

GET TO KNOW YOUR MEDICAL PLAN

Cigna FocusIn Flex Silver 5000 | 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 and nationwide. Plus, access to care both in- and out-of-network.²
- 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.⁴ 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.

Our Networks: it's about quality and savings

Cigna's FocusIn health insurance plans offer you a choice of quality care in your local area. You get access to top providers (that fit your personal needs) – no referral needed. Some of the health care professionals in our Network have separately earned the Cigna Care Designation – recognized for achieving top results on Cigna quality and cost-efficiency measures.

Our network includes access to Baylor University Medical Center, which has been ranked the #1 hospital in Dallas-Fort Worth by U.S. News & World Report for 22 consecutive years.³

1. Some preventive care services may not be covered, including most immunizations for travel. Refer to your policy for a complete listing of covered and non-covered services.
2. Emergency services as defined in your plan.
3. <http://www.baylorhealth.com/About/AwardsAccreditations/pages/besthospitals.aspx>.
4. 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.

Contact your local broker or a licensed Cigna agent at **866.Get.Cigna** or visit **Cigna.com** to learn more.

Together, all the way.®



This Exclusive Provider plan is available to residents in parts of Texas, depending on county. Please see last page for full listing. Exclusive Provider Organization (EPO) plans do not provide benefits outside of your local area or out-of-network, except for emergency services as defined in the plan.

| MEDICAL BENEFIT | Cigna FocusIn Flex Silver 5000 | |
|--|--------------------------------|----------------|
| | IN-NETWORK | OUT-OF-NETWORK |
| Individual Deductible (Medical and pharmacy) | \$5,000 | Not covered |
| Family Deductible (Medical and pharmacy) | \$10,000 | 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 20% after deductible | Not covered |
| Individual Out-of-Pocket Maximum | \$6,700 | Not covered |
| Family Out-of-Pocket Maximum | \$13,400 | 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 \$20, deductible waived | Not covered |
| Specialist Physician (Office visit) | You pay \$60, deductible waived | Not covered |
| Office Related Services | You pay 20% after deductible | Not covered |

PREVENTIVE CARE

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

INPATIENT SERVICES

| | | |
|---|------------------------------|-------------|
| Facility Services (Inpatient room and board, lab & x-ray, operating room, etc.) | You pay 20% after deductible | Not covered |
| Physician Services | You pay 20% after deductible | Not covered |

MATERNITY CARE

| | | |
|---|------------------------------|-------------|
| Prenatal and Postnatal Care | You pay 20% after deductible | Not covered |
| Delivery and Inpatient Services for Maternity Care | You pay 20% 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 5% after deductible | Not covered |
| CT/PET Scans and MRI | You pay 20% after deductible | Not covered |
| Cardiac & Pulmonary Rehabilitation Calendar year maximum of 36 visits. | You pay 20% after deductible | Not covered |
| Short-Term Rehabilitative Therapy | You pay 20% after deductible | Not covered |
| Outpatient Surgery (Facility) | You pay 20% after deductible | Not covered |
| Outpatient Surgery (Physician services) | You pay 20% after deductible | Not covered |
| Acupuncture | Not covered | Not covered |

EMERGENCY AND URGENT CARE SERVICES

| | | |
|--------------------------------|---------------------------------|--|
| Hospital Emergency Room | You pay 20% 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, 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 20% 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 Calendar year maximum of 25 visits. | You pay 20% after deductible | Not covered |
| Home Health Calendar year maximum of 60 visits. | You pay 20% after deductible | Not covered |
| Hospice | You pay 20% after deductible | Not covered |

DURABLE MEDICAL EQUIPMENT (DME)

| | | |
|----------------------------------|------------------------------|-------------|
| Durable Medical Equipment | You pay 20% 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 20% after deductible | Not covered |
| Outpatient (Includes individual, group & intensive outpatient treatment) | You pay 5% after deductible | Not covered |
| Outpatient (Office Visit) | You pay \$60, deductible waived | Not covered |

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

| | | |
|--|----------------------------------|-------------|
| TIER 1: Retail Preferred Generics (Available at the lowest cost) Up to a 90 day supply. For copay plans, You pay copay for each 30 day supply. | You pay \$4, deductible waived | Not covered |
| TIER 2: Retail Non-preferred Generics (Medications at a higher cost than Tier 1) Up to a 90 day supply. For copay plans, You pay copay for each 30 day supply. | You pay \$15, deductible waived | Not covered |
| TIER 3: Retail Preferred Brands (Brand-name drugs at a lower cost than Tier 4) Up to a 90 day supply. For copay plans, You pay copay for each 30 day supply. | You pay \$50, 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) Up to a 90 day supply | You pay 20% after deductible | Not covered |
| TIER 5: Retail Specialty (Drugs for complex chronic conditions) Up to a 30 day supply | You pay \$550, 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 \$10, 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 \$37, 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 \$125, 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 20% after deductible | Not covered |
| TIER 5: Home Delivery Specialty (Drugs for complex chronic conditions) Up to a 30 day supply | You pay \$475, deductible waived | Not covered |

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.
- › **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 certain household size and 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 Focus Network flyer
Visit **Cigna.com/ifp-providers**.
Call **866.494.2111**.

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2016 PLAN EXCLUSIONS AND LIMITATIONS

Excluded Services

- › Services obtained from an Out-of-Network (Non-Participating) Provider, except for Emergency Services (including those provided by an Urgent Care facility).
- › Any **amounts in excess of maximum amounts of Covered Expenses** stated in this Policy.
- › Services **not specifically listed** as Covered Services in this Policy.
- › Services or supplies that are **not Medically Necessary**; however You have the right to appeal an adverse determination regarding medical necessity.
- › Services or supplies that Cigna considers to be for **Experimental Procedures or Investigative Procedures**; however You the right to appeal an adverse determination regarding experimental procedures or investigative procedures.
- › Services received **before the Effective Date** of coverage.
- › Services received **after coverage under this Policy ends**, except for treatment approved under the Continuity of Care provision.
- › 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, except to the extent that the availability of insurance or health plan coverage may be considered by a tax supported institution of the State of Texas providing treatment of mental illness or mental retardation to determine if a patient is non-indigent, as provided in Article 3196a of Vernon's Texas Civil Statutes.
- › 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, even if the Insured Person does not claim those benefits.
- › Conditions caused by: (a) an **act of war (declared or un-declared)**; (b) the inadvertent release of nuclear energy when government funds are

available for treatment of Illness or Injury arising from such release of nuclear energy; (c) an Insured Person participating in the **military service** of any country; (d) an Insured Person participating in an **insurrection, rebellion, or riot**; (e) services received as a direct result of an Insured Person's commission of, or attempt to commit a **felony** (whether or not charged) **or as a direct result of the Insured Person being engaged in an illegal occupation**; (f) an Insured Person **being intoxicated**, as defined by applicable state law in the state where the Illness occurred or under the influence of illegal narcotics or non-prescribed controlled substances unless administered or prescribed by Physician.

- › Any services provided by a local, state or federal **government agency**, except (a) when payment under this Policy is expressly required by federal or state law; or (b) services provided for the treatment of mental or nervous disorders by a tax supported institution of the State of Texas.
- › Any services required by state or federal law to be supplied by a public school system or school district.
- › **If the Insured Person is eligible for Medicare** part A, B or D, Cigna will provide claim payment according to this Policy minus any amount paid by Medicare, not to exceed the amount Cigna would have paid if it were the sole insurance carrier.
- › **Court-ordered treatment or hospitalization**, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- › 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.
- › 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 Insured Person's home, or that person's employer;
- a person who is related to the Insured Person by blood, marriage or adoption, or that person's employer.

This does not apply to covered dental services provided by a dentist licensed in the state of Texas and operating within the scope of his or her licensure.

- › Custodial Care.
- › **Private duty nurse**, except as specifically stated under Home Health Care in the section of this Policy.
- › Inpatient room and board charges in connection with a **Hospital stay primarily for environmental change or physical therapy**; Custodial Care or rest cures; services provided by a rest home, a home for the aged, a nursing home or any similar facility service.
- › **Assistance in activities of daily living**, including but not limited to: bathing, eating, dressing, or other Custodial Care, self-care activities or homemaker services, and services primarily for rest, domiciliary or convalescent care.
- › 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.
- › **Dental services**, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically provided in this Policy.
- › **Orthodontic Services**, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction.
- › **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.
- › **Hearing aids**, except as specifically stated in this Policy.

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2016 PLAN EXCLUSIONS AND LIMITATIONS

- › **Routine hearing tests** except as specifically provided in this Policy under “Comprehensive Benefits, What the Plan Pays For”.
- › **Genetic screening** or pre-implantations 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.
- › **Optometric services**, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Policy under Pediatric Vision.
- › An **eye surgery** solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
- › **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.
- › Procedures, surgery or treatments to change characteristics of the body to those of the opposite sex including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery. This also includes any medical, surgical or psychiatric treatment or study related to sex change.
- › Aids or devices that assist with nonverbal communication, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books, except as specifically stated in this Policy.
- › **Non-Medical counseling or ancillary services**, including but not limited to: education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities and developmental delays.
- › Services for redundant skin surgery, removal of skin tags, acupressure, acupuncture, craniosacral/ cranial therapy, dance therapy, movement therapy, applied kinesiology, rolfing, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, regardless of clinical indications.
- › 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.
- › All services related to the **evaluation or treatment of fertility and/or Infertility**, including, but not limited to, all tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including sterilization reversals and In vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), except as specifically stated in this Policy.
- › All **non-prescription Drugs**, devices and/or supplies, except drugs designated as preventive by the Patient Protection and Affordable Care Act (PPACA), that are available over the counter or without a prescription; **Injectable drugs** (“self-injectable medications) **that do not require Physician supervision; All non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision** and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, and **Self-administered Injectable Drugs**, except as stated in the Benefit Schedule and in the Prescription Drug Benefits Schedule.
- › **Any Infusion or Injectable Specialty Prescription Drugs that require Physician supervision**, except as otherwise stated in this Policy, if not provided by an approved Participating Provider specifically designated to supply that specialty prescription. Infusion and Injectable Specialty drugs include, but are not limited to, hemophilia factor and supplies, enzyme replacements and intravenous immunoglobulin.
- › Fees 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.
- › Blood administration **for the purpose of general improvement in physical condition**.
- › **Cryopreservation** of sperm or eggs, or storage of sperm for artificial insemination (including donor fees).
- › **Orthopedic shoes** (except when joined to braces), shoe inserts, foot orthotic devices except as specifically stated under External Prosthetic Appliances and Devices in the Benefits section of this Policy.
- › 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. This includes any morbid obesity surgery, even if the Insured Person has other health conditions that might be helped by a reduction of obesity or weight, or any program, product or medical treatment for weight reduction or any expenses of any kind to treat obesity, weight control or weight reduction.
- › **Routine physical exams or tests** that do not directly treat an actual illness, injury or condition, including those required by employment or government authority, physical exams required for or by an employer, or for school, or sports physicals, except as otherwise specifically stated in this Plan.
- › Therapy or treatment **intended primarily to improve or maintain general physical condition** or for the purpose of enhancing job, school, athletic or recreational performance,

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2016 PLAN EXCLUSIONS AND LIMITATIONS

- including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- › 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 wigs etc.).
 - › Massage therapy.
 - › **Educational services** except for Diabetes Self-Management Training Programs and those offered by Cigna.
 - › **Nutritional counseling** or food supplements, except as stated in this Policy.
 - › **Durable medical equipment** not specifically listed as Covered Services in the Covered Services section of this Policy. Excluded durable medical equipment includes, but is not limited to: orthopedic shoes or shoe inserts (except as specifically stated under External Prosthetic Appliances and Devices in the Benefits section of this Policy), air purifiers, air conditioners, humidifiers; exercise equipment, treadmills; spas; elevators; supplies for comfort, hygiene or beautification; disposable sheaths and supplies; correction appliances or support appliances and supplies such as stockings, and consumable medical supplies other than ostomy supplies and urinary catheters, including, but not limited to, bandages and other disposable medical supplies, skin preparations and test strips except as stated under Diabetes treatment or otherwise stated in this Policy.
 - › Any **Drugs**, medications, or other substances dispensed or administered in any outpatient setting except as specifically stated in this Policy. This includes, but is not limited to, items dispensed by a Physician.
 - › **All Foreign Country Provider** charges are excluded under this Policy except as specifically stated under Treatment received from Foreign Country Providers in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For".
 - › **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.
 - › **Charges for which We are unable to determine Our liability** because the Insured Person failed, within 60 days, or as soon as reasonably possible to: (a) authorize Us to receive all the medical records and information We requested; or (b) provide Us with information We requested regarding the circumstances of the claim or other insurance coverage.
 - › Charges for the services of a **standby Physician**.
 - › Charges for **animal to human organ transplants**.
 - › Claims received by Cigna after 15 months from the date service was rendered, except in the event of a legal incapacity.

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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) and tobacco use.

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 60 days notice.

This medical insurance policy (INDTXEP0042015) 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.

In Texas, LocalPlus Network plans are considered Preferred Provider plans with certain managed care features; LocalPlus Network Health Savings plans are considered Preferred Provider plans with certain managed care features and are compatible with Health Savings Accounts.

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

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

| | |
|--------|----------|
| Collin | Ellis |
| Dallas | Rockwall |
| Denton | Tarrant |

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 FocusIn Flex Silver 5000 is a Qualified Health Plan in the Texas Health Insurance Marketplace.



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