Multi-language Interpreter Services

If you, or someone you're helping, has questions about this document you have the right to get help and information in your language at no cost. To talk to an interpreter, call 866-494-2111. **English**

إن كانت لديك أو لدي الشخص الذي تقوم بمساعدته أية استفسارات عن هذه الوثيقة، فإنه من حقك الحصول على المساعدة و المعلومات بلغتك و بدون أي تكلفة. للتحدث إلى أحد الأشخاص للمساعدة، اتصل على / 866-494-2111 . **Arabic**

如果您或您要幫助的人有關於本文件的疑問，您有權免費以您的語言取得協助和相關資訊。如欲與口譯員洽談，請致電 866-494-2111 。 **Chinese**

Si vous, ou quelqu'un que vous aidez, a des questions à propos de ce document, vous avez le droit d'obtenir de l'aide et des informations dans votre langue, sans frais. Pour parler à un interprète, composez le 866-494-2111. **French**

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Εάν εσείς, ή κάποιος που βοηθάτε, έχετε ερωτήσεις σχετικά με αυτό το έγγραφο, έχετε το δικαίωμα να λάβετε δωρεάν βοήθεια και πληροφορίες στη γλώσσα σας. Για να μιλήσετε σε ένα διερμηνέα, καλέστε 866-494-2111. **Greek**

જો તમને, અથવા તમે જેને મદદ કરી રહ્યાં છો, તેને આ દસ્તાવેજ વિશે પ્રશ્નો હોય, તો તમને કોઇ પણ જાતનો ખર્ચ કર્યા વગર તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો અધિકાર છે. એક દુભાષિયા સાથે વાત કરવા માટે સંપર્ક કરો ૮૬૬-૪૯૪-૨૧૧૧. **Gujarati**

अगर आप या आप जिस की सहायता कर रहे हैं, किसी के भी इस दस्तावेज़ के बारे में सवाल हैं, तो आपके पास कोई भी कीमत चुकाये बिना अपनी भाषा में सहायता और जानकारी प्राप्त करने का अधिकार है। एक दुभाषिये से बात करने के लिए, 866-494-2111 पर फ़ोन करें। **Hindi**

Se Lei, o qualcuno che sta aiutando, ha domande riguardanti il presente documento, ha il diritto di ricevere assistenza e informazioni nella Sua lingua senza costi aggiuntivi. Per parlare con un interprete, chiami il numero 866-494-2111. **Italian**

귀하 또는 귀하가 돕는 사람이 본 문서와 관련하여 문의사항이 있는 경우, 귀하는 무료로 귀하의 모국어를 이용해 도움 및 정보를 받을 권리가 있습니다. 통역사와 대화하시려면 866-494-2111 번으로 전화하십시오. **Korean**

W przypadku gdy osoba zainteresowana lub osoba, której pomagasz, ma pytania dotyczące niniejszego dokumentu, przysługuje jej prawo do uzyskania bezpłatnej pomocy i informacji w jej języku ojczystym. Aby rozmawiać z tłumaczem, zadzwoń pod numer 866-494-21 11. **Polish**

Если у Вас или кого-либо, кому Вы оказываете помощь, возникли вопросы по поводу данного документа, Вы имеете право получить бесплатную помощь и информацию на Вашем родном языке. Для того чтобы связаться с переводчиком, позвоните по телефону 866-494-2111. **Russian**

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este documento tiene derecho a obtener ayuda e información en su idioma sin costo. Para hablar con un intérprete, llame al 866-494-2111. **Spanish**

Kung ikaw, o ang isang taong tinutulungan ninyo, ay may mga tanong tungkol sa dokumentong ito, mayroon kayong karapatang humingi ng tulong at impormasyon sa inyong wika nang libre. Upang makipag-usap sa isang interpreter, tumawag sa 866-494-2111. **Tagalog**

اگر آپ یا کوئی اور جس کی آپ مدد کر رہے ہیں، کو اس دستاویز کے بارے میں کوئی سوال ہے تو یہ آپ کا حق ہے کہ اس کے بارے میں مفت مدد یا معلومات حاصل کرسکتے ہیں۔ مترجم سے بات کرنے کے لیے کال کریں
Urdu 866-494-2111

Nếu quý vị, hoặc một người nào đó mà quý vị đang giúp đỡ, có câu hỏi về tài liệu này quý vị có quyền nhận được sự giúp đỡ và thông tin bằng ngôn ngữ của quý vị mà không mất khoản phí nào. Để nói chuyện với phiên dịch viên, vui lòng gọi số 866-494-2111. **Vietnamese**

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This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.cigna.com/individuals-families/illinois-health-insurance-plans-2017 or by calling 1-866-494-2111.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$700** person/ **$1,400** family Does not apply to preventive care, specialty drugs and eye exam/glasses for children.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$1,900** person/ **$3,800** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premium, balanced-billed charges, penalties for failure to obtain pre-authorization for services, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits
Does this plan use a network of providers?	Yes. For a list of Participating providers, see www.cigna.com/ifp-providers or call 1-866-494-2111.	If you use a Participating doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your Participating doctor or hospital may use a Non-participating **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers.**

Do I need a referral to see a specialist?	Yes	This plan will pay some or all of the costs to see a **specialist** for covered services, but only if you have the plan's permission before you see the specialist.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page **5**. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a Non-participating **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a Non-participating hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	15% co-insurance	Not Covered	Expanded Access Telehealth visit-15% co-insurance if from a provider in the expanded access telehealth network. Refer to the policy for more information.
	Specialist visit	15% co-insurance	Not Covered	----------None----------
	Other practitioner office visit	15% co-insurance	Not Covered	----------None----------
	Preventive care/screening/immunization	No charge	Not Covered	----------None----------
If you have a test	Diagnostic test (x-ray, blood work)	15% co-insurance	Not Covered	----------None----------
	Imaging (CT/PET scans, MRIs)	15% co-insurance	Not Covered	----------None----------

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available www.cigna.com/ifp-drug-list .	Preferred generic drugs	15% co-insurance (retail/home delivery)	Not Covered	Up to a 30-day supply; 90 day supply at Designated 90 day Pharmacy (retail). Up to a 90 day supply (home delivery).
	Non-preferred generic drugs	15% co-insurance (retail/home delivery)	Not Covered	Up to a 30-day supply; 90 day supply at Designated 90 day Pharmacy (retail). Up to a 90 day supply (home delivery).
	Preferred brand drugs	15% co-insurance (retail/home delivery)	Not Covered	Up to a 30-day supply; 90 day supply at Designated 90 day Pharmacy (retail). Up to a 90 day supply (home delivery).
	Non-preferred brand drugs	50% co-insurance (retail/home delivery)	Not Covered	Up to a 30-day supply; 90 day supply at Designated 90 day Pharmacy (retail). Up to a 90 day supply (home delivery).
	Specialty drugs	40% co-insurance (retail/home delivery)	Not Covered	Up to a 30-day supply; 90 day supply at Designated 90 day Pharmacy (retail). Up to a 90 day supply (home delivery).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% co-insurance	Not Covered	----------None----------
	Physician/surgeon fees	15% co-insurance	Not Covered	----------None----------
If you need immediate medical attention	Emergency room services	15% co-insurance	Not Covered	You pay the same level as in-network if it is an emergency as defined in your plan, otherwise Not Covered.
	Emergency medical transportation	15% co-insurance	Not Covered	
	Urgent Care	15% co-insurance	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	15% co-insurance	Not Covered	----------None---------- .
	Physician/surgeon fee	15% co-insurance	Not Covered	----------None----------

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services – office visit	15% co-insurance	Not Covered	----------None----------
	Mental/Behavioral health outpatient services – all other outpatient	15% co-insurance	Not Covered	
	Mental/Behavioral health inpatient services	15% co-insurance	Not Covered	----------None---------- .
	Substance use disorder outpatient services – office visit	15% co-insurance	Not Covered	----------None----------
	Substance use disorder outpatient services – all other outpatient	15% co-insurance	Not Covered	
	Substance use disorder inpatient services	15% co-insurance	Not Covered	----------None---------- .
If you are pregnant	Prenatal and postnatal care	15% co-insurance	Not Covered	All prenatal and first postpartum consultations
	Delivery and all inpatient services	15% co-insurance	Not Covered	----------None---------- .
If you need help recovering or have other special health needs	Home Health Care	15% co-insurance	Not Covered	----------None----------
	Rehabilitation Services	15% co-insurance	Not Covered	Cardiac - Limited to a maximum of 36 Outpatient treatment sessions within a 6 month period.
	Habilitation Services	15% co-insurance	Not Covered	----------None----------
	Skilled nursing care	15% co-insurance	Not Covered	----------None----------
	Durable medical equipment	15% co-insurance	Not Covered	----------None----------
	Hospice service	15% co-insurance	Not Covered	----------None----------
If your child needs dental or eye care	Eye exam	No charge	Not Covered	Children up to age 19. Coverage is limited to 1 exam per year
	Glasses	No charge	Not Covered	Children up to age 19. Coverage is limited to 1 pair of glasses per year

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-participating Provider	Limitations & Exceptions
	Dental check-up	Not Covered	Not Covered	Coverage is available through a stand-alone dental policy

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Elective abortion
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Hearing aids (limited to 1 hearing aid per ear every 3 years)
- Infertility treatment
- Private-duty nursing

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

• You commit fraud

Questions: Call 1-866-494-2111 or visit us at www.cigna.com/individuals-families/Illinois-insurance-plans-2017
If you aren't clear about any of the bolded terms used in this form, see the Glossary.
You can view the Glossary at **www.cciio.cms.gov** or call **1-866-494-2111** to request a copy.

• The insurer stops offering services in the State
• You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-866-494-2111.
You may also contact your state insurance department at 1-877-527-9431.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**.
For questions about your rights, this notice, or assistance, you can contact: Illinois Department of Insurance at 1-877-527-9431.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-494-2111.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-494-2111.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-866-494-2111.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-494-2111.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,800
- **Patient pays** $1,740

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$700
Copays	$0
Coinsurance	$1,010
Limits or exclusions	$30
Total	**$1,740**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,770
- **Patient pays** $1,630

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$700
Copays	$0
Coinsurance	$650
Limits or exclusions	$280
Total	**$1,630**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.