Together, all the way.®

Cigna®

Cigna Medicare Supplement Insurance policies

Insured by Cigna Health and Life Insurance Company

THIS IS A LIMITED POLICY which must be used to supplement your Medicare coverage. This is a solicitation for insurance. **An insurance agent may contact you. Our company and agents are not connected with or endorsed by the U.S. Government or the federal Medicare program.** Premium and benefits vary by plan selected.

CHLIC-01-0002-K-BRO-V3-WI 929258 03/20

Feel confident in your decision

A Medicare Supplement insurance plan, also called a Medigap plan, is a separate policy that works with Medicare Part A (hospital services) and Part B (doctor's services and supplies) and helps you manage your medical costs. Cigna Medicare Supplement insurance helps protect you against high out-of-pocket costs by helping pay for eligible health care expenses not covered by Medicare.

Freedom to choose your doctors

You can use any doctor who accepts Medicare. There are no provider networks or referrals required.[1] So, you can go to the doctors you know and trust.

Value for your money

Our goal is to provide cost-effective coverage without sacrificing the quality service and support you deserve. A household premium discount may be available for qualified applicants.

1. In some cases, a referral is required.

Service you can count on

Our knowledgeable, caring representatives are ready to assist you by answering your questions and providing guidance. We aim to provide fast, friendly and efficient customer service at all times. Our claims team is also hard at work for you behind the scenes. Medicare Part A & Part B claims are managed electronically, which eliminates paperwork for both you and your doctor.

Access to benefit information

You have access to your benefit and claim information online. Set up automatic premium payments, print a temporary ID card, update your contact information, and review claims on your computer, tablet or phone – anytime, anywhere.

Guaranteed renewable policy for life[2]

Your policy is guaranteed to be renewed if premiums are paid on time. And you cannot be singled out for a rate increase based on your health, no matter if your health changes. Premium rates change annually if the policy purchased is attained-age rated. Your premium may also change if the premiums for all policies like yours in the state where your policy was issued change or if coverage under Medicare changes.

Health Information Line

A health advocate is ready to help answer your health questions and guide you to find the right care. Call and get the help you need 24 hours a day, seven days a week.

Healthy Rewards® Discount Programs

As a Cigna Medicare Supplement customer, you get access to discount programs that provide additional value.[3]

Vision discounts
Save on routine vision services like exams and eyeglasses at more than 25,000[4] locations nationwide.

Hearing discounts
Receive an average of 62% off retail on name-brand hearing aids and 40% off diagnostic services and testing at more than 5,600[4] locations.

Health and wellness discounts
Enjoy savings on popular weight management, nutrition programs and alternative medicine services such as acupuncture, massage therapy and occupational therapy.

The Active&Fit Direct™ program[5]
Access to over 10,000[4] fitness centers nationwide for $25 per month.

2. Your policy cannot be terminated for any reason other than nonpayment of premium or material misrepresentation in the application for insurance. The company reserves the right to increase premiums on a class basis.
3. **These programs are NOT insurance and do not provide reimbursement for financial losses.** Program availability may vary by location and is subject to change. Services may be added or discontinued at any time. Customers are required to pay the entire discounted charge for any discounted products or services available through these programs. Programs are provided through third party vendors who are solely responsible for their products and services.
4. As of 2/1/2019.
5. Plus a $25 enrollment fee and applicable taxes. **This is a discount program and is NOT insurance.** This program is separate from your medical plan benefits. You are required to pay the entire discounted charge. ASH is an independent company/entity and is solely responsible for the Active&Fit Direct program. ASH is not an affiliate of Cigna. Always consult your doctor prior to beginning a new exercise program. Your participation in this program may be subject to program terms and conditions and is at your sole risk. The Active&Fit Direct program is provided by American Specialty Health Fitness, Inc. (ASH Fitness), a subsidiary of American Specialty Health Incorporated (ASH). Active&Fit Direct is a trademark of ASH and used with permission herein.

Policy benefits

Cigna Medicare Supplement plan coverage[6]	Basic Plan
Basic Benefits – Included in Medicare Supplement Policies (Inpatient Hospital Care, Medical Costs and Blood).	
Medicare Part A: Skillled Nursing Facility Coinsurance	✓
Inpatient Mental Health Coverage – 175 days per lifetime in addition to Medicare	✓
Home Health Care – 40 visits in addition to those paid by Medicare	✓
Medicare Part B: Coinsurance	✓
Outpatient Mental Health	✓
Additional Benefits	
Inpatient Psychiatric Care – Usual and customary charges incurred during a psychiatric hospital stay after all Medicare Part A benefits have been exhausted. Limited to 175 days of care during your lifetime.	✓
Breast Reconstruction – 100% of the usual and customary charges for breast reconstruction of the affected tissue as a result of a mastectomy.[5]	✓
Chiropractic Services – 100% of the usual and customary charges for chiropractic services provided by a licensed chiropractor which incur even though such expense may not be a Medicare eligible expense.	✓
Hospital and Ambulatory Surgery Center and Anesthetics for Dental Care – 100% of the usual and customary charges[7] for hospital or ambulatory surgery center charges and anesthetics provided in conjunction with dental care if the insured has a (1) chronic disability or (2) medical condition that requires hospitalization or general anesthesia for dental care.	✓
Kidney Disease Treatment – 100% of the usual and customary charges for hospital inpatient and outpatient kidney disease treatment for dialysis, transplantation and donor-related services. Benefits are limited to $30,000 in a 12-month period.	✓
Additional Skilled Nursing Care – Pays 30 days of medically necessary skilled nursing facility care if confined to a skilled nursing facility per benefit period, or to the extent not covered by Medicare or any other provision of the policy. The daily rate payable under this benefit shall be the maximum daily rate established for skilled nursing care by the Wisconsin Department of Health and Family Services. Does not apply to care that is essentially domiciliary or custodial, or to care that is available to you.	✓
Equipment/Supplies for Treatment of Diabetes – 100% of the usual and customary charges for an insulin infusion pump or other equipment, supplies or prescription medication or nonprescription equipment and supplies for use in the treatment of diabetes or diabetic self-management educational programs, to the extent not covered by Medicare or any other provision of the policy. Coverage is limited to the purchase of one infusion pump per year, which must be used for at least 30 days prior to purchase.	✓
Additional riders for added flexibility (available on your Basic Plan for an additional premium)	**Riders**
Part A Deductible Rider – 100% of Medicare Part A Deductible.	✓
Part B Deductible Rider – 100% of Medicare Part B Deductible (per calendar year and only available if you were eligible for Medicare prior to January 1, 2020).	✓
Part B Copayment or Coinsurance Rider – 100% of Part B coinsurance, except for $20 copay for office visits, and $50 copay for an emergency room visit that does not result in an inpatient admission.	✓
Part B Excess Charges Rider – Difference between what Medicare pays and the amount charged by the provider who does not accept Medicare assignment, up to limiting charges allowed by Medicare.	✓
Foreign Travel Emergency Rider – 80% of medically necessary emergency care received outside of the U.S. which began during the first 60 days of each trip. You must pay $250 each calendar year, not to exceed a lifetime maximum of $50,000.	✓
Additional Home Health Care Rider – 100% of charges for visits (an aggregate of 365 visits per calendar year) considered medically necessary by Medicare.	✓

6. **Medicare Supplement Insurance –** The Wisconsin Insurance Commissioner has set standards for Medicare Supplement insurance. The policy meets these standards. It, along with Medicare, may not cover all of your medical costs. You should review carefully all policy limitations. For an explanation of these standards and other important information, see the "Wisconsin Guide to Health Insurance for People with Medicare," given to you when you applied for this policy. Do not buy the policy if you did not get this guide.

Apply for a Medicare Supplement insurance policy, contact your licensed insurance agent today.

Exclusions and limitations

The benefits of this policy will not duplicate any benefits paid by Medicare. The combined benefits of this policy and the benefits paid by Medicare will not exceed 100% of the Medicare eligible expenses incurred.

These policies will not pay benefits for:

- Skilled nursing facility care costs beyond what is covered by Medicare and the Wisconsin mandated 30-day skilled nursing benefit;
- Home health care visits above the number of visits covered by Medicare and the Wisconsin mandated 40 visits in a twelve-month period;
- Physician charges above Medicare's approved charge, unless the optional Medicare Part B Excess Charges Rider is purchased;
- Outpatient prescription drugs;
- Most care received outside the U.S., unless the optional Foreign Travel Emergency Rider is purchased;
- Dental care (except anesthesia charges for dental care provided in a hospital or ambulatory surgery center), dentures, check-ups, routine immunizations, cosmetic surgery, routine foot care, examinations for and the cost of eyeglasses or hearing aids, unless eligible by Medicare;
- Any expense incurred in excess of the usual and customary charge or not medically necessary as determined by us for all required Wisconsin mandated benefits;
- Any expense which you are not legally obligated to pay; or services for which no charge is normally made in the absence of insurance;
- Any services that are not medically necessary as determined by Medicare;
- Any portion of any expense for which payment is made by Medicare or other government programs (except Medicaid) or for which payment would have been made by Medicare if you were enrolled in Parts A and B of Medicare; and
- Any type of expense not a Medicare Eligible Expense except as provided in the policy.

Preexisting conditions

The policy nor the riders will not pay for any expenses incurred for care or treatment of a preexisting condition for the first six months from the effective date of coverage. This exclusion does not apply if you applied for and were issued a policy under guaranteed issue status; if on the date of application for the policy you had at least six months of prior creditable coverage; or, if the policy is replacing another Medicare Supplement policy and a six-month waiting period has already been satisfied. Evidence of prior coverage or replacement must have been disclosed on the application for the policy.

If you had less than six months of prior creditable coverage, the preexisting conditions limitation will be reduced by the aggregate amount of creditable coverage. If the policy is replacing another Medicare Supplement policy, credit will be given for any portion of the waiting period that has been satisfied.

A preexisting condition is a condition for which medical advice was given or treatment was recommended by or received from a physician within six months prior to the policy effective date.

Household discount

Household discount is a discount that is available when more than one member of your household enrolls or is enrolled in a Medicare Supplement policy provided by or through an affiliate of Cigna Health and Life Insurance Company. Household is defined as a condominium unit, a single family home or an apartment unit within an apartment complex. Assisted living facilities, group homes, adult day care facilities and nursing homes, or any other residential health facility are not included in the definition of "Household." The household discount will be removed if the other Medicare supplement policyholder whose policy status entitles you to the discount no longer resides with you or no longer has a Medicare Supplement policy through Cigna Health and Life Insurance Company or an affiliate of Cigna Health and Life Insurance Company. However, if that person becomes deceased, your discount will still apply. The addition or removal of the discount will occur on the billing cycle following the date we learn your eligibility has changed.

Cigna Health and Life Insurance Company, PO Box 25710, Scranton, PA 18505, 866-459-4272.

This brochure is designed as a marketing aid and is not to be construed as a contract for insurance. It provides a brief description of the important features of our Medicare Supplement plans. Full terms and conditions of coverage are defined by and governed by an issued Medicare Supplement policy. Please refer to the policy for the full terms and conditions of coverage.

Policy Form and Riders Form Numbers: CHLIC-MS-BASIC-WI – Basic Policy; CHLIC-MS-PTBD-WI – Medicare Part B Deductible Rider; CHLIC-MS-FTV-WI – Medicare Foreign Travel Emergency Rider; CHLIC-MS-PBCO-WI – Medicare Part B Copayment or Coinsurance Rider; CHLIC-MS-PTAD-WI – Medicare Part A Deductible Rider; CHLIC-MS-AHC-WI – Additional Home Health Care Rider; CHLIC-MS-PBEX-WI – Medicare Part B Excess Charges Rider

CHLIC-01-0002-K-BRO-V3-WI 929258 03/20