GET TO KNOW YOUR MEDICAL PLAN

Cigna Connect 6400 | 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.
- **Easy access to doctors.** Talk with a doctor by phone 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 on 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.[1]
- **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.[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 Houston*:

Brazoria	Harris
Fort Bend	Liberty
Galveston	Montgomery

* Partial counties based on zip code.

1. Telehealth providers participating in the Cigna Telehealth Connection program are independent contractors and separate from Plan network providers. PCP referral is not required. Refer to plan documents for a complete description of covered services, including other telehealth/telemedicine benefits.
2. 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, Customer call **800.Cigna.30**.

Together, all the way.®

Cigna®

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.

For more network information 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 services are ***not*** covered under this plan.
In the case of an emergency	Emergency care is covered, in- and out-of-network.[3]
When traveling	Covered for emergency medical services as defined by the plan. Telehealth benefits are available for minor acute care on the phone anywhere, anytime.[4]
To find providers in-network visit	**Cigna.com/ifp-providers**

1. For children, you may select a participating pediatrician as the PCP. See plan documents 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 plan documents 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. 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
- Your copay is the same or less than a primary care physician (PCP) visit, depending on the plan when using these benefits
- Providers 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 BENEFITS[1]
You pay $35, 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. 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 Texas, 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 6400 IN-NETWORK	Cigna Connect 6400 OUT-OF-NETWORK
Individual Deductible (Medical and pharmacy)	NOT INTEGRATED Medical - $6,400 Pharmacy - $750	Not Covered
Family Deductible (Medical and pharmacy)	NOT INTEGRATED Medical - $12,800 Pharmacy - $1,500	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 $35, 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	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 Connect 6400 IN-NETWORK	Cigna Connect 6400 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	You pay 50% after deductible	Not Covered
Outpatient Surgery (Facility)	You pay 50% after deductible	Not Covered
Outpatient Surgery (Physician services)	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	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 Connect 6400 IN-NETWORK	Cigna Connect 6400 OUT-OF-NETWORK
MENTAL HEALTH & SUBSTANCE ABUSE		
Inpatient (Includes acute, partial & residential treatment)	You pay 50% after deductible	Not Covered
Outpatient (Office Visits)	You pay 50% after deductible	Not Covered
Outpatient (All other 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. 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. 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**. Coverage information for the Cigna Dental + Family pediatric plans can be found on the **Family + Pediatric Dental Summary of Benefits**.

Vision

The Pediatric Vision plan is included with the purchase of a medical plan off Marketplace 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 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 below
2. Type **Cigna.com/TX-2017-Cigna-Connect-Plans-Exclusions** into your browser or
3. Call **866.Get.Cigna**.

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

Exclusions And Limitations: What Is Not Covered By This Policy

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 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 under this Plan, except as approved under the Continuity of Care provision.
- 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.
- 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 the Plan.
- 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) a Member participating in the military service of any country; (d) a Member 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 Member 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 Member 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 the Member was not eligible for Medicare.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Participating Physician or otherwise specifically covered under "Services and Benefits".
- 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.
- Care, services, supplies or treatment for health conditions 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.

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 hospital rooms and/or private duty nursing except as provided in the "Home Health Services" section of "Services and Benefits.", or when deemed medically appropriate by Us. Private duty nursing will not be excluded in an inpatient setting, if skilled nursing is not available.
- 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.
- 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.
- Dental Implants for any condition.
- 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).

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- 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.
- 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, radial keratomy 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, therapy or surgical procedure 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 Plan);
- 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.
- Reversal of male and female voluntary sterilization procedures.
- Services for macromastia or gynecomastia surgeries, surgical treatment of varicose veins, abdominoplasty, panniculectomy, rhinoplasty, blepharoplasty, 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.
- 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.
- Telephone, email and internet consultations, except for benefits described in "Telehealth and Telemedicine Medical Services".
- All services related to infertility once diagnosed, including but not limited to, infertility services, infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees); Cryopreservation of donor sperm and eggs are also excluded from coverage.
- Non medical counseling or ancillary services including, but not limited to Custodial Services, 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, developmental delays, or mental retardation, except otherwise specifically covered in this Plan.
- 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 are covered under the Prescription Drug benefits of this Policy.
- All noninjectable 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, if not provided by an approved Participating Provider specifically designated to supply that specialty drugs including, 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 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.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Plan.
- 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 Plan.
- Any medical and surgical services for the treatment or control of obesity that are not included under the "Services and Benefits" section of this Plan;
- Unless specifically covered under "Services and Benefits," reports, evaluations, physical

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examinations, or hospitalization not required for health reasons including, employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.

- 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: 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.
- Nutritional counseling or formulas are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
- 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 and Supplies", or "Breast Reconstruction and Breast Prostheses" sections of the "Services and Benefits" section.
- The following are not covered for treatment of Mental Health or Substance Use Disorder: 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 Plan; Special education, including but not limited to, school tuition; Treatment of mental disorders that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain or 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 borderline intellectual functioning, or related to consciousness-raising or of an educational, vocational or religious nature; I.Q. testing; Wilderness programs, animal therapy programs; Residential treatment (unless associated with a Substance Use Disorder as defined by this Plan; 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; Biofeedback.
- 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.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Claims received by Cigna after 15 months from the date service wan 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.
- **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.
- **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. Telehealth providers participating in the Cigna Telehealth Connection program are independent contractors and separate from Plan network providers. 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.

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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. 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: INDSCCH012017, TN: TNINDOAP042016

Exclusive Provider: CA: CACHIND-EPO012017, FL: FLCHINDEPO012017, MD: MDINDEPOCH012017, MO: MOINDEPO072016, TN: TNINDEPO042016, TX: INDTXEPO042016, 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.

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).

Cigna Connect 6400

IMPORTANT PLAN INFORMATION

With a Cigna Connect Plan, you will select a PCP. Your PCP will direct you to Specialists when needed.

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