

GET TO KNOW YOUR MEDICAL PLAN

Cigna Access HSA Silver 2750 | 2016 Summary of Benefits

Why Choose Cigna?

Cigna's Individual and Family insurance plans are designed to work with your needs and your budget, offering a range of coverage options, quality care and helpful, easy-to-use tools and services. All of our plans offer:

- › Coverage options to give you choices, so you can find what works best for you.
- › Affordable premiums and lower negotiated rates to help keep your costs down.
- › 100% coverage for in-network preventive care¹ to help keep you healthy and well.
- › A network of quality providers in your local area. Plus, access to care both in- and out-of-network.
- › 24/7 customer service to answer questions on your health care needs, providers, or claims – speaking in plain, simple language.
- › Tools and services to help make it easy for you to select plans and doctors, and predict costs.

See if you can save money with a subsidy

- › If you qualify, tax credit subsidies can reduce your monthly premium. You may also qualify for a cost-sharing reduction subsidy to reduce the amount you pay out-of-pocket when you get care – such as copays or coinsurance.
- › If your household size and income falls within a certain range, you'll save on monthly premium and out-of-pocket costs.² The lower your income and greater your household size is within these ranges, the more you'll save.
- › To see if you're eligible, call 866.494.2111.

2. Subsidies may only be applied to a Qualified Health Plan (QHP) purchased on the Marketplace. Customers must select a Silver level Marketplace QHP to take advantage of cost-sharing reduction subsidies. View the [Summary of Benefits and Coverage](#) for the cost-sharing subsidies that may apply to you.

Our Networks: it's about quality and savings

The Cigna Open Access Plus (OAP) Network provides access to health care professionals nationwide. Some of the quality health care professionals in the network are further recognized with the Cigna Care Designation for their quality and cost effective care.

When you receive care from a health care professional or hospital in the OAP Network, the visit is considered in-network which helps you save by getting access to the lower rates that we've negotiated with providers in the network. You have the freedom to see any healthcare professional in the network with no referral required. You can also seek care outside of our network, but you'll save more when you stay in-network.

To find a doctor in our network, visit Cigna.com/ifp-providers.

1. Some preventive care services may not be covered, including immunizations for travel. Refer to your policy for a complete listing of covered and non-covered services.

Contact your local broker or a licensed Cigna agent at [866.Get.Cigna](tel:866.Get.Cigna) or visit Cigna.com to learn more.

Together, all the way.®



This plan is available statewide for residents living in Maryland.

This Health Savings Plan can be paired with a tax-advantaged Health Savings Account (HSA).*

| MEDICAL BENEFIT | Cigna Access HSA Silver 2750 | |
|--|------------------------------|------------------------------|
| | IN-NETWORK | OUT-OF-NETWORK |
| Individual Deductible (Medical and pharmacy) | \$2,750 | \$12,500 |
| Family Deductible (Medical and pharmacy) | \$5,500 | \$25,000 |
| Individual/family deductible is satisfied when each member has reached their annual individual deductible or when the total annual family deductible amount has been reached by any combination of family members. | | |
| Coinsurance** | You pay 15% after deductible | You pay 35% after deductible |
| Individual Out-of-Pocket Maximum | \$6,200 | \$25,000 |
| Family Out-of-Pocket Maximum | \$12,400 | \$50,000 |

Individual/family copays, deductibles, coinsurance and pharmacy charges apply to the out-of-pocket maximum.

PHYSICIAN SERVICES

| | | |
|--|------------------------------|------------------------------|
| Primary Care Physician (Office visit) | You pay 15% after deductible | You pay 35% after deductible |
| Specialist Physician (Office visit) | You pay 15% after deductible | You pay 35% after deductible |
| Office Related Services | You pay 15% after deductible | You pay 35% after deductible |

PREVENTIVE CARE

| | | |
|--|-------------------------------|------------------------------|
| Preventive Care for All Ages (Routine physicals and other preventive services) | You pay 0%, deductible waived | You pay 20% after deductible |
|--|-------------------------------|------------------------------|

INPATIENT SERVICES

| | | |
|---|------------------------------|------------------------------|
| Facility Services (Inpatient room and board, lab & x-ray, operating room, etc.) | You pay 15% after deductible | You pay 35% after deductible |
| Physician Services | You pay 15% after deductible | You pay 35% after deductible |

MATERNITY CARE

| | | |
|---|------------------------------|------------------------------|
| Prenatal and Postnatal Care | You pay 15% after deductible | You pay 35% after deductible |
| Delivery and Inpatient Services for Maternity Care | You pay 15% after deductible | You pay 35% after deductible |

*HSA contributions and earnings are not subject to federal taxes and not subject to state taxes in most states. If HSA funds are used for anything other than IRS "Qualified Medical Expenses," the amount will be subject to income tax and will be subject to a 20% penalty prior to you reaching age 65.

**Amount you pay for covered medical services. Out-of-network you may pay more, if the provider's charges exceed the amount Cigna reimburses for billed services.

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MEDICAL BENEFIT

IN-NETWORK

OUT-OF-NETWORK

OUTPATIENT SERVICES

| | | |
|--|------------------------------|------------------------------|
| Lab, X-ray and Ultrasound | You pay 15% after deductible | You pay 35% after deductible |
| CT/PET Scans and MRI | You pay 15% after deductible | You pay 35% after deductible |
| Cardiac & Pulmonary Rehabilitation Calendar year maximum of 36 visits, combined in- and out-of-network | You pay 15% after deductible | You pay 35% after deductible |
| Rehabilitative Services 30 visits per condition per contract year for each therapy (physical therapy, speech therapy, and occupational therapy); 20 visits per condition per contract year for chiropractic care. Visit limit does not apply to otological, audiological, and speech/ language treatment for cleft lip or cleft palate, or both. | You pay 15% after deductible | You pay 35% after deductible |
| Outpatient Surgery (Facility) | You pay 15% after deductible | You pay 35% after deductible |
| Outpatient Surgery (Physician services) | You pay 15% after deductible | You pay 35% after deductible |
| Acupuncture | You pay 15% after deductible | You pay 35% after deductible |

EMERGENCY AND URGENT CARE SERVICES

| | | |
|--------------------------------|------------------------------|---|
| Hospital Emergency Room | You pay 15% after deductible | You pay the same level as in-network if it is an emergency as defined by the plan, otherwise you pay 35% after deductible |
| Urgent Care Services | You pay 15% after deductible | You pay the same level as in-network if it is an emergency as defined by the plan, otherwise you pay 35% after deductible |
| Ambulance | You pay 15% after deductible | You pay the same level as in-network if it is an emergency as defined by the plan, otherwise you pay 35% after deductible |

OTHER HEALTH CARE FACILITIES AND SERVICES

| | | |
|---|------------------------------|------------------------------|
| Skilled Nursing Facility Calendar year maximum of 90 days, combined in- and out-of-network. | You pay 15% after deductible | You pay 35% after deductible |
| Home Health Calendar year maximum of 100 days, combined in- and out-of-network. | You pay 15% after deductible | You pay 35% after deductible |
| Hospice | You pay 15% after deductible | You pay 35% after deductible |

DURABLE MEDICAL EQUIPMENT (DME)

| | | |
|----------------------------------|------------------------------|------------------------------|
| Durable Medical Equipment | You pay 15% after deductible | You pay 35% after deductible |
|----------------------------------|------------------------------|------------------------------|

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MEDICAL BENEFIT

IN-NETWORK

OUT-OF-NETWORK

MENTAL HEALTH & SUBSTANCE USE

| | IN-NETWORK | OUT-OF-NETWORK |
|--|------------------------------|------------------------------|
| Inpatient (Includes acute, partial & residential treatment) | You pay 15% after deductible | You pay 35% after deductible |
| Outpatient (Includes individual, group & intensive outpatient treatment) | You pay 15% after deductible | You pay 35% after deductible |

PRESCRIPTION DRUGS (RETAIL & HOME DELIVERY)

IN-NETWORK

OUT-OF-NETWORK

To see a complete list of drugs covered under your plan, visit Cigna.com/ifp-drug-list

PRESCRIPTIONS FILLED AT RETAIL

| | IN-NETWORK | OUT-OF-NETWORK |
|---|--------------------------------------|------------------------------|
| TIER 1: Retail Preferred Generics (Available at the lowest cost) Up to a 90 day supply | You pay 15% after deductible | You pay 35% after deductible |
| TIER 2: Retail Non-preferred Generics (Medications at a higher cost than Tier 1) Up to a 90 day supply | You pay 15% after deductible | You pay 35% after deductible |
| TIER 3: Retail Preferred Brands (Brand-name drugs at a lower cost than Tier 4) Up to a 90 day supply | You pay 15% after deductible | You pay 35% after deductible |
| TIER 4: Retail Non-preferred Brands (A mix of non-preferred brand-name and generic drugs at a higher cost than Tier 2 and Tier 3) Up to a 90 day supply | You pay 50% after deductible | You pay 50% after deductible |
| TIER 5: Retail Specialty (Drugs for complex chronic conditions) Up to a 90 day supply. A copay for each 30 day supply will be applied | You pay \$150 copay after deductible | You pay 20% after deductible |

PRESCRIPTIONS FILLED THROUGH HOME DELIVERY

| | IN-NETWORK | OUT-OF-NETWORK |
|--|--------------------------------------|------------------------------|
| TIER 1: Home Delivery Preferred Generics (Available at the lowest cost) Up to a 90 day supply | You pay 15% after deductible | You pay 35% after deductible |
| TIER 2: Home Delivery Non-preferred Generics (Medications at a higher cost than Tier 1) Up to a 90 day supply | You pay 15% after deductible | You pay 35% after deductible |
| TIER 3: Home Delivery Preferred Brands (Brand-name drugs at a lower cost than Tier 4) Up to a 90 day supply | You pay 15% after deductible | You pay 35% after deductible |
| TIER 4: Home Delivery Non-preferred Brands (A mix of non-preferred brand-name and generic drugs at a higher cost than Tier 3) Up to a 90 day supply | You pay 50% after deductible | You pay 50% after deductible |
| TIER 5: Home Delivery Specialty (Drugs for complex chronic conditions) Up to a 30 day supply | You pay \$450 copay after deductible | You pay 20% after deductible |

This summary contains highlights only.

UNDERSTANDING THE TOTAL COST OF YOUR CARE

Here are some basic terms that may be used to explain the costs of your health care plan.

- › **Premium**
Amount you pay monthly for your health insurance plan.
- › **Annual out-of-pocket maximum**
Maximum dollar amount you pay per calendar year for covered medical services. Copays, deductibles, and pharmacy charges apply to the out-of-pocket maximum.
- › **Coinsurance**
In-network: Amount you pay for covered medical services after you have satisfied the annual deductible.
Out-of-network: Amount you pay for covered medical services after you have satisfied the annual out-of-network deductible. You may pay more if the provider's charges exceed the amount Cigna reimburses for billed services.
- › **Copayment (copay)**
A flat fee you pay toward services such as doctor visits or prescriptions.
- › **Annual Deductible**
The amount you pay each year before Cigna begins to pay for covered services.
- › **Tax credit subsidies**
If you qualify and enroll in a Marketplace Qualified Health Plan (QHP),¹ tax credit subsidies can reduce your monthly premium payments. All or a portion of the subsidy can be applied to your premium. Subsidies are based on certain household size and income requirements.
- › **Cost-sharing reductions²**
Reduce the amount you pay out-of-pocket when you get care — such as copays or coinsurance. Subsidies are based on household size and certain income requirements, and may be available in addition to tax credit subsidies.

¹ Tax Credit subsidies can only be applied to the purchase of a Marketplace QHP.

² Customers must select a Silver level Marketplace QHP to take advantage of cost-sharing reduction subsidies.

For more information or to find in-network doctors:

See the Open Access Plus Network flyer
Visit **Cigna.com/ifp-providers**.
Call **866.494.2111**.

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2016 PLAN EXCLUSIONS AND LIMITATIONS

What Is Not Covered By This Policy

Excluded Services

In addition to any other exclusions and limitations described in this Policy, there are no benefits provided for the following:

- › Services or supplies that are not **Medically Necessary**.
- › Services performed or prescribed under the direction of **a person who is not a licensed health care practitioner**.
- › Services that are **beyond the scope of practice** of the Provider performing the service.
- › Any **services for which payment may be obtained from any local, state or federal government agency** (except Medicaid). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.
- › Services **for which You have no legal obligation to pay** or for which no charge would be made if You did not have health plan or insurance coverage.
- › **The purchase, examination or fitting of eyeglasses or contact lenses**, except for aphakic patients and also for rigid gas permeable lenses or sclera shells intended for use in the treatment of a disease or injury; this exclusion does not apply to Pediatric Vision benefits.
- › **Personal care services** and domiciliary care services
- › Services **rendered by a health care practitioner who is an Insured Person's spouse, mother, father, daughter, son, brother, or sister**
- › Services or supplies that are considered to be for **Experimental Procedures or Investigative Procedures**.
- › An **eye surgery** that is **not Medically Necessary**.
- › Services to **reverse a voluntary sterilization** procedure;
- › Services for sterilization or reverse sterilization **for a dependent minor**; this exclusion will not apply to FDA-approved sterilization procedures for women with reproductive capacity.
- › Services primarily for **weight reduction or treatment of obesity including morbid obesity**, or any care which involves weight reduction as a main method for treatment except as otherwise specifically stated in this Policy.
- › Services **received before the Effective Date of coverage**.
- › Services **received after coverage under this Policy ends**, including any extension of benefits.
- › **Cosmetic surgery** or other services for beautification, to improve or alter appearance or self-esteem or to treat psychological or psychosocial complaints regarding one's appearance including macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty/ panniculectomy; rhinoplasty. This exclusion does not apply to Reconstructive Surgery to restore a bodily function or to correct a deformity caused by Injury or congenital defect of a Newborn child, or for Medically Necessary Reconstructive Surgery performed to restore symmetry incident to a mastectomy or lumpectomy.
- › Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, **under any workers' compensation, employer's liability law or occupational disease law**, to the extent the Insured Person is required to be covered by a workers' compensation law.
- › Services rendered from a **dental or medical department maintained by or on behalf of an employer**, mutual benefit association, labor union, trust, or similar persons or groups.
- › **Items which are furnished primarily for personal comfort or convenience** (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for hygiene or beautification, including cranial prostheses, etc.).
- › Charges for **Telephone consultations, failure to keep a scheduled appointment, or for completion of any form**.
- › Inpatient room and board **charges in connection with a Hospital stay primarily for diagnostic tests** which could have been performed safely on an outpatient basis.
- › Purchase, examination or fitting of **Hearing aids** and supplies including but not limited to semi-implantable hearing devices, audient bone conductors and Bone Anchored Hearing Aids (BAHAs), except as specifically stated in this Policy. For the purposes of this exclusion, a hearing aid is any device that amplifies sound.
- › Except for covered ambulance services or as otherwise stated in this Policy, **travel**, whether or not recommended by a health care practitioner;
- › Any **services received while the covered person is outside the United States** except for emergency services.
- › **Immunizations related to foreign travel**.
- › Unless otherwise specified in this Plan, **dental work or treatment** which includes hospital or professional care in connection with:
 - The operation or treatment for the fitting or wearing of dentures,
 - Orthodontic care or malocclusion,
 - Operations on or for the treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or treatment of injury to natural teeth due to an accident if the treatment is received within 6 months of the accident;
 - Dental implants - Dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants
- › **Accidents occurring while** and as a result of **chewing**; this exclusion does not apply to Pediatric Dental benefits.
- › **Routine foot care** including the cutting or removal of corns or calluses; the trimming of nails, unless the services are determined to be Medically Necessary.
- › **Orthopedic shoes** (except when joined to braces), arch supports, shoe inserts, foot orthotic devices.
- › **Inpatient admissions primarily for physical therapy**, unless authorized by Cigna.

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2016 PLAN EXCLUSIONS AND LIMITATIONS

- › **Treatment of sexual dysfunction**, impotence and/or inadequacy except if this is a result of an Accidental Injury, organic cause, trauma, infection, or congenital disease or anomalies.
- › Services that duplicate benefits provided under federal, State or local laws, regulations or programs;
- › Charges for **animal to human organ transplants**.
- › Fees for **non-replacement** of blood and blood products; associated with the **collection or donation of blood or blood products**, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- › **Lifestyle improvements, nutritional counseling or food supplements**, except as stated in this Policy, physical fitness programs.
- › **Wigs or cranial prosthetics**, except as specifically stated in this Policy.
- › **Weekend admission charges**, except for emergencies and maternity, unless authorized by Cigna.
- › Outpatient orthomolecular therapy, including nutrients, vitamins and food supplements.
- › Services resulting from **accidental bodily injuries arising out of a motor vehicle accident** to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
- › Any services required by state or federal law to be supplied by a public school system, school district or other public institutions.
- › Treatment for mental health or substance abuse not authorized by Cigna through its managed care system, or a mental health or substance abuse condition determined by Cigna through its managed care system to be untreatable.
- › Any **amounts in excess of maximum amounts of Covered Expenses** stated in this Policy.
- › Services **not specifically listed as Covered Services** in this Policy.

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2016 PLAN IMPORTANT DISCLOSURES

Rates will vary by plan design and the plan deductible, copay, coinsurance and out-of-pocket maximums selected. Rates may vary based on age, family size, geographic location (residential zip code).

Rates for new medical policies with an effective date on or after 01/01/2016 are guaranteed through 12/31/2016. After the initial guarantee, rates are subject to change upon 45 days notice.

This medical insurance policy (MDINDCH012016) has exclusions, limitations, reduction of benefits and terms under which the policy may be continued in force or discontinued. Applications are accepted during annual open enrollment period, or within 60 calendar days of a qualifying life event. Benefits are provided only for those services that are medically necessary as defined in the policy and for which the insured person has benefits. The policy/service agreement may be cancelled by Cigna due to failure to pay premium, fraud, ineligibility, when the insured no longer lives in the service area, or when we cease to offer policies of this type or cease to offer any plans in the individual market in the state, in accordance with applicable law. You may cancel the policy/service agreement, on the first of the month following our receipt of your written notice. We reserve the right to modify the policy/service agreement, including plan provisions, benefits and coverages, consistent with state or federal law. Policies/service agreements renew on a calendar year basis.

Cigna does not intentionally discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

For costs, and additional details about coverage, contact Cigna at 900 Cottage Grove Rd., Hartford, CT 06152 or call 866.GET.Cigna. (866.438.2446).

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IMPORTANT PLAN INFORMATION

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at **866.494.2111**.

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al **866.494.2111**.

