Additional Resources

FAQ

The chart below outlines an example of the annual cost for a full-time employee with Employee Only coverage who does not use tobacco and only visits in-network providers. This example represents someone who sees a specialist on a regular basis, gets preventive visits, takes one generic medication, and has knee surgery during the plan year.

Annual Costs Example

	Cigna Open Access Plus Traditional PPO Health Plan	Cigna Choice Fund Open Access Plus HSA High-Deductible Health Plan
Annual Paycheck Contributions (Employee Only Coverage for a Non-Tobacco User)	$2,265 ($87.11 per paycheck)	$1,323 ($50.89 per paycheck)
1 Preventive Office Visit (average cost $150)	$0	$0
6 Office Visits (2 Primary Care visits and 4 Specialist visits)	$250 (Primary Care Physician: $25, Specialist: $50)	$894 (Average costs – Primary Care Physician: $119, Specialist: $164)
1x 30-day Generic Maintenance Drug per Month	$120 ($10 generic copay x 12 months)	$240 until deductible is met ($20 average cost x 12 months)
1 Knee Arthroscopy Procedure (approximation of $4,000 bundled rate, facility, physician, anesthesia)	$4,000 ($750 deductible and $614.80 coinsurance)	$4,000 ($866 deductible and $626.80 coinsurance)
Annual Colonial HSA Contribution	**N/A**	**+$500**
Total Employee Out-of-Pocket Expenses (including Contributions) – Non-Tobacco User	**$4,035**	**$3,449.80**

What Should I Consider Before Making Elections?

- Before making elections, learn more about your benefits by reviewing this Benefits Guide. You can also contact the Benefits Department with any questions.
- In the myCigna dashboard, review your 2022 and 2023 out-of-pocket health care and contribution costs and consider upcoming events, such as the birth of a child, which may impact your decision and help you estimate your costs for 2024.
- Consider your spouse's benefit options.

Why Do Preventive Care/Wellness Visits Sometimes Cost Money? Aren't They Covered 100% Under Both Medical Benefit Options?

Many in-network preventive care or wellness services are covered at 100% and are not subject to the deductible. The services that vary based on your age and gender may include, but are not limited to, routine physical exams for covered employees and dependents, routine mammograms, routine prostate screenings, and routine colorectal screenings. There are times, however, when a preventive care visit turns into a diagnostic visit and is, therefore, not covered at 100%. If your physician includes a diagnostic (instead of preventive) code on the paperwork submitted to Cigna, the diagnostic care benefits – and not the preventive care benefits – will apply. Please refer to your doctor should you have any questions concerning the coding of your claim.

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Balance Billing
Balance billing is when a provider bills you for the difference between the provider's charge and the contracted amount. For example, if the provider's charge is $100 and the Cigna contracted amount is $70, the provider may bill you for the remaining $30. However, if the provider is in Cigna's network, they cannot balance bill you. Contact Cigna if you believe that you are balance billed unfairly.

Coinsurance
Coinsurance is a health or dental care cost sharing between you and your insurance company.

Under both the Open Access Plan and the High-Deductible Health Plan, the coinsurance, after the deductible is met, is an 80/20 cost sharing. This means that Cigna will cover 80% of eligible medical expenses and you pay the remaining 20% up to an out-of-pocket maximum (see next page for out-of-pocket explanation). **Please note: the Open Access Plan has copays for medical office visits.**

Under the Cigna Dental PPO plan, the cost share split between Cigna and you for eligible expenses is 80/20 for basic services and 50/50 for major services. Please refer to your benefits summary to determine which services are considered basic or major.

Contracted or Negotiated Rates
A contract between an insurance company and a network of doctors, hospitals, urgent care centers, x-ray and lab facilities, and other providers to reduce the provider's normal rates.

Copayment or Copay (Open Access Plan)
A copayment or copay is a fixed amount for a covered service, paid by the patient to the provider of service before receiving the service. This is usually for an office visit, emergency room visit, urgent care visit, or inpatient admission.

Cost of Care – Ways to Save Money
This is the actual cost of the services, supplies, or prescriptions related to the delivery of health care. This is different from health expenses, which is the amount paid for the services regardless of cost. Log into myCigna.com or your myCigna App to find the lowest cost under your plan in your area.

Deductible
The amount you pay for covered health care services before your insurance plan starts to pay.

Dispense as Written
Cigna pharmacies will dispense generic prescriptions, which are a lower cost to you as a consumer, unless the physician marks the prescription as "dispense as written (DAW)." Prescriptions written as DAW will be filled as written and will not be substituted with a generic formula.

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. Examples of covered DME may include CPAP, oxygen equipment, wheelchairs, crutches, or blood testing strips for diabetics.

Excluded Services
Health care services that your health insurance or plan does not pay for or cover.

Medical Usual and Customary (U&C) Charge or Reasonable & Customary
The lower of the actual charge for the services or supplies, or the usual charge of most other doctors, dentists, or other providers of similar training or experience in the same geographic area for the same or similar services or supplies. The terms "reasonable, usual, and customary" refers to charges made by your health insurance provider for a given medical service. A charge is considered reasonable, usual, and customary if it matches the general prevailing cost of that service within your geographic area, which is calculated by your insurance company. Applies to non-network providers only.

Medically Necessary
Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, disease, or its symptoms, that meet accepted standards of medicine. If you have questions regarding services or supplies from your physician, please contact Cigna to verify coverage.

Network Providers
These are the facilities, providers, and suppliers that the insurance company has contracted with to provide health or dental care. Providers sign a contract with the insurance company to join the network and provide health or dental coverage at a reduced or contracted rate.

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Non-Preferred Provider
A provider who does not have a contract with your health insurer (Cigna) to provide services to you. You will pay additional fees in the form of out-of-pocket expenses and deductibles to see a non-preferred provider.

Out-of-Pocket Maximum
This is the maximum amount of your own money you will have to pay for eligible care during the year. The out-of-pocket maximum under both of Colonial's medical plans includes the sum of your deductible, coinsurance, and copayments up to the total dollar amount listed in your benefit summary. Bi-weekly premiums do not count toward your out-of-pocket limit.

Pharmacy Usual and Customary (U&C) Charge
The usual fee that a Pharmacy charges individuals for a Prescription Drug Product. This includes the charge for the dispensing fee and applicable sales tax.

Premium
The amount you pay out of your paycheck on a bi-weekly basis to have insurance coverage. This amount does not go toward your deductible with the plan nor is it deposited into your Health Savings Account or Flexible Spending Account. This is your premium contribution along with Colonial's portion to the insurance carrier for coverage. Currently, Colonial is funding approximately 80% of the Cigna premium for your health and dental coverage.

Primary Care Physician (PCP)
A primary care physician (PCP) is a physician who qualifies as a participating provider in general practice, internal medicine, family practice or pediatrics. Often your PCP is your first point of care for undiagnosed health concerns as well as yearly preventive care.

Specialist
A physician who has completed advanced education in a specific field of medicine, and provides specialized services such as Obstetrics/Gynecology, Orthopedic, Cardiologist, Otolaryngologist (Ear Nose & Throat), etc.

Step Therapy
Step therapy encourages you to try the most cost-effective and appropriate medications available to treat your condition. The practice begins with medication for a medical condition with the most cost-effective drug therapy and progresses to other more costly or risky therapies, only if necessary.

Preauthorization/Precertification/Prior Authorization
Cigna requires prior approval for inpatient admission (except emergency), along with certain outpatient surgical and non-surgical procedures such as MRI's, CT scans, durable medical equipment, speech therapy, and radiation. With precertification, you know in advance whether a procedure, treatment or service will be covered under your health care plan. Preauthorization helps ensure that you get the right care in the right setting and may save you from costly and unnecessary services. Failure to have your physician pre-certify any admissions, surgical procedures, test, x-rays, and other services, may result in a denial of the service.

Who is responsible for getting the precertification?
- **In-network services:** Your doctor is responsible.
- **Out-of-network services:** You're responsible. Before you choose an out-of-network provider, contact Cigna to verify if your service will be covered.

Urgent Care
A walk-in clinic to treat an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care. Check with Cigna to see which urgent care facilities are in Cigna's network.