Open Enrollment for Plan Year 2015

Presentation Questions and Answers

Medical Plan Q &A

There's still a little bit of confusion about how the deductibles work. Individual coverage is pretty straightforward. You have a $1500 in-network deductible, $3000 out of pocket maximum if you're in-network. Preventive care at 100%. Family coverage is a $3000 deductible. So if you have a spouse, or if you have a spouse and 10 kids, or if you have 3 kids, that's all considered family coverage and it is a combined deductible of $3000 for the entire family. So you do not owe $3000 for each member. It's for the entire group. The same is said for the $6000 out of pocket maximum. As long as you remain in-network, that's the amount for the entire family.

Q. Audience Member: So, just a question for the current year. So I reached the $3000 deductible a while ago, the little bar is all green (Denise: "You're in the elite club"), and so I thought, I haven't gotten to the $6,000 yet. So, after it got to the $3000, I thought something good is going to happen…but nothing changed.

> **Denise:** It should have.
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> **Audience Member:** Well, I didn't see any changes.
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> **Denise:** It should have. Once you got here, then the plan should be paying at 90% for your medical services. If you're doing pharmacy, if all you have is pharmacy and you have generic drugs, then you're not going to see a big difference, because the generic drugs are paid outside of the deductible. And they immediately get the benefit of the co-insurance. So, once you meet your deductible, you're still paying the same co-insurance, but it will add up to your out of pocket maximum which will then pay 100% for everything after the fact.
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> **Audience Member:** So the little green bar (on the website) doesn't tell me when it reached it. It's kind of hard to know. I want to analyze it to figure out whether or not this 90% promised land…
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> **Audience Member 2:** Yeah, you have to go back and look at your EOBs (Explanations of Benefits) to find out when they were processed, because they're not going to process in order. And I had a hospital claim that took four months to process, and so that, you know, put me over the $3000; but the stuff behind it, you know, by date of service didn't.
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> **Denise:** And it does depend on when it hit Cigna, not when the date of service was.
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> **Audience Member:** So do they retroactively refund?
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> **Denise:** It's whatever you…
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> **Audience Member:** I mean, if you've been paying out and suddenly they realize…

Audience Member 2: If you have a $4000 hospital bill and it takes five months to process, then you're way closer to the end of the year when you hit that $3000 limit and it's very annoying.

Audience Member: Yes.

Denise: Yes, so it does depend on when it hit Cigna to process, not when your date of service was. Now, if you have three or four bills that come in at the same time and process and you're in the mid-stream when you hit the deductible, which I've had happen twice, it does, the system does correct itself. It's just confusing because you don't know which one of those services, to your point, actually hit the $3000; but then I started seeing bills coming in at the 90%. So, you just have to look at your explanation of benefits cause it's based on that processing date. Yes, another question?

Audience Member 3: If you have $2000 of expenses for in-network, and $2000 of expenses for out of network, is that considered a $4000…?

Denise: Your deductible for out of network is actually $6000.

Audience Member 3: Yeah, but so what I'm saying is the expenses of out of network doctors don't count towards your total.

Denise: Yes, they do.

Audience Member 3: Oh they do?

Denise: They do.

Audience Member 2: Can you back up a slide? (to slide 8)

Denise: Sure, sure. I did at the bottom…your out of network costs do cross-accumulate to your in-network amounts. So if you have to go to an out of network physician, those costs are going to be more expensive because you're not getting the negotiated discounts. But, they will count towards your in-network deductible and out of pocket.

Audience Member 3: And if you have the option of going to an in-network, but you chose to go to an out of network, it's still the same?

Denise: It's still the same. It's still going to accumulate; it's just going to be more expensive.

Q. Audience Member 4: Two questions, one is about the mechanics, so how are the… out of pocket expenses tracked and in particular is it my responsibility to track or does Cigna actually track that through the billing process?

Denise: If it's going through Cigna, if you're using your Cigna card and its getting billed to them, they're tracking it.

Audience Member 4: The Cigna insurance?

Denise: That's correct. If you have expenses that are not going through Cigna insurance, it's not going to get tracked because it's not part of the medical plan. So vision expenses, dental expenses, pharmacy that you don't run through the plan, none of that's going to go toward your

deductible or out of pocket maximum. You can use the health savings account to pay for those things, but they're not going to hit the medical plan, so they don't get attributed to the deductible or out of pocket maximum.

Audience Member 4: So they never…?

Denise: No.

Audience Member 4: So, I can't send receipts in or whatever….?

Denise: It would have to be something that would process through the medical plan for it to be applicable.

Audience Member 2: Are you talking about out of network care?

Audience Member 4: I was talking about the mechanics of it. So you're saying that if it is processed through Cigna, they track my…

Denise: That's correct. If you have out of network care for medical services, that then, or even pharmacy and I'll talk about that in another slide, but if you have out of network medical care and that doctor says "I'm not submitting it to Cigna," you can submit it to Cigna. There's a claim form on MyCigna.com that allows you to do that and then it will go into the medical plan. Yes, so as long as a claim is filed with Cigna either by the provider or by you, and it's an eligible expense, it'll get tracked.

Audience Member 4: Another quick question; I think this is the case, but this is all on a calendar year basis?

Denise: That's right. Yes.

Q. Audience Member 5: I had a situation where I was at an in-network facility, using an in-network doctor, and while under anesthesia an out-of-network doctor came in and sent a bill that was through the roof. Does Cigna deal with that?

Denise: Linda, before your answer, Linda Trainham with Cigna is actually with us today; I got yelled at another site for not introducing her, and I'm sorry for not doing that today. She's in the back corner and she can actually answer that question…

Linda Trainham: Yes, if you're in the hospital and a radiologist or a pathologist or an anesthesiologist comes in and sees you, you have no control over those providers. You don't request them; they are just put into the hospital and its paid out of network. You need to call Cigna and we can get that taken care of. We're going to go ahead and pay it out of network because it will probably come to Cigna before the hospital bill gets to us, and we'll process it because it's out of network. And the claim is paid by the time we get the hospital bill, and we're not going to know to go back and reprocess it. So you'll need to call, or you'll let Denise know and she'll let me know, and I'll go back and have the claim reprocessed. If you have one that's like that come see me today and I'll get it taken care of for you…have it reprocessed at the in-network level of benefits.

Q. Audience Member 6: Could I follow-up on a question that John asked? So let's say that I had a procedure at a hospital that cost $3500. That bill didn't get to Cigna right away. I had another procedure two weeks later that cost $1000. Because when my provider puts in the claim or calls Cigna, they're going to say that I owe that $1000 because they don't know that I've met the deductible yet.

Denise: For purposes of Cigna, you haven't hit the deductible yet.

Audience Member 6: Exactly…I paid the $1000 because my doctor says I've got to have it, but then Cigna gets that $3000 bill and realizes that I've met the deductible. Am I going to get back that $1000 that I paid?

Denise: No, it's going to offset the second bill. It's going to take the $1000 off the second bill. You'll owe 100% of the $2000, and 90% of the $1000 for the second bill is what's going to happen.

Audience Member 6: I see what you're saying…

Denise: So it just breaks up the individual processing.

Linda: We can't control the way the providers send the bills in. It's whatever bills come into Cigna is how they're processed. Generally hospital bills come into us quickly. They want their money and those are usually the larger bills, and they're usually the first things we get. But anesthesiologists and radiologists, in-patient bills, they want their money quickly too. So they're pretty quick at sending them to us, and generally claims are processed fairly quickly. You know, within the time they're received, they're usually processed within seven to ten days.

Denise: So in that instance, it would just offset the second claim, so you'd get the benefit of it.

Q. Audience Member 7: So going back to the question about out of pocket expenses, so if I have dental care, of course is covered up to a certain limit, I have to pay a certain amount out of pocket, no question. So, can I submit that as a notification to Cigna?

Denise: No, because dental coverage is not provided through Cigna.

Audience Member 7: Oh, I see, so no dental expense?

Denise: Not unless you're having oral surgery that is associated with an injury or an illness; anything else is not.

Audience Member 2: And the dentist should be able to sort out what's a medical claim?

Denise: Correct.

Audience Member 7: But this was, no I mean vision not dental.

Denise: Exactly, if you have diabetes and you have glaucoma or you have a condition that requires a medical diagnosis for your vision, then that's going to go through Cigna. If you're just going in for your annual check-up, to make sure that your vision hasn't changed, that is not.

Audience Member 7: And the second question was about generic medication. Now the problem is I couldn't afford generic medication manufactured in the US. I just couldn't afford it, so I get it from Singapore. Is that claimable?

Denise: No, and I'll get to that in two slides; give me a minute.

Audience Member 7: But if I'd gone through the American system, it would have been as an out of pocket expense?

Denise: Yes.

Provider Payments Q & A

Q. Audience Member: How are we supposed to know when we are supposed to provide a payment to a provider up front?

Denise: You really shouldn't on a high-deductible plan, because you don't know what the negotiated rate is going to be. If they're insisting that you give them something, tell them that you have $20 and that's all you can have. They can't force you to pay at the time of service if you don't have a co-pay plan. They can say that's their policy, but you don't know what the negotiated rate is. They cannot overcharge you for medical expenses. So if they want something, give them $20, but don't pay the whole thing because they're going to owe you money. A medical provider is not going to be in a hurry to give you back money.

Audience Member: Well I'm already in that situation where they owe me money after insisting that I give them a copay.

Denise: So, just limit it to a small amount. Don't give them the whole thing.

Audience Member: It's situations like this where they want something that seems like a co-pay up front.

Denise: Right and like I said, if it's $10 or $20, you know your visit is going to be more than that, unless you've gotten into your 90% or 100%.

Audience Member: No, in this case it actually wasn't.

Denise: Right, so just try to limit it, because you're not on a co-pay plan. You don't know what the negotiated rate is, so if you're on a high-deductible plan they really can't tell you, you owe me $200 because they have a contracted rate and it may not be $200.

Linda: If you pay a provider, keep looking for your explanation of benefits to come in the mail to true-it-up. Make sure that if you paid them $20, make sure that when you get that EOB in the mail, you really owed them $20.

Audience Member: No, in this case I didn't owe them $20.

Linda: Well then you need to go back to the provider, send them this EOB and tell them "I paid you too much money, you owe me a refund."

Audience Member: Is there any good document we could bring, or any other strategy that would convince these providers, no I really don't have a co-pay?

Denise: Most providers understand, but there are some that just don't get that.

Linda: Tell them, "I've met my deductible; I only owe you 10% of the contracted amount."

Denise: Yes, they argue with you though, Linda.

Q. Audience Member 2: So, in principle, we don't ever have to pay them anything up front on a high-deductible plan, so we can absolutely refuse and say bill the insurance company?

Linda: Some doctors will refuse to treat you. I would pay them $5 and say "Look this is all I have today, I'll pay you this" you do what I can to get them to treat me. If you know your deductible is not met, you know you're going to owe some money, but remember you have your HSA card.

Denise: I have had both circumstances happen. I went to an urgent care facility where they said, "No its $180; you have to pay it." So I paid it with my HSA card. My EOB came back, and I said this is what you were supposed to charge me, and they credited back my HSA card. It was really easy. But then I've also had providers that were like, "Ok, you're on a high-deductible plan; we'll bill your insurance and let you know." It just depends. Some providers are very savvy and they understand how it works, other just have no clue. So, you just have to work with them to try to get them to understand you don't owe a co-pay, and until it runs through the insurance, you don't know what the amount is that you owe. But admittedly, there are some providers who are just going to say "No, you need to pay us something." So, make it as small as you can.

Q. **Audience Member 3:** I just want to make sure I understand what you were just saying; you're talking about the case where you've already met the deductible for the year, right?

Denise: Not in that case; I didn't meet the deductible.

Audience Member3: I thought if we haven't met the deductible, we have to pay 100%.

Denise: You do, but it's the contracted rate. So if that provider is an in-network provider, for instance in my urgent-care example, they charged me $180 at the visit. But it was only $76 through Cigna, so they owed me the difference of that, which they then credited back to my HSA. So that's the difference.

Audience Member 3. So, if you're in a situation where it's the spouse and you have an HRA rather than an HSA, the spouse can't pay using the card; so you have to just be careful.

Denise: Yes, and an HRA is a little different than an HSA.

Pharmacy Q &A

Q. Audience Member: So if I go and get a drug that my doctor ordered for me, am I supposed to file that with Cigna?

Denise: Not if it's an in-network pharmacy.

Audience Member: So Cigna automatically knows if they've gotten something?

Denise: Yes, they have contracts set up with retail pharmacies. Most of the retail pharmacies in Charlottesville are in-network, so you just have to go, you pick up your prescription, you run your HSA card and that's it.

Audience Member 2: CVS runs it through Cigna almost immediately when you drop off a prescription.

Audience Member: Well, I went to the doctor the other day and they sent a bill into Cigna, and it was the first time I had been all year to the doctor. So, it was like $86, and they said I've only met $86 towards my deductible. But I know I had some prescriptions previously in the year. Wouldn't that have counted?

Denise: It should have.

Linda: What the doctor was doing was a lot of doctors are hooked up to our medical system where they will look through and see if you have a high deductible plan. They will see if you've met your deductible, and a lot of them will make you pay whatever you owe at the point of service. And they probably had checked to see if you had met your deductible, and they could see that you hadn't met the deductible. The pharmacy does not show up on their medical system, what they can see, so they wouldn't see that. What they look at is not sophisticated enough for them to see.

Denise: Where you would see it is on MyCigna.com.

Linda: But Cigna would see that. We would know how much you've met on the backend. The pharmacy stuff is trued-up with your medical stuff bi-weekly.

Q. Audience Member: Will it still be the case that 90 day refills are only covered if they're bought through the Cigna online pharmacy?

Denise: Yes, that is the case, so that did not change.