

GET TO KNOW YOUR MEDICAL PLAN

Cigna Connect 2500 | 2017 Summary of Benefits

Why Choose Cigna?

A health plan and partner

When you choose Cigna, you get more than a health plan. You also get a trusted partner who can help you select the plan that's right for you and help you get the most out of your plan. So, you get a good choice and a good value. Cigna's committed to helping you live well and stay well – at an affordable price.

Cigna's Individual and Family health insurance plans offer:

- **Help explaining your plan options before you buy.** Online, you will find detailed coverage information and tools that can help you choose a plan. You can also talk to a licensed representative who will walk you through the shopping process, provide coverage details and help you get the most out of your plan.
- **Help finding quality doctors near you.** Just use our online provider directory or speak to a customer service representative 24 hours a day, 7 days a week, 365 days a year.
- Affordable rates and you can save even more if you qualify for financial assistance.
- **Plans with \$0 copay** for your first 3 visits with your primary care doctor.
- **Preventive care coverage, at no additional cost to you.** All plans include annual check-ups, flu shots, cholesterol and blood pressure screenings, when you see an in-network doctor.¹
- **Easy access to doctors.** Talk with a doctor by phone or secure video chat using the Cigna Telehealth

Connection program. Your out-of-pocket cost is the same or less than a Primary Care Provider (PCP) visit as outlined in the Cigna Telehealth Connection Benefits grid. Get treatment for minor acute conditions like sinus and ear infections, allergies or pink eye, day or night, while at home, work, on the go or when you are traveling.²

- **Health advice and wellness coaching from WebMD®.** We've partnered with one of the most trusted online sources to provide health coaching through *My Health Assistant*. Reach your health and wellness goals with a customized online program.

Plan availability

This plan is available to residents living in the following counties in Illinois:

Cook	Kane	Will
DuPage	Kankakee	

1. Includes eligible in-network preventive care services. Some preventive care services may not be covered, including most immunizations for travel. Reference your plan documents for a list of covered and non-covered preventive care services. 2. Telehealth providers participating in the Cigna Telehealth Connection program are independent contractors and separate from Plan network providers. Not all providers have video chat capabilities. Video chat is not available in all areas. PCP referral is not required. Refer to plan documents for a complete description of covered services, including other telehealth/telemedicine benefits.

Contact your local broker or a licensed Cigna agent at **866.Get.Cigna** or visit **Cigna.com** to learn more. If you are an existing Cigna medical plan customer, Customer call **800.Cigna.30**.

Together, all the way.®



You may be able to save money with Federal financial assistance

Depending on your household size and income, you may qualify for a “premium tax credit” that lowers your monthly premium. This tax credit (subsidy) can be used with this plan to help you reduce your plan premium or you can choose to get money back when you file your taxes. You may also qualify for a ‘cost-sharing reduction’ which will reduce your out-of-pocket costs when you get care during the year. Call **866.Get.Cigna** and we will help to see if you may qualify. Current Cigna health plan customers, please call **800.Cigna.30**.

Your Cigna Connect plan.

Our Networks: it’s about quality and savings

Cigna’s Connect health insurance plans are designed to provide you with quality care. You have access to personalized care and attention from providers in the Connect Network in your local area. Some of the health care professionals in our Network have separately earned the Cigna Care Designation (CCD), recognized for achieving top results on Cigna quality and cost-efficiency measures. Find providers with this designation at **Cigna.com/ifp-providers**.

How it works

Simply choose your in-network primary care physician (PCP)¹ who will get to know your needs, direct you to specialists when needed,² and ensure that your providers are communicating and coordinating your care.

You will have access to quality care in your local area, including Presence Health.

For more network information check out our [Important Medical Plan Information flyer](#) or call the number indicated at the bottom of page one. Visit **Cigna.com/ifp-providers** to find providers in the Connect network.

Details at a glance.

	IMPORTANT INFORMATION ABOUT YOUR PLAN
Network name	Connect Network
Plan type	Health Maintenance Organization (HMO)
To remain in-network:	
Primary care physician (PCP)	Visit an in-network PCP. PCP selection is required. ¹
Specialist physician	Visit specialists in the Connect Network. Referral is required by a PCP ²
Out-of-network coverage	Out-of-network benefits are <i>not</i> covered under this plan.
In the case of an emergency	Emergency care is covered, in- and out-of-network. ³
When traveling (away from home care)	Covered for emergency medical services as defined by the policy. Telehealth benefits are available for minor acute care on the phone or via secure video chat anywhere, anytime. ⁴
Additional network information	Important Plan Information Flyer
To find providers in-network visit	Cigna.com/ifp-providers

1. For children, you may select a participating pediatrician as the PCP. See policy for more information on selecting a PCP.

2. Females can obtain services for obstetrical or gynecological care from a participating provider without a referral from their PCP. See policy for this and other exceptions to the referral process.

3. Eligible out-of-network emergency services are covered at the in-network benefit level as defined in plan documents.

4. Telehealth providers participating in the Cigna Telehealth Connection program are independent contractors and separate from Plan network providers. Not all providers have video chat capabilities. Video chat is not available in all areas. PCP referral is not required. Refer to plan documents for a complete description of covered services, including other telehealth/telemedicine benefits.

Your Cigna Telehealth Connection Benefits

Cigna Telehealth Connection benefits are included with the purchase of a medical plan. The program provides you access to telehealth providers via phone or secure video chat, when you need them: at home, work, on the go or when traveling.¹

- Use the benefits for minor acute conditions like allergies, cold, flu, ear infections, fever, headache and a sore throat
- You don't have to worry about traveling to the doctor's office for these minor conditions
- For minor acute conditions, your out-of-pocket costs are the same or less than a primary care physician (PCP) visit, depending on the plan when using these benefits
- Providers that you will talk with are U.S. based and board certified
- Providers participating in the program can be found on **myCigna.com** on the *Find a Doctor* page.

CIGNA TELEHEALTH CONNECTION BENEFITS¹

You pay \$0, deductible waived

Information can be found on the [Cigna Telehealth Connection Flyer](#)

1. Telehealth providers participating in the Cigna Telehealth Connection program are independent contractors and separate from Plan network providers. Not all providers have video chat capabilities. Video chat is not available in all areas. PCP referral is not required. Refer to plan documents for a complete description of covered services, including other telehealth/telemedicine benefits.

This HMO plan is available to residents in parts of Illinois, depending on county. Please see first page for full listing.
 This plan does not provide out-of-network benefits, except for emergency services as defined by the plan.

MEDICAL BENEFIT	Cigna Connect 2500	
	IN-NETWORK	OUT-OF-NETWORK
Individual Deductible (Medical and pharmacy)	\$2,500	Not covered
Family Deductible (Medical and pharmacy)	\$5,000	Not covered
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 30% after deductible	Not covered
Individual Out-of-Pocket Maximum	\$7,150	Not covered
Family Out-of-Pocket Maximum	\$14,300	Not covered

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

PHYSICIAN SERVICES

Primary Care Physician (Office visit)	You pay \$0 for visits 1, 2 & 3, deductible waived. You pay 30% after deductible for additional visits.	Not covered
Specialist Physician (Office visit)	You pay 30% after deductible	Not covered
Office Related Services	You pay 30% after deductible	Not covered

PREVENTIVE CARE

Preventive Care for All Ages (Routine physicals and other preventive services)	You pay 0%, deductible waived	Not covered
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INPATIENT SERVICES

Facility Services (Inpatient room and board, lab & x-ray, operating room, etc.)	You pay 30% after deductible	Not covered
Physician Services	You pay 30% after deductible	Not covered

MATERNITY CARE

Prenatal and Postnatal Care (If a mother and newborn are discharged prior to 48 or 96 hours after delivery, one post-discharge home or office visit is covered within 48 hours. Additional visits may be covered if determined medically necessary.)	You pay 30% after deductible	Not covered
Delivery and Inpatient Services for Maternity Care (Facility/Physicians Services unless otherwise noted)	You pay 30% after deductible	Not covered

* Amount you pay for covered medical services.

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MEDICAL BENEFIT	IN-NETWORK	OUT-OF-NETWORK
OUTPATIENT SERVICES		
Lab, X-ray and Ultrasound	You pay 30% after deductible	Not covered
CT/PET Scans and MRI	You pay 30% after deductible	Not covered
Cardiac & Pulmonary Rehabilitation Cardiac: Limited to a maximum of 36 Outpatient treatment sessions within a six month period.	You pay 30% after deductible	Not covered
Rehabilitative Services Including Physical, Occupational and Speech Therapy and medically necessary preventive physical therapy for multiple sclerosis. 25 visits per year for chiropractic care.	You pay 30% after deductible	Not covered
Outpatient Surgery (Facility)	You pay 30% after deductible	Not covered
Outpatient Surgery (Physician Services)	You pay 30% after deductible	Not covered
Acupuncture	Not covered	Not covered
EMERGENCY AND URGENT CARE SERVICES		
Hospital Emergency Room	You pay 30% after deductible	You pay the same level as in-network if it is an emergency as defined in your plan, otherwise you pay 100%
Urgent Care Services	You pay \$75 per visit copay, deductible waived	You pay the same level as in-network if it is an emergency as defined in your plan, otherwise you pay 100%
Ambulance	You pay 30% after deductible	You pay the same level as in-network if it is an emergency as defined in your plan, otherwise you pay 100%
OTHER HEALTH CARE FACILITIES AND SERVICES		
Skilled Nursing Facility Includes rehab hospital and sub-acute facilities.	You pay 30% after deductible	Not covered
Home Health	You pay 30% after deductible	Not covered
Hospice	You pay 30% after deductible	Not covered
DURABLE MEDICAL EQUIPMENT (DME)		
Durable Medical Equipment	You pay 30% after deductible	Not covered

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MEDICAL BENEFIT	IN-NETWORK	OUT-OF-NETWORK
MENTAL HEALTH & SUBSTANCE ABUSE		
Inpatient (Includes acute, partial & residential treatment)	You pay 30% after deductible	Not covered
Outpatient (Office visits)	You pay 30% after deductible	Not covered
Outpatient (All other services)	You pay 30% after deductible	Not covered

PRESCRIPTION DRUGS (RETAIL & HOME DELIVERY)	IN-NETWORK	OUT-OF-NETWORK
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To see a complete list of drugs covered under your plan, visit Cigna.com/ifp-drug-list

PRESCRIPTIONS FILLED AT RETAIL

TIER 1: Retail Preferred Generics (Available at the lowest cost) 30 day supply – at any Participating Pharmacy. Up to a 90 day supply – at a Designated 90 day Pharmacy. You pay copay for each 30 day supply.	You pay \$10, deductible waived	Not covered
TIER 2: Retail Non-preferred Generics (Medications at a higher cost than Tier 1) 30 day supply – at any Participating Pharmacy. Up to a 90 day supply – at a Designated 90 day Pharmacy. You pay copay for each 30 day supply.	You pay \$25, deductible waived	Not covered
TIER 3: Retail Preferred Brands (Brand-name drugs at a lower cost than Tier 4) 30 day supply – at any Participating Pharmacy. Up to a 90 day supply – at a Designated 90 day Pharmacy. You pay copay for each 30 day supply.	You pay \$60, deductible waived	Not covered
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) 30 day supply – at any Participating Pharmacy. Up to a 90 day supply – at a Designated 90 day Pharmacy.	You pay 50% after deductible	Not covered
TIER 5: Retail Specialty (Drugs for complex chronic conditions) 30 day supply – at any Participating Pharmacy. Up to a 90 day supply – at a Designated 90 day Pharmacy.	You pay 30%, deductible waived	Not covered

PRESCRIPTIONS FILLED THROUGH HOME DELIVERY

TIER 1: Home Delivery Preferred Generics (Available at the lowest cost) Up to a 90 day supply	You pay \$30, deductible waived	Not covered
TIER 2: Home Delivery Non-preferred Generics (Medications at a higher cost than Tier 1) Up to a 90 day supply	You pay \$75, deductible waived	Not covered
TIER 3: Home Delivery Preferred Brands (Brand-name drugs at a lower cost than Tier 4) Up to a 90 day supply	You pay \$180, deductible waived	Not covered
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	Not covered
TIER 5: Home Delivery Specialty (Drugs for complex chronic conditions) Up to a 90 day supply.	You pay 30%, deductible waived	Not covered

Pediatric Coverage
Dental

The Cigna Pediatric Dental Plan is included with the purchase of a Cigna Medical plan off Marketplace and covers dependents up to age 19.¹

When purchasing a Cigna Medical plan on the Marketplace, the Cigna Pediatric Dental plan is not included.

Pediatric Dental	Coverage information for the Cigna Dental Pediatric plan can be found on the <u>Pediatric Dental Summary of Benefits</u> .
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Vision

The Pediatric Vision plan is included with the purchase of a medical plan and covers dependents up to age 19.¹

BENEFITS		IN-NETWORK	OUT-OF-NETWORK
Pediatric Vision	Comprehensive eye exam with refraction for children Limit 1 visit per 12 month period.	You pay 0%, deductible waived	Not covered
	Eye glasses for children Limited to 1 pair of glasses (lenses and frames from pediatric selection) per 12 month period.		
	Therapeutic contact lenses for children Contact lenses are covered for a one year supply, regardless of the contact lens type, including professional services, in lieu of frame and lenses.		

This summary contains highlights only. See Pediatric Dental and Pediatric Vision policies for Exclusions and Limitations.

For more information about Pediatric coverage call the number on the bottom of the first page.

1. Pediatric dental and vision coverage continues through the end of the calendar year in which the dependent turns age 19.

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2017 PLAN EXCLUSIONS AND LIMITATIONS

The Exclusions and Limitations for this medical plan are subject to change based on regulatory approvals.

For an updated version:



1. Click on the link below
 2. Type **Cigna.com/IL-2017-Cigna-Connect-Plans-Exclusions** into your browser or
 3. Call **866.Get.Cigna**.
- Current customers, call 800.Cigna.30.*

BENEFIT EXCLUSIONS AND LIMITATIONS

Exclusions

Any services which are not described as covered in the Schedule of Benefits, Services and Benefits section, or in an attached rider, or are specifically excluded in the Services and Benefits section benefit language or an attached rider, are not covered under this EOC.

Benefit Exclusions

In addition, the following are specifically excluded Services:

- Care for health conditions that has not been provided by, or provided by referral from, Your PCP or has not been authorized by Your PCP or the Cigna Medical Director, except for immediate treatment of a Medical Emergency/Emergency Medical Condition.
 - Services received before the Effective Date of coverage.
 - Services received after coverage under this Plan ends.
 - Professional services or supplies received or purchased directly or on Your behalf by anyone, including a Physician, from any of the following:
 - Yourself or Your employer;
 - A person who lives in the Member's home, or that person's employer;
 - A person who is related to the Member by blood, marriage or adoption, or that person's employer.
 - Care for health conditions that are required by state or local law to be treated in a public facility.
 - Care required by state or federal law to be supplied by a public schools system or school district.
 - Care for military service disabilities treatable through governmental services if the Member is legally entitled to such treatment and facilities are reasonably available.
 - Treatment of an Illness or Injury which is due to war, declared or undeclared.
 - Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this EOC.
 - Assistance in the activities of daily living, including, but not limited to, eating, bathing, dressing or other Custodial Services or self care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
 - Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational or unproven services do not include routine patient care costs related to qualified clinical trials as described in your Plan document.
 - Cosmetic surgery, therapy or surgical procedures primarily for the purpose of altering appearance (except as provided in the definition of Reconstructive Surgery or the description of the Reconstructive Surgery benefit in this EOC); Cosmetic surgery, therapy or surgical procedures primarily for the purpose of altering appearance. 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. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance. The exclusions include surgical excision or reformation of any sagging skin on any part of the body, including, the eyelids, face, neck, abdomen, arms, legs or buttocks; and services performed in connection with the enlargement, reduction, implantation, or change in appearance of portion of the body, including, the breast, face, lips, jaw, chin, nose, ears or genital; hair transplantation; chemical face peels or abrasion of the skin; electrolysis diplation; or any other surgical or non-surgical procedures which are primarily for the purpose of altering appearance. This does not exclude services or benefits that are primarily for the purpose of restoring normal bodily function, or surgery, which is Medically Necessary.
- The following services are excluded from coverage regardless of clinical indications;
- Macromastia or gynecomastia surgeries;
 - Surgical treatment of varicose veins;
 - Abdominoplasty;
 - Panniculectomy;
 - Rhinoplasty;
 - Blepharoplasty;
 - Redundant skin surgery;
 - Removal of skin tags;
 - Acupressure;
 - Craniosacral/cranial therapy;
 - Dance therapy, movement therapy;
 - Applied kinesiology;
 - Rolwing;
 - Prolotherapy; and
 - Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, Charges

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- made for services or supplies provided for or in connection with a fractured jaw, or an accidental injury to sound natural teeth are covered, where the continuous course of treatment is started within six (6) months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch, except for pediatric dental services.
- ▶ Any medical and surgical services for the treatment or control of obesity that are not included under the "Covered Services" section of this EOC;
 - ▶ Unless otherwise covered under "Services and Benefits," reports, evaluations, physical examinations, or hospitalization not required for health reasons including, employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
 - ▶ Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise specifically covered under "Services and Benefits."
 - ▶ Reversal of male and female voluntary sterilization procedures.
 - ▶ Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
 - ▶ Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
 - ▶ Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the EOC.
 - ▶ Non medical counseling or ancillary services including, but not limited to Custodial Services, education, training, vocational rehabilitation, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety and services, training, except otherwise specifically covered in this EOC.
 - ▶ Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to routine, long-term or maintenance which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected, except as specifically stated in this EOC.
 - ▶ Complementary and alternative medicine services, including but not limited to: animal therapy, including but not limited to equine therapy or canine therapy; art therapy; meditation; visualization; acupuncture; acupressure; reflexology; light therapy; aromatherapy; music or sound therapy; dance therapy; sleep therapy; hypnosis; energy-balancing; breathing exercises; movement and/or exercise therapy including but not limited to yoga, pilates, tai-chi, walking, hiking, swimming, golf; and any other alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. Services specifically listed as covered under "Short Term Rehabilitative Therapy" and "Habilitative Therapy" are not subject to this exclusion.
 - ▶ Any services or supplies provided by or at a place for the aged, a nursing home, or any facility a significant portion of the activities of which include rest, recreation, leisure, or any other services that are not Covered Services.
 - ▶ Educational services except for Diabetes Self-Management Training; counseling/ educational services for breastfeeding; physician counseling regarding alcohol misuse, preventive medication, obesity, nutrition, tobacco cessation and depression; preventive counseling and educational services specifically required under Patient Protection and Affordable Care Act (PPACA) and as specifically provided or arranged by Cigna.
 - ▶ Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Inpatient Hospital Services", "Outpatient Facility Services", "Home Health Services", "Diabetic Services", or "Breast Reconstruction and Breast Prostheses" sections of the "Services and Benefits" section. Unless covered in connection with the services described in the "Inpatient Services at Other Participating Health Care Facilities" or "Home Health Services" provisions, Durable Medical Equipment items that are not covered, include but are not limited to those listed below:
 - Hygienic or self-help items or equipment;
 - Items or equipment primarily used for comfort or convenience such as bathtub chairs, safety grab bars, stair gliders or elevators, over-the-bed tables, saunas or exercise equipment;
 - Environmental control equipment, such as air purifiers, humidifiers and electrostatic machines;
 - Institutional equipment, such as air fluidized beds and diathermy machines;
 - Elastic stockings and wigs;
 - Equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, braces and splints;
 - Items, such as auto tilt chairs, paraffin bath units and whirlpool baths, which are not generally accepted by the medical profession as being therapeutically effective;
 - Items which under normal use would constitute a fixture to real property, such as lifts, ramps, railings, and grab bars; and
 - Hearing aid batteries (except those for cochlear implants) and chargers.
 - ▶ Private hospital rooms and/or private duty nursing except as provided in the "Home Health Services" or "Hospice Services" section of "Services and Benefits.", or when deemed medically appropriate by Us.
 - ▶ Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
 - ▶ Orthopedic shoes (except when joined to braces), shoe inserts, foot orthotic devices except as required by law for diabetic patients.
 - ▶ Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, orthotics, elastic stockings, garter belts, corsets, dentures and wigs, except as provided in "Services and Benefits" section of the EOC.
 - ▶ Aids or devices that assist with non-verbal communications, including, but not limited to

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- communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery and pediatric vision).
 - Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy, except for pediatric vision.
 - Treatment by acupuncture.
 - All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non prescription drugs, and investigational and experimental drugs, except as provided in "Services and Benefits."
 - Growth Hormone Treatment except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured Person's condition. Growth hormone treatment for idiopathic short stature, or improved athletic performance is not covered under any circumstances.
 - Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary as part of another Covered Service.
 - Membership costs or fees associated with health clubs, weight loss programs.
 - Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.
 - Dental implants for any condition.
 - Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Cigna Medical Director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
 - Blood administration for the purpose of general improvement in physical condition.
 - Cost of biologicals that are immunizations or medications for purposes of travel, or to protect against occupational hazards and risks unless Medically Necessary or indicated.
 - Cosmetics, dietary supplements and health and beauty aids.
 - All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
 - All vitamins and medications and contraceptives available without a prescription ("over-the-counter") except for those covered under mandate of the 2010 Patient Protection and Affordable Care Act (PPACA).
 - Expenses incurred for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
 - Orthognathic treatment and surgery, dental and orthodontic services, and dental and orthodontic appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral).
 - The following mental health and substance use disorder services are specifically excluded from coverage under this Plan:
 - Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless medically necessary and otherwise covered under this EOC;
 - Treatment of mental disorders that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
 - Treatment of chronic conditions not subject to favorable modification according to generally accepted standards of medical practice;
 - Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
 - Counseling for activities of an educational nature.
 - Counseling for borderline intellectual functioning.
 - Counseling for occupational problems.
 - Counseling related to consciousness raising.
 - Vocational or religious counseling.
 - I.Q. testing.
 - Residential treatment (unless associated with Mental Health or chemical or alcohol dependency as described in the Mental Health Residential Treatment Services or the Substance Use Disorder Residential Treatment provisions);
 - marriage counseling;
 - Custodial Care, including but not limited to geriatric day care.
 - Psychological testing on children requested by or for a school system.
 - Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline; and
 - Biofeedback is not covered for reasons other than pain management.
- In addition to the provisions of this "Exclusions and Limitations" section, You will be responsible for payments on a fee-for-service basis for Service under the conditions described in the "Reimbursement" provision of "Other Sources of Payment for Services and Supplies."

Benefit Limitations

Circumstance Beyond the Cigna HMO Plan's Control. To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within Our control results in Our facilities, personnel, or financial resources being unavailable to provide or arrange for the provisions of a basic or supplemental health service or supplies in accordance with this EOC, We will make a good faith effort to provide or arrange for the provision of the service or supplies, taking into account the impact of the event.

UNDERSTANDING THE BENEFITS AND HOW THEY WORK

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

DEFINITIONS

- › **Premium** The amount you pay each month for your health insurance plan.
- › **Annual Out-of-Pocket Maximum** The maximum dollar amount you pay each calendar year for covered medical services. Copays, deductibles, and coinsurance apply to the annual out-of-pocket maximum.
- › **Coinsurance (In-network)** The percentage you pay for covered medical services or prescriptions after you have met the annual in-network deductible.
- › **Coinsurance (Out-of-network)** The percentage you pay for covered medical services or prescriptions after you have met the annual out-of-network deductible. You may pay more if the healthcare provider's charges exceed the amount Cigna reimburses for billed services (Maximum Reimbursable Charge).
- › **Copayment (copay)** A flat fee you pay toward services such as doctor visits or prescriptions.
- › **Annual Deductible** The amount you pay each year out-of-pocket for covered medical services or prescriptions before the plan starts to pay.
- › **Advanced Premium Tax Credit** If you qualify and enroll in a Marketplace Qualified Health Plan (QHP),¹ tax credit subsidies/financial assistance can lower your monthly premium payments or you can get the money back when you file your taxes. All, or a part of the subsidy can be used towards your premium. Subsidies are based on certain household size and income requirements.
- › **Cost-sharing reductions²** These may lower the amount you pay out-of-pocket when you get medical care like copays or coinsurance. Cost-sharing reduction subsidies/financial assistance are based on certain household size and income requirements and may be available in addition to tax credit subsidies.
- › **In-network** Using a healthcare provider that Cigna has contracted with (doctors, hospitals, labs, etc.) and is in the Cigna network used by your plan.
- › **Network** A group of hospitals, health care professionals and labs that have contracted with Cigna to provide health care services.
- › **Participating Provider (In-network Provider)** A hospital, doctor or any other health care professional that is contracted by Cigna to provide covered medical services to an insured person as part of a policy/service agreement.
- › **Primary Care Physician** A participating physician who, through an agreement with Cigna, provides basic health services to and arranges specialized services for customers.
- › **Non-Participating Provider (Out-of-network Provider)** A doctor or any other health care professional that does not belong to the Cigna network defined by the plan.
- › **Health Maintenance Organization (HMO)** An HMO plan provides a localized network of doctors and other health care professionals. Premiums are generally lower when compared to other plan types. Customers select a Primary Care Physician to coordinate their care. Referrals are required to see a Specialist. Away from home care and out-of-network care are **not** covered, except for emergency services as defined in the plan. See the See the Details at a Glance Grid for specific plan information.
- › **Cigna Telehealth Connection Physician** A doctor who participates in the Cigna Telehealth Connection program, separate from the Plan network, who is contracted with our telehealth partners to provide consultations by phone or via secure video chat.³
- › **Cigna Telehealth Connection Partner Service** A Telehealth visit, requested by the insured person and provided by a provider who is participating in the Cigna Telehealth Connection program, by phone or via secure video chat, for minor acute medical conditions such as a cold, flu, sore throat, rash or headache. Providers are separate from the Plan network providers, are contracted through our telehealth partners and are available for services identified in the plan documents.³
- › **Coverage Area** Where a plan is available for enrollment, in an area that Cigna has designated.
- › **Prior Authorization** Approval from the insurance carrier (Cigna) before a routine hospital stay, outpatient procedure or certain prescription drugs and related supplies.
- › **Referral** Approval a Primary Care Physician provides when referring a patient to another health care professional, usually a specialist, for treatment or consultation. Required by some plans, see page 2 for plan specific information. Services provided by a participating OB/GYN doctor and services for Pediatric Dental Care and Pediatric Vision Care do not require a referral.

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.

3. Telehealth providers participating in the Cigna Telehealth Connection program are independent contractors and separate from Plan network providers. Not all providers have video chat capabilities. Video chat is not available in all areas. PCP referral is not required. Refer to plan documents for a complete description of covered services, including other telehealth/telemedicine benefits.

For more information or to find in-network doctors:

Visit **Cigna.com/ifp-providers** or call the number on the bottom of the first page.

Cigna Connect 2500

2017 PLAN IMPORTANT DISCLOSURES

Medical plan rates vary based on plan design, age, family size, geographic location (residential zip code) and tobacco use. Tobacco use is not a rating factor in California and Maryland. Rates for new medical policies/service agreements with an effective date on or after 01/01/2017 are guaranteed through 12/31/2017. Thereafter, medical rates are subject to change upon 30 days' prior notice in CT, IL, MO and TN, 31 days' prior notice in SC, 45 days' prior notice in FL, MD and NC, 60 days' prior notice in AZ, CA, GA, and TX, and 75 days prior notice in VA.

Insurance policies/service agreements have exclusions, limitations, reduction of benefits and terms under which the policies/service agreements may be continued in force or discontinued. Medical applications are accepted during the 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/service agreement and for which the insured person has benefits.

Form Series for Cigna Health and Life Insurance Company:

Major Medical: AZ: INDAZCH042016, CA: CACHIND012017, CT: CTINDCH062016, FL: FLCHIND012017, GA: INDGACH042016, MD: MDINDOAPCH012017, NC: NCINDCH042016, SC: INSCCH012017, TN: TNINDOAP042016

Exclusive Provider: CA: CACHIND-EPO012017, FL: FLCHINDEPO012017, MD: MDINDEPOCH012017, MO: MOINDEPO072016, TN: TNINDEPO042016, TX: INDTXEP0042016, VA: VAINDEPO042016

Form Series for Cigna HealthCare of Arizona, Inc., Cigna HealthCare of Illinois, Inc., Cigna HealthCare of North Carolina, Inc., Cigna HealthCare of Texas, Inc.:

HMO: AZ: INDHMOAZ01-2017, IL: INDHMOIL01-2017, NC: INDHMONC042016, TX: INDTXHMO042016

The policy/service agreement may be canceled 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/service agreements 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 1-866-GET-Cigna. (1-866-438-2446).

Cigna Connect 2500

IMPORTANT PLAN INFORMATION

With a Cigna Connect Plan, you will select a PCP. Referrals to see a Specialists are required by your PCP.

When traveling outside your network area emergency care is covered as defined by the plan, office visits are covered in the network area only. Out-of-network benefits are not covered by this plan.

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**.

Cigna Connect 2500 is a Qualified Health Plan in the Illinois Health Insurance Marketplace.



Health Insurance Marketplace



All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company (CHLIC), Cigna HealthCare of Arizona, Inc., Cigna HealthCare of Illinois, Inc., Cigna HealthCare of North Carolina, Inc., Cigna HealthCare of Texas, Inc., Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C. In Arizona, HMO plans are offered by Cigna HealthCare of Arizona, Inc. All other individual medical plans are insured by CHLIC. In North Carolina, HMO plans are offered by Cigna HealthCare of North Carolina, Inc. All other individual medical plans are insured by CHLIC. In Texas, HMO plans are offered by Cigna HealthCare of Texas, Inc. All other individual medical plans are insured by CHLIC. "Cigna Home Delivery Pharmacy" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.