



Multi-language Interpreter Services

If you, or someone you're helping, has questions about this document you have the right to get help and information in your language at no cost. To talk to an interpreter, call 866-494-2111. **English**

إن كانت لديك أو لدي الشخص الذي تقوم بمساعدته أية استفسارات عن هذه الوثيقة، فإنه من حقك الحصول على المساعدة و المعلومات بلغتك و بدون أي تكلفة. للتحدث إلى أحد الأشخاص للمساعدة، اتصل على / 866-494-2111. **Arabic**

如果您或您要幫助的人有關於本文件的疑問，您有權免費以您的語言取得協助和相關資訊。如欲與口譯員洽談，請致電 866-494-2111。 **Chinese**

Si vous, ou quelqu'un que vous aidez, a des questions à propos de ce document, vous avez le droit d'obtenir de l'aide et des informations dans votre langue, sans frais. Pour parler à un interprète, composez le 866-494-2111. **French**

Falls Sie oder eine von Ihnen unterstützte Person Fragen zu diesem Dokument haben, haben Sie Anrecht auf kostenfreie Hilfe und Information in Ihrer Sprache. Sie erreichen unsere Dolmetscher unter der Rufnummer 866-494-2111. **German**

જો તમને, અથવા તમે જેને મદદ કરી રહ્યાં છો, તેને આ દસ્તાવેજ વિશે પ્રશ્નો હોય, તો તમને કોઈ પણ જાતનો ખર્ચ કર્યા વગર તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો અધિકાર છે. એક દુભાષિયા સાથે વાત કરવા માટે સંપર્ક કરો ૮૬૬-૪૯૪-૨૧૧૧. **Gujarati**

अगर आप या आप जिस की सहायता कर रहे हैं, किसी के भी इस दस्तावेज़ के बारे में सवाल हैं, तो आपके पास कोई भी कीमत चुकाये बिना अपनी भाषा में सहायता और जानकारी प्राप्त करने का अधिकार है। एक दुभाषिये से बात करने के लिए, 866-494-2111 पर फ़ोन करें। **Hindi**

Yog koj los sis tus neeg koj pab muaj lus nug txog tsab ntawv no, koj muaj txoj cai nrhiav kev pab thiab tau cov xov xwm ua koj hom lus tsis raug nqi dab tsi. Xav tham nrog ib tug neeg txhais lus, hu rau 866-494-2111. **Hmong**

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귀하 또는 귀하가 돕는 사람이 본 문서와 관련하여 문의사항이 있는 경우, 귀하는 무료로 귀하의 모국어를 이용해 도움 및 정보를 받을 권리가 있습니다. 통역사와 대화하시려면 866-494-2111 번으로 전화하십시오. **Korean**

ຖ້າຫາກວ່າທ່ານ, ຫຼືຜູ້ໃດທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ມີຄຳຖາມກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນທີ່ເປັນພາສາຂອງທ່ານໂດຍທີ່ບໍ່ເສຍຄ່າ. ວົມກັບນາຍພາສາ, ໂທຫາເບີ 866-494-2111.
Laotian

ប្រសិនបើអ្នកឬនរណាម្នាក់ដែលអ្នកកំពុងជួយមានសំណួរអំពីឯកសារនេះអ្នកមានសិទ្ធិក្នុងការទទួលបានជំនួយនិងព័ត៌មានក្នុងភាសារបស់អ្នកជាមិនមានការចំណាយនោះទេ។ ដើម្បីនិយាយទៅកាន់អ្នកបកប្រែភាសាសូមហៅទូរស័ព្ទទៅ \ 866-494-2111 ។ **Mon-Khmer, Cambodian**

Если у Вас или кого-либо, кому Вы оказываете помощь, возникли вопросы по поводу данного документа, Вы имеете право получить бесплатную помощь и информацию на Вашем родном языке. Для того чтобы связаться с переводчиком, позвоните по телефону 866-494-2111. **Russian**

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este documento tiene derecho a obtener ayuda e información en su idioma sin costo. Para hablar con un intérprete, llame al 866-494-2111.
Spanish

Kung ikaw, o ang isang taong tinutulongan ninyo, ay may mga tanong tungkol sa dokumentong ito, mayroon kayong karapatang humingi ng tulong at impormasyon sa inyong wika nang libre. Upang makipag-usap sa isang interpreter, tumawag sa 866-494-2111. **Tagalog**

Nếu quý vị, hoặc một người nào đó mà quý vị đang giúp đỡ, có câu hỏi về tài liệu này quý vị có quyền nhận được sự giúp đỡ và thông tin bằng ngôn ngữ của quý vị mà không mất khoản phí nào. Để nói chuyện với phiên dịch viên, vui lòng gọi số 866-494-2111. **Vietnamese**





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.cigna.com/individuals-families/north-carolina-health-insurance-plans-2017 or by calling 1-866-494-2111.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| <p>What is the overall <u>deductible</u>?</p> | <p>\$250 person/ \$500 family Does not apply to preventive care, office visits, urgent care visits, prescription drugs subject to a copay, speciality drugs and pediatric vision.</p> | <p>You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u>.</p> |
| <p>Are there other <u>deductibles</u> for specific services?</p> | <p>No.</p> | <p>You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</p> |
| <p>Is there an <u>out-of-pocket limit</u> on my expenses?</p> | <p>Yes, \$1,250 person/ \$2,500 family</p> | <p>The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</p> |
| <p>What is not included in the <u>out-of-pocket limit</u>?</p> | <p>Premium, balanced-billed charges, penalties for failure to obtain pre-authorization for services, and health care this plan doesn't cover</p> | <p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p> |
| <p>Is there an overall annual limit on what the plan pays?</p> | <p>No.</p> | <p>The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits</p> |
| <p>Does this plan use a <u>network of providers</u>?</p> | <p>Yes. For a list of in-network providers, see www.cigna.com/lfp-providers or call 1-866-494-2111</p> | <p>If you use an in-network doctor or other health care <u>provider</u>, 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u>, or participating for <u>providers</u> in their <u>network</u>. See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u></p> |

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If you aren't clear about any of the bolded terms used in this form, see the Glossary.

You can view the Glossary at www.cciio.cms.gov or call 1-866-494-2111 to request a copy.

| | | |
|---|---|---|
| Do I need a referral to see a <u>specialist</u>? | Yes. You do need a referral to see a specialist | This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist . |
| 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 . |



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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 charges \$1,500 for an overnight stay and the **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**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|--|---|---|--|
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$5 co-pay/visit | Not Covered | Expanded Access Telehealth visits – refer to the policy for benefit information. |
| | Specialist visit | \$15 co-pay/visit | Not Covered | -----None----- |
| | Other practitioner office visit | \$15 co-pay/visit | Not Covered | -----None----- |
| | Preventive care/screening/immunization | No charge | Not Covered | -----None----- |
| If you have a test | Diagnostic test (x-ray, blood work) | 5% co-insurance | Not Covered | -----None----- |
| | Imaging (CT/PET scans, MRIs) | 5% co-insurance | Not Covered | -----None----- |

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| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|--|--|---|---|
| <p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available www.cigna.com/ifp-drug-list</p> | Preferred generic drugs | \$2 co-pay (retail)/ \$6 co-pay (home delivery) | Not Covered | Coverage is limited up to a 90-day supply (retail/home delivery) You pay co-pay for each 30 day supply (retail) |
| | Non-preferred generic drugs | \$3 co-pay (retail)/ \$9 co-pay (home delivery) | Not Covered | Coverage is limited up to a 90-day supply (retail/home delivery) You pay co-pay for each 30 day supply (retail) |
| | Preferred brand drugs | \$5 co-pay (retail)/ \$15 co-pay (home delivery) | Not Covered | Coverage is limited up to a 90-day supply (retail/home delivery) You pay co-pay for each 30 day supply (retail) |
| | Non-preferred brand drugs | \$10 co-pay (retail)/ \$30 co-pay (home delivery) | Not Covered | Coverage is limited up to a 90-day supply (retail/home delivery) |
| | Specialty drugs | 25% co-insurance (retail/home delivery) | Not Covered | Coverage is limited up to a 90-day supply (retail/home delivery) You pay co-pay for each 30 day supply (retail) |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 5% co-insurance | Not Covered | -----None----- |
| | Physician/surgeon fees | 5% co-insurance | Not Covered | -----None----- |
| If you need immediate medical attention | Emergency room services | \$100 co-pay/visit | Not Covered | You pay the same level as in-network if it is an emergency as defined in your plan, otherwise Not Covered |
| | Emergency medical transportation | 5% co-insurance | Not Covered | |
| | Urgent care | \$25 co-pay/visit | Not Covered | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 5% co-insurance | Not Covered | -----None----- |
| | Physician/surgeon fee | 5% co-insurance | Not Covered | -----None----- |

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| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|--|
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services – office visit | \$5 co-pay/visit | Not Covered | -----None----- |
| | Mental/Behavioral health outpatient services – all other outpatient | 5% co-insurance | | -----None----- |
| | Mental/Behavioral health inpatient services | 5% co-insurance | Not Covered | -----None----- |
| | Substance use disorder outpatient services – office visit | \$5 co-pay/visit | Not Covered | -----None----- |
| | Substance use disorder outpatient services – all other outpatient | 5% co-insurance | | -----None----- |
| | Substance use disorder inpatient services | 5% co-insurance | Not Covered | -----None----- |
| If you are pregnant | Prenatal and postnatal care | 5% co-insurance | Not Covered | All prenatal and first postpartum consultations |
| | Delivery and all inpatient services | 5% co-insurance | Not Covered | -----None----- |
| If you need help recovering or have other special health needs | Home health care | 5% co-insurance | Not Covered | -----None----- |
| | Rehabilitation services | 5% co-insurance | Not Covered | Coverage of physical, occupational and chiropractic therapy is limited to 30 visits annual max |
| | Habilitation services | 5% co-insurance | Not Covered | Coverage is limited to 30 visits annual max |
| | Skilled nursing care | 5% co-insurance | Not Covered | Coverage is limited to 60 days annual max |
| | Durable medical equipment | 5% co-insurance | Not Covered | -----None----- |
| | Hospice service | 5% co-insurance | Not Covered | -----None----- |

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| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|--|-----------------------|---|---|--|
| If your child needs dental or eye care | Eye exam | No charge | Not Covered | Children up to end of the month age 19. Coverage is limited to 1 exam per 12 month period |
| | Glasses | No charge | Not Covered | Children up to end of the month age 19. Coverage is limited to 1 pair of glasses per 12 month period |
| | Dental check-up | Not Covered | Not Covered | Coverage is available through a stand-alone dental policy |

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 <u>excluded services</u> .) | | |
| <ul style="list-style-type: none"> Acupuncture Cosmetic surgery | <ul style="list-style-type: none"> Dental care (Adult) Elective Abortion Long-term care | <ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S Routine eye care (Adults) |
| 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.) | | |
| <ul style="list-style-type: none"> Bariatric surgery Chiropractic care | <ul style="list-style-type: none"> Hearing aids Infertility treatment | <ul style="list-style-type: none"> Private-duty nursing Routine foot care Weight loss programs |

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

Questions: Call 1-866-494-2111 or visit us at www.cigna.com/individuals-families/north-carolina-health-insurance-plans-2017

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- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-866-494-2111.
You may also contact your state insurance department at 1-800-662-7777.

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: North Carolina Department of Insurance at 1-800-662-7777. Additionally, a consumer assistance program can help you file your appeal, contact Health Insurance Smart NC at 1-855-408-1212.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-494-2111.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-494-2111.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-866-494-2111.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-866-494-2111.

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

Questions: Call 1-866-494-2111 or visit us at www.cigna.com/individuals-families/north-carolina-health-insurance-plans-2017

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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.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,890
- Patient pays \$650

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:

| | |
|----------------------|--------------|
| Deductibles | \$250 |
| Copays | \$20 |
| Coinsurance | \$350 |
| Limits or exclusions | \$30 |
| Total | \$650 |

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

- Amount owed to providers: \$5,400
- Plan pays \$4,800
- Patient pays \$600

Sample care costs:

| | |
|--------------------------------|----------------|
| Prescriptions | \$2,900 |
| Medical Equipment and Supplies | \$1,300 |
| Office Visits and Procedures | \$700 |
| Education | \$300 |
| Laboratory tests | \$100 |
| Vaccines, other preventive | \$100 |
| Total | \$5,400 |

Patient pays:

| | |
|----------------------|--------------|
| Deductibles | \$140 |
| Copays | \$180 |
| Coinsurance | \$0 |
| Limits or exclusions | \$280 |
| Total | \$600 |

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Questions and answers about the 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-of-pocket costs, such as **co-payments, deductibles, and co-insurance**. You should also 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.

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