program can help you file your appeal. Contact the program for this plan's situs state: Georgia Office of Insurance and Safety Fire Commissioner at 800-656-2298. However, for information regarding your own state's consumer assistance program refer to www.healthcare.gov.

## 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, kwiijigo holne' 1-800-244-6224.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*----------

# Coverage Examples

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Please consider any contributions you may receive in an HRA, HSA or FSA.

Note: These numbers assume enrollment in individual-only coverage.

## Having a baby
(normal delivery)

- Amount owed to providers: $7,540
- Plan pays: $3,630
- Patient pays: $3,910

Sample care costs:

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine Obstetric Care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| Total | $7,540 |

Patient pays:

| | |
|---|---|
| Deductible | $3,000 |
| Co-pays | $0 |
| Co-insurance | $880 |
| Limits or exclusions | $30 |
| Total | $3,910 |

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- Amount owed to providers: $5,400
- Plan pays: $1,670
- Patient pays: $3,730

Sample care costs:

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical equipment and supplies | $1,300 |
| Office visits & procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| Total | $5,400 |

Patient pays:

| | |
|---|---|
| Deductible | $3,000 |
| Co-pays | $0 |
| Co-insurance | $410 |
| Limits or exclusions | $320 |
| Total | $3,730 |

# Questions and answers about Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ No. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-ofpocket costs, such as co-payments, deductibles, and co-insurance. You also should consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Plan ID: 79900
Plan Name: HSA Plan