GET TO KNOW YOUR MEDICAL PLAN

Cigna LocalPlusIN 6700 | 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.
- **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]
- **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.

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.

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, call **800.Cigna.30**.

Together, all the way.®

Cigna®

Plan availability

This plan is available in the following counties in Texas:

North Texas (DFW) – 20 full counties

Collin	Erath	Hunt	Parker
Cooke	Fannin	Johnson	Rockwall
Dallas	Grayson	Kaufman	Somervell
Denton	Henderson	Navarro	Tarrant
Ellis	Hood	Palo Pinto	Wise

Houston – 5 full counties

Austin	Galveston	San Jacinto*
Brazoria*	Grimes	Walker*
Brazos	Harris	Waller
Chambers*	Liberty	Washington
Fort Bend	Montgomery	

Austin – 3 full counties

Hays
Travis
Williamson

* Partial counties based on zip code.

Your Cigna LocalPlusIN plan.

Our Networks: it's about quality and savings

Cigna's LocalPlusIN health insurance plans provide access to health care professionals in your area and other parts of the country in the LocalPlus Network. The network is comprised of a select group of health care professionals who Cigna contracts with to ensure that you have referral-free access to care.

How it works

When you receive care from a health care professional or hospital in the LocalPlus Network, the visit is considered in-network which helps you keep you out-of-pocket costs down. When traveling, visit LocalPlus providers to receive in-network benefits. If outside of a LocalPlus Network area when away from home, visit **Cigna.com/ifp-providers** to find providers in your network.

For more network information call the number indicated at the bottom of page one. Visit **Cigna.com/ifp-providers** to find providers in your network.

Details at a glance.

	IMPORTANT INFORMATION ABOUT YOUR PLAN
Network name	LocalPlus Network
Plan type	Exclusive Provider Organization (EPO)
To remain in-network:	
Primary care physician (PCP)	Visit an in-network PCP. PCP selection is encouraged.
Specialist physician	Visit specialists in the LocalPlus Network. Referral not required by a PCP.
Out-of-network coverage	Out-of-network services are ***not*** covered under this plan.
In the case of an emergency	Emergency care is covered, in- and out-of-network[1]
When traveling	When traveling in a LocalPlus network area, customers must see a LocalPlus network provider for in-network coverage. When traveling outside of a LocalPlus Network area, visit **Cigna.com/ifp-providers** to find providers in your network.
To find providers in-network visit	**Cigna.com/ifp-providers**

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

This Exclusive Provider plan is available to residents in parts of Texas, depending on county. Please see second page for full listing.
Plan does not provide out-of-network benefits, except for emergency services as defined in the plan.

MEDICAL BENEFIT	Cigna LocalPlusIN 6700 IN-NETWORK	Cigna LocalPlusIN 6700 OUT-OF-NETWORK
Individual Deductible (Medical and pharmacy)	$6,700	Not Covered
Family Deductible (Medical and pharmacy)	$13,400	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 50% 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 $60, deductible waived	Not Covered
Specialist Physician (Office visit)	You pay 50% after deductible	Not Covered
Office Related Services	You pay 50% 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 50% after deductible	Not Covered
Physician Services	You pay 50% after deductible	Not Covered
MATERNITY CARE		
Prenatal and Postnatal Care (Mother and Newborn)	You pay 50% after deductible	Not Covered
Delivery and Inpatient Services for Maternity Care (Facility/Physicians Services unless otherwise noted)	You pay 50% after deductible	Not Covered

* Amount you pay for covered medical services.

MEDICAL BENEFIT	Cigna LocalPlusIN 6700 IN-NETWORK	Cigna LocalPlusIN 6700 OUT-OF-NETWORK
OUTPATIENT SERVICES		
Lab, X-ray and Ultrasound	You pay 50% after deductible	Not Covered
CT/PET Scans and MRI	You pay 50% after deductible	Not Covered
Cardiac & Pulmonary Rehabilitation Calendar year maximum of 36 visits.	You pay 50% after deductible	Not Covered
Rehabilitative Therapy Physical, Occupational, and Chiropractic care.) Calendar year maximum of 35 visits.	You pay 50% after deductible	Not Covered
Outpatient Surgery (Facility/Physicians Services unless otherwise noted)	You pay 50% after deductible	Not Covered
Acupuncture	Not covered	Not covered
EMERGENCY AND URGENT CARE SERVICES		
Hospital Emergency Room	You pay 50% after deductible	You pay the same level as in-network if it is an emergency as defined by the 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 by the plan, otherwise you pay 100%
Ambulance	You pay 50% after deductible	You pay the same level as in-network if it is an emergency as defined by the plan, otherwise you pay 100%
OTHER HEALTH CARE FACILITIES AND SERVICES		
Skilled Nursing Facility Calendar year maximum of 25 days	You pay 50% after deductible	Not Covered
Home Health Calendar year maximum of 60 visits	You pay 50% after deductible	Not Covered
Hospice	You pay 50% after deductible	Not Covered
DURABLE MEDICAL EQUIPMENT (DME)		
Durable Medical Equipment	You pay 50% after deductible	Not Covered

MEDICAL BENEFIT	Cigna LocalPlusIN 6700 IN-NETWORK	Cigna LocalPlusIN 6700 OUT-OF-NETWORK
MENTAL HEALTH & SUBSTANCE ABUSE		
Inpatient (Includes acute, partial & residential treatment)	You pay 50% after deductible	Not Covered
Outpatient (Office Visit)	You pay 50% after deductible	Not Covered
Outpatient (All others services)	You pay 50% after deductible	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 $8, 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 $40, 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.	You pay 50% after deductible	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 50% after deductible	Not Covered
TIER 5: Retail Specialty (Drugs for complex chronic conditions) Up to a 30 day supply.	You pay 50%, 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 $20, 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 $100, 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 50% after deductible	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 30 day supply.	You pay 40%, deductible waived	Not Covered

This summary contains highlights only. See Plan Exclusions and Limitations on following pages.

Pediatric Coverage

Dental

ON MARKETPLACE

The Cigna Dental Family + Pediatric plan and Cigna Pediatric plan are available for purchase independently on the Health Insurance Marketplace.

OFF MARKETPLACE

The Cigna Pediatric Dental plan is included with the purchase of a medical plan.

Pediatric Dental	Coverage information for the Cigna Dental Pediatric plan can be found on the **Pediatric Dental Summary of Benefits**.

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 Vision coverage off Marketplace continues through the end of the calendar year in which the dependent turns age 19.

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2017 MEDICAL 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/TX-2017-Cigna-LocalPlusIN-Plans-Exclusions** into your browser or
3. Call **866.Get.Cigna**.

*Current customers, call **800.Cigna.30**.*

Your plan does not provide coverage for the following except as required by law:

- Services or supplies that are not Medically Necessary.
- Services or supplies that Cigna considers to be for Experimental Procedures or Investigative Procedures.
- Services received before the Effective Date of coverage.
- Services received after coverage under this Policy ends.
- 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 undeclared); (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.
- 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 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.
- Inpatient or outpatient services of a private duty nurse.
- 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.
- Smoking cessation programs, except as specifically provided in this Policy.
- 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.

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- Hearing aids, except as specifically stated in this Policy.
- 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. 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.
- Nonmedical counseling or ancillary services.
- 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 invitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), except as specifically stated in this Policy.
- Injectable drugs (self-injectable medications) that do not require Physician supervision are covered under the Prescription Drug benefits of this Policy.
- 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, except as provided in the Prescription Drug benefits of this Policy.
- Any Infusion or Injectable Specialty Prescription Drugs that require Physician supervision, except as otherwise stated in this Policy. 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, 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

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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 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.
- Syringes, except as stated in the Policy.
- 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 titles "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.
- Routine foot care including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, Injury or symptoms involving the feet, except as otherwise stated in this Policy.
- 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.

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.
- **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.
- **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.
- **Exclusive Provider Organization (EPO)** An EPO plan provides a localized network of doctors and other health care professionals. Depending on the plan, Primary Care Physician selection and referrals to see Specialists are either not required, may be required or encouraged. Away from home care may or may not be included. Plans do not offer out-of-network coverage except for emergency services as defined in the plan. See the Details at a Glance grid at the beginning of this document for specific plan information.
- **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.

For more information or to find in-network doctors:

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

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2017 PLAN IMPORTANT DISCLOSURES

Medical plan rates vary based on plan design, age, family size, geographic location (residential zip code) and tobacco use.

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 60 days' prior notice in TX.

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:

Exclusive Provider: TX: INDTXEPO042016

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.

In Texas, Cigna Focus and Cigna LocalPlus plans are considered Exclusive Provider plans with certain managed care features.

These rates are for illustrative purposes only. A person should not send money to the issuer of the health benefit plan in response to the advertisement. A person cannot obtain coverage under the health benefit plan until the person completes an application for coverage. Benefit exclusions and limitations may apply to the health benefit plan.

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).

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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**.

Depending on your household size and income, you may be able to qualify for federal financial assistance and save by purchasing a Marketplace insurance plan. Call Cigna to learn more at **866.494.2111.** Current Cigna health plan customers, please call **800.Cigna.30**.