HOW YOUR OUT-OF-NETWORK CLAIMS ARE PAID

Maximum reimbursable charge

Out-of-network care

Your health plan provides coverage for services from doctors and facilities that are not in your plan's network. But if you receive covered out-of-network care, your share of the costs (i.e., deductibles, copays or coinsurance) will usually be higher than if you receive those services in-network.

Maximum reimbursable charge

There's a limit to the amount your plan will pay for covered out-of-network services called the **maximum reimbursable charge** (MRC).

An out-of-network doctor or facility can bill you directly for any amount above your plan's MRC. This is often referred to as "balance billing." You will be responsible for paying that amount and these payments do not apply to your deductible or out-of-pocket maximum.

How is a maximum reimbursable charge determined?

A maximum reimbursable charge is based on the lesser of the normal charge for the service or a percentile of what other doctors or facilities in your area typically charge for the same service. These charges are based upon information from independent third-party databases.

Emergency care

Emergency services are covered at the in-network cost sharing level (i.e., deductibles, copays or coinsurance) even when you receive care from an out-of-network doctor or facility.

Before you choose out-of-network care

- **Know your coverage.** Make sure your health plan has out-of-network coverage. Know your deductible, copay or coinsurance amounts.
- **Know the cost.** Ask the doctor or facility about the cost of the services before you receive them.
- **Ask if the price is negotiable.** Some doctors and facilities are willing to negotiate charges.
- **Ask about setting up a payment schedule.** If you have a flexible spending account, you can also use it to help pay for eligible expenses.

See the next page for sample maximum reimbursable charge calculations. For complete details on how your plan determines maximum reimbursable charge, see your plan documents.

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Cost comparison: In-network vs. out-of-network

The examples below compare costs for typical services.[1]

DOCTOR OFFICE VISIT	IN-NETWORK	OUT-OF-NETWORK
Covered charges	Billed charge: $280 Cigna discounted charge: $170	$280
Maximum reimbursable charge under your plan	N/A	$280[3]
Amount above maximum reimbursable charge	N/A	$0
Your coinsurance obligation[2]	20% of $170 = $34	40% of $280 = $112
Your total cost	**$34**	**$112**

OUTPATIENT SERVICES	IN-NETWORK	OUT-OF-NETWORK
Covered outpatient facility charges	Billed charge: $7,740 Cigna discounted charge: $2,740	$7,740
Maximum reimbursable charge under your plan	N/A	$7,740[3]
Amount above maximum reimbursable charge	N/A	$0
Your coinsurance obligation[2]	20% of $2,740 = $548	40% of $7,740 = $3,096
Your total cost	**$548**	**$3,096**

INPATIENT SERVICES	IN-NETWORK	OUT-OF-NETWORK
Covered hospital charges	Billed charge: $13,628 Cigna discounted charge: $6,815	$13,628
Maximum reimbursable charge under your plan	N/A	$13,628[3]
Amount above maximum reimbursable charge	N/A	$0
Your coinsurance obligation[2]	20% of $6,815 = $1,363	40% of $13,628 = $5,451
Your total cost	**$1,363**	**$5,451**

1. This is an example used for illustrative purposes only. It assumes plan deductibles have been met. Actual covered charges and out-of-pocket costs will vary by plan. Refer to your plan documents or call the number on your Cigna ID card for details about your specific health plan.

2. Assumes coinsurance of 20% for in-network services and 40% for out-of-network services.

3. The covered charges billed by the out-of-network doctor or facility are less than the maximum reimbursable charge, therefore the MRC is set equal to the covered charge amount.

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