# BENEFIT SUMMARY

**Cigna Health and Life Insurance Co.**
**For - Ministry Brands**
**Choice Fund Open Access Plus HSA Plan**
**HSA Plan**
**Effective - 01/01/2026**

**Selection of a Primary Care Provider** - your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

**Direct Access to Obstetricians and Gynecologists** - You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

**A notice for Missouri, Oklahoma and Texas residents:** This plan does not include an optional rider to cover elective abortions.

| **Your coverage includes a health savings account that you can use to pay for eligible out-of-pocket expenses.** | |
|---|---|
| **Employer Contribution** | Employee - $600<br>Family - $1,200 |

| Plan Highlights | In-Network | Out-of-Network |
|---|---|---|
| **Lifetime Maximum** | Unlimited | Unlimited |
| **Plan Year Accumulation** | Your plan's deductibles, out-of-pockets and benefit level limits accumulate on a calendar year basis unless otherwise stated. In addition, all plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between in- and out-of-network unless otherwise noted. | |
| **Plan Coinsurance** | Plan pays 80% | Plan pays 60% |
| **Maximum Reimbursable Charge** | Not Applicable | 110% |


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| Plan Highlights | In-Network | Out-of-Network |
|---|---|---|
| **Plan Deductible** | Individual - Employee Only: $5,000<br>Individual - within a Family: $5,000<br>Family Maximum: $10,000 | Individual - Employee Only: $10,000<br>Individual - within a Family: $10,000<br>Family Maximum: $20,000 |
| • Only the amount you pay for in-network covered expenses counts towards your in-network deductible. Only the amount you pay for out-of-network covered expenses counts towards your out-of-network deductible.<br>• Plan deductible always applies before any benefit copay/deductible or coinsurance.<br>• Plan deductible does not apply to in-network preventive services.<br>• Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.<br>• This plan includes a combined Medical/Pharmacy plan deductible.<br>**Note:** Services where plan deductible applies are noted with a caret (^). | | |
| **Plan Out-of-Pocket Maximum** | Individual - Employee Only: $6,000<br>Individual - within a Family: $6,000<br>Family Maximum: $12,000 | Individual - Employee Only: $12,000<br>Individual - within a Family: $12,000<br>Family Maximum: $24,000 |
| • Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. Only the amount you pay for out-of-network covered expenses counts toward your out-of-network out-of-pocket maximum.<br>• Plan deductible contributes towards your out-of-pocket maximum.<br>• All benefit copays/deductibles contribute towards your out-of-pocket maximum.<br>• Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder. Out-of-network non-compliance penalties or charges in excess of Maximum Reimbursable Charge do not contribute towards the out-of-pocket maximum.<br>• After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.<br>• This plan includes a combined Medical/Pharmacy out-of-pocket maximum. | | |
| **Benefit** | **In-Network** | **Out-of-Network** |
| **Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.** | | |
| **Physician Services - Office Visits** | | |
| **Primary Care Physician (PCP) Services/Office Visit** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Specialty Care Physician Services/Office Visit** | Plan pays 80% ^ | Plan pays 60% ^ |
| **NOTE:** Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist). | | |
| **Surgery Performed in Physician's Office** | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| **Allergy Treatment/Injections and Allergy Serum**<br>Allergy serum dispensed by the physician in the office | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |


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| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.** | | |
| **Virtual Care** | | |
| **Dedicated Virtual Providers - MDLIVE** | | |
| **MDLIVE Urgent Virtual Care Services** | Plan pays 80% ^ | Not Covered |
| **MDLIVE Primary Care Services** | Plan pays 80% ^ | Not Covered |
| **MDLIVE Specialty Care Services** | Plan pays 80% ^ | Not Covered |
| • Primary Care cost share applies to routine care. Virtual wellness screenings are payable under Preventive Care.<br>• For MDLIVE Behavioral Services, please refer to the Mental Health and Substance Use Disorder section (below).<br>• Lab services supporting a virtual visit must be obtained through dedicated labs.<br>• Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies. | | |
| **Virtual Physician Services - Office Visits** | | |
| **Primary Care Physician (PCP) Services/Office Visit** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Specialty Care Physician Services/Office Visit** | Plan pays 80% ^ | Plan pays 60% ^ |
| • Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services).<br>• Includes charges for the delivery of medical and health-related services and consultations as medically appropriate through audio, video, and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting.<br>**NOTE:** Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist). | | |
| **Convenience Care Clinic** | | |
| **Convenience Care Clinic** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Preventive Care** | | |
| **Preventive Care**<br>• Annual Limit: Unlimited | Plan pays 100% | PCP: Plan pays 60% ^<br>Specialist: Plan pays 60% ^ |
| **Immunizations** | Plan pays 100% | PCP: Plan pays 60% ^<br>Specialist: Plan pays 60% ^ |
| **Mammogram, PAP, and PSA Tests**<br>• Coverage includes the associated Preventive Outpatient Professional Services.<br>• Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on Place of Service. | Plan pays 100% | Covered same as other x-ray and lab services, based on Place of Service |


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| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.** | | |
| **Inpatient** | | |
| **Inpatient Hospital Facility Services** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Note:** Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Pharmaceutical Drugs | | |
| **Inpatient Hospital Physician's Visit/Consultation** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Inpatient Professional Services** | Plan pays 80% ^ | Plan pays 60% ^ |
| • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists | | |
| **Outpatient** | | |
| **Outpatient Facility Services** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Outpatient Professional Services** | Plan pays 80% ^ | Plan pays 60% ^ |
| • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists | | |
| **Emergency Services** | | |
| **Emergency Room**<br>• Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit. | Plan pays 80% ^ | Plan pays 80% ^ |
| **Urgent Care Facility**<br>• Includes Professional, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the urgent care visit. | Plan pays 80% ^ | Plan pays 60% ^ |
| **Ambulance** | Plan pays 80% ^ | Plan pays 80% ^ |
| Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered. | | |
| **Ambulance - Mental Health and Substance Use Disorder** | Plan pays 80% ^ | Plan pays 80% ^ |
| Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered. | | |
| **Inpatient Services at Other Health Care Facilities** | | |
| **Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities**<br>• Annual Limit: 90 days | Plan pays 80% ^ | Plan pays 60% ^ |
| **Laboratory Services** | | |
| **Physician's Services/Office Visit** | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| **Independent Lab** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Outpatient Facility** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Radiology Services** | | |
| **Physician's Services/Office Visit** | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| **Outpatient Facility** | Plan pays 80% ^ | Plan pays 60% ^ |


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| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.** | | |
| **Advanced Radiological Imaging (ARI)** | Includes MRI, MRA, CAT Scan, PET Scan, etc. | |
| **Outpatient Facility** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Physician's Services/Office Visit** | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| **Outpatient Therapy Services** | | |
| **Outpatient Therapy Services** | Covered same as Primary Care Physician Services – Office Visit | Covered same as Physician Services - Office Visit |
| Annual Limits:<br>• All Therapies Combined - Includes Cognitive Therapy, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation, and Speech Therapy - Unlimited days<br><br>**Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum. | | |
| **Chiropractic Services** | Covered same as Primary Care Physician Services – Office Visit | Covered same as Physician Services - Office Visit |
| Annual Limit:<br>• Chiropractic Care - Unlimited days | | |
| **Cardiac Rehabilitation Services** | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| Annual Limit:<br>• Cardiac Rehabilitation - Unlimited days | | |
| **Hospice** | | |
| **Inpatient Facilities** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Outpatient Services** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Note:** Includes Bereavement counseling provided as part of a hospice program. | | |
| **Bereavement Counseling (for services not provided as part of a hospice program)** | | |
| Services Provided by a Mental Health Professional | Covered under Mental Health benefit | Covered under Mental Health benefit |
| **Medical Pharmaceutical Drugs** | | |
| **Cigna Pathwell Specialty® Medical Pharmaceuticals** | Plan pays 80% ^ | Not Covered |
| **Other Medical Pharmaceuticals** | Plan pays 80% ^ | Plan pays 60% ^ |
| • Cigna Pathwell Specialty® Medical Pharmaceuticals are only covered when administered by a Cigna Pathwell Specialty® designated provider.<br>• This benefit only applies to the cost of Medical Pharmaceutical drugs administered. Related Facility, Office Visit or Professional charges are covered according to the plan design. | | |


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| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.** | | |
| **Maternity** | | |
| **Initial Visit to Confirm Pregnancy** | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| **All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges** (Global Maternity Fee) | Plan pays 80% ^ | Plan pays 60% ^ |
| **Office Visits in Addition to Global Maternity Fee** (Performed by OB/GYN or Specialist) | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| **Delivery - Facility** (Inpatient Hospital, Birthing Center) | Covered same as plan's Inpatient Hospital benefit | Covered same as plan's Inpatient Hospital benefit |
| **Abortion** | | |
| **Abortion Services**<br>**Note:** Non-elective procedures only | Coverage varies based on Place of Service | Coverage varies based on Place of Service |
| **Family Planning** | | |
| **Women's Services**<br>Includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals) | Plan pays 100% | Coverage varies based on Place of Service |
| **Men's Services**<br>Includes surgical sterilization services, such as vasectomy (excludes reversals) | Coverage varies based on Place of Service | Coverage varies based on Place of Service |
| **Infertility** | | |
| **Infertility Treatment**<br>**Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness. | | |
| **Outpatient Dialysis Services** | | |
| **Physician's Services/Office Visit** | Covered same as Physician Services - Office Visit | Covered same as Physician Services - Office Visit |
| **Home Dialysis**<br>**Note:** Dialysis visits will not accumulate to Home Health Care maximum | Covered same as plan's Home Health Care benefit | Covered same as plan's Home Health Care benefit |
| **Outpatient Facility Services** | Covered same as plan's Outpatient Facility Services benefit | Covered same as plan's Outpatient Facility Services benefit |
| **Outpatient Professional Services** | Covered same as plan's Outpatient Professional Services benefit | Covered same as plan's Outpatient Professional Services benefit |


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| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.** | | |
| **Other Health Care Facilities/Services** | | |
| **Home Health Care**<br>• Annual Limit: 100 days (The limit is not applicable to mental health and substance use disorder conditions.)<br>• 16 hour maximum per day<br>**Note:** Includes outpatient private duty nursing when approved as medically necessary | Plan pays 80% ^ | Plan pays 60% ^ |
| **Organ Transplants** | | |
| **Inpatient Hospital Facility Services** | | |
| LifeSOURCE Transplant Network® facility | Plan pays 100% ^ | Not Applicable |
| Other Facility | Plan pays 60% ^ | Plan pays 60% ^ up to the transplant maximums |
| **Inpatient Professional Services** | | |
| LifeSOURCE Transplant Network® facility | Plan pays 100% ^ | Not Applicable |
| Other Facility | Plan pays 60% ^ | Plan pays 60% ^ up to the following transplant maximums:<br><br>Bone Marrow - $320,000<br>Heart - $430,000<br>Lung - $500,000<br>Heart/Lung - $500,000<br>Liver - $280,000<br>Kidney - $140,000<br>Pancreas - $135,000<br>Kidney/Pancreas - $205,000 |
| • Travel Maximum - Cigna LifeSOURCE Transplant Network® facility only: After the plan deductible is met, Unlimited maximum per Transplant per Lifetime<br>• The amount you pay for Other Facility covered expenses counts toward your out-of-network plan deductible and out-of-pocket maximums. | | |
| **Durable Medical Equipment**<br>• Annual Limit: Unlimited | Plan pays 80% ^ | Plan pays 60% ^ |


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| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.** | | |
| **Breast Feeding Equipment and Supplies**<br>• Limited to the rental of one breast pump per birth as ordered or prescribed by a physician<br>• Includes related supplies | Plan pays 100% | Plan pays 60% ^ |
| **External Prosthetic Appliances (EPA)**<br>• Annual Limit: Unlimited | Plan pays 80% ^ | Plan pays 60% ^ |
| **Temporomandibular Joint Disorder (TMJ)**<br>• Unlimited lifetime maximum | Coverage varies based on Place of Service | Coverage varies based on Place of Service |
| **Note:** Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment. | | |
| **Routine Foot Care** | Not Covered | Not Covered |
| **Note:** Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary. | | |
| **Hearing Aids**<br>• Annual Limit: Unlimited<br>• Maximum of 2 devices (one per ear) per 3 years<br>• Includes testing and fitting of hearing aid devices at Physician Office Visit cost share<br>• Coverage through age 17 | Plan pays 80% ^ | Plan pays 60% ^ |


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| Benefit | In-Network | Out-of-Network |
|---|---|---|
| **Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.** | | |
| **Mental Health and Substance Use Disorder** | | |
| **Inpatient Mental Health** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Outpatient Mental Health – Physician's Office** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Outpatient Mental Health - MDLIVE Behavioral Services** | Plan pays 80% ^ | Not Covered |
| **Outpatient Mental Health – All Other Services** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Inpatient Substance Use Disorder** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Outpatient Substance Use Disorder – Physician's Office** | Plan pays 80% ^ | Plan pays 60% ^ |
| **Outpatient Substance Use Disorder - MDLIVE Behavioral Services** | Plan pays 80% ^ | Not Covered |
| **Outpatient Substance Use Disorder – All Other Services** | Plan pays 80% ^ | Plan pays 60% ^ |

Annual Limits:

- Unlimited maximum

Notes:

- Inpatient includes Acute Inpatient and Residential Treatment.
- Outpatient - Physician's Office and MDLIVE Behavioral Services - may include Individual, family and group therapy, psychotherapy, medication management, etc.
- Outpatient - All Other Services - may include Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy), etc.
- Services are paid at 100% after you reach your out-of-pocket maximum.

**Important Note on Mental Health and Substance Use Disorder Coverage:** Covered medical services listed above, which are received to diagnose or treat a Mental Health or Substance Use Disorder condition will be payable according to this section titled "Mental Health and Substance Use Disorder."

**Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs**

**Cigna Total Behavioral Health - Inpatient and Outpatient Management**

- Inpatient utilization review and case management
- Outpatient utilization review and case management
- Partial Hospitalization
- Intensive outpatient programs
- Changing Lives by Integrating Mind and Body Program
- Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management.
- Narcotic Therapy Management
- inMynd℠ program - a comprehensive, holistic solution to help recognize and find resources to treat behavioral health conditions.


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| Pharmacy | In-Network |
|---|---|
| **Cost Share and Supply** | |
| **Cigna Pharmacy Cost Share**<br>• Retail – up to 90-day supply (except Specialty up to 30-day supply)<br>• Home Delivery – up to 90-day supply (except Specialty up to 30-day supply) | **Retail (per 30-day supply):**<br>Generic: You pay 20% ^<br>Preferred Brand: You pay 20% ^<br>Non-Preferred Brand: You pay 20% ^<br><br>**Retail and Home Delivery (per 90-day supply):**<br>Generic: You pay 20% ^<br>Preferred Brand: You pay 20% ^<br>Non-Preferred Brand: You pay 20% ^ |

- **Cigna 90 Now CVS:** Retail drugs for a 30-day supply may be obtained in-network at a wide range of pharmacies across the nation although prescriptions for a 90-day supply (such as maintenance drugs) will be available at select network pharmacies. Walgreens will be considered out-of-network for a 90-day supply.
- Cigna 90 Now Program: You can choose to fill your medications in a 30- or 90-day supply. If you choose to fill a 30-day prescription, it can be filled at any network retail pharmacy or network home delivery pharmacy. If you choose to fill a 90-day prescription, it must be filled at a 90-day network retail pharmacy or network home delivery pharmacy to be covered by the plan.
- This plan will not cover out-of-network pharmacy benefits.
- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- When patient requests brand drug, patient pays the brand cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug (unless the physician indicates "Dispense As Written" DAW).
- Your pharmacy benefits share an annual deductible and out-of-pocket maximum with the medical/behavioral benefits. The applicable cost share for covered drugs applies after the combined deductible has been met.
- Specialty Drugs provided at Home Delivery at the Retail (per 30-day supply) cost share.

## Drugs Covered

**Prescription Drug List:**
Your Cigna Value Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. Some of the more expensive drugs are excluded when there are less expensive alternatives. To check which drugs are included in your plan, please log on to myCigna.com.
Some highlights:

- Self Administered injectables are covered.
- Contraceptive devices and drugs are covered with federally required products covered at 100%.
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges are covered.


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## Pharmacy Program Information

**Pharmacy Clinical Management: Essential**

Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for the medical condition, including:

- Prior authorization requirements
- Step Therapy on select classes of medications and drugs new to the market
- Quantity limits, including maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
- Age edits, and refill-too-soon edits
- Plan exclusion edits
- Current users of Step Therapy medications will be allowed one 30-day fill during the first three months of coverage before Step Therapy program applies.
- Your plan includes Specialty Drug Management features, such as prior authorization and quantity limits, to ensure the safe prescribing and access to specialty medications.
- For customers with complex conditions taking a specialty medication, we will offer Accredo Therapeutic Resource Centers (TRCs) to provide specialty medication and condition counseling. For customers taking a specialty medication not dispensed by Accredo, Cigna experts will offer this important specialty medication and condition counseling.

**Patient Assurance Program**

Your plan includes the Patient Assurance Program, which waives the deductible and reduces the amount you owe for certain medications used to treat chronic conditions included in the program. Additionally:

- Any amount you pay for these medications count toward meeting both your deductible and out-of-pocket maximum.
- Any discount provided by a pharmaceutical manufacturer for these medications count toward meeting both your deductible and out-of-pocket maximum.

## Additional Information

**Case Management**

Coordinated by Cigna HealthCare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

**Cigna Diabetes Prevention Program in collaboration with Omada**

Cigna Diabetes Prevention Program in collaboration with Omada is a program to help you avoid the onset of diabetes, as well as health risks that might lead to heart disease or a stroke. The program is covered by your health plan at the preventive level, just like for your wellness visit. Program participants have access to a professional virtual health coach, an online support group, interactive lessons, and a smart-technology scale. The program will help you make small changes in your eating, activity, sleep, and stress to achieve healthy weight loss through a series of 16 weekly lessons and tools to help you maintain weight loss over time. You will also be offered the opportunity to join a gym for a low monthly fee and no enrollment fee.

| | |
|---|---|
| **Comprehensive Oncology Program**<br>• Care Management outreach<br>• Case Management | Included |
| **Healthy Pregnancies/Healthy Babies**<br>• Care Management outreach<br>• Maternity Case Management<br>• Neo-natal Case Management | $150 (1st trimester) / $75 (2nd trimester) - Option 3 |


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## Additional Information

**Maximum Reimbursable Charge**
The allowable covered expense for non-network services is based on the lesser of the health care professional's normal charge for a similar service or a percentage of a fee schedule (110%) developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule will not be used and the Maximum Reimbursable Charge for covered services is based on the lesser of the health care professional's normal charge for a similar service or a percentile (80th) of charges made by health care professionals of such service or supply in the geographic area where it is received. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. Out-of-network services are subject to a calendar year deductible and Maximum Reimbursable Charge limitations.

**Out-of-Network Emergency Services Charges**
1. Emergency Services are covered at the in-network cost-sharing level as required by applicable state or federal law if services are received from a non-participating (out-of-network) provider.
2. The allowable amount used to determine the plan's benefit payment for covered Emergency Services rendered in an out-of-network hospital, or by an out-of-network provider in an in-network hospital, is the amount agreed to by the out-of-network provider and Cigna, or as required by applicable state or federal law.

The member is responsible for applicable in-network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. If the out-of-network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

**Medicare Coordination**
In accordance with the Social Security Act of 1965, this plan will pay Secondary to Medicare Part A and B as follows:
(a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent Spouse and/or Dependent Child(ren), including a former Employee's Domestic Partner, or a COBRA continuant (whose insurance is continued for any reason), and who is also eligible for Medicare due to age or disability;
(b) an Employee's Domestic Partner who is also eligible for Medicare due to age;
(c) an Employee, a former Employee, an Employee's or former Employee's Dependent Spouse and/or Dependent Child(ren), an Employee's Dependent, including a Domestic Partner, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

When a person is eligible for Medicare A and B as described above, this plan will pay as the Secondary Plan to Medicare Part A and B **regardless if the person is actually enrolled in Medicare Part A and/or Part B and regardless if the person seeks care at a Medicare Provider or not for Medicare covered services.**

**Multiple Surgical Reduction**
Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

**One Guide**
Available by phone or through myCigna mobile application. One Guide helps you navigate the health care system and make the most of your health benefits and programs.


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## Additional Information

**Pre-Certification - Continued Stay Review - Preferred Care Management Inpatient** - required for all inpatient admissions
In-Network: Coordinated by your physician
Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- 20% penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.
- Benefits are denied for any admission reviewed by Cigna Healthcare and not certified.
- Benefits are denied for any additional days not certified by Cigna Healthcare.

**Pre-Certification - Preferred Care Management Outpatient Prior Authorization** - required for selected outpatient procedures and diagnostic testing
In-Network: Coordinated by your physician
Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- 20% penalty applied to outpatient procedures/diagnostic testing charges for failure to contact Cigna Healthcare and to precertify admission.
- Benefits are denied for any outpatient procedures/diagnostic testing reviewed by Cigna Healthcare and not certified.

**Pre-Existing Condition Limitation (PCL)** does not apply.

**Well-Being Solution: Core Plus**

- Health assessment
- Device/app integration
- Personalized online content and data-driven actions
- Social connections/challenges

**Your Health First - 200**
Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:

- Condition Management
- Medication adherence
- Risk factor management
- Lifestyle issues
- Health & Wellness issues
- Pre/post-admission
- Treatment decision support
- Gaps in care

Holistic health support for the following chronic health conditions:

- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- Peripheral Arterial Disease
- Asthma
- Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)
- Diabetes Type 1
- Diabetes Type 2
- Metabolic Syndrome/Weight Complications
- Osteoarthritis
- Low Back Pain
- Anxiety
- Bipolar Disorder
- Depression


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## Definitions

**Coinsurance** - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.
**Copay** - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.
**Deductible** - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.
**Out-of-Pocket Maximum** - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.
**Place of Service** - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.
**Prescription Drug List** - The list of prescription brand and generic drugs covered by your pharmacy plan.
**Professional Services** - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists
**Transition of Care** - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

## Exclusions

**What's Not Covered (not all-inclusive):**
Your plan provides for most medically necessary services. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- Charges which you are not obligated to pay and/or for which you are not billed. This exclusion includes, but is not limited to:
    - any instance where Cigna determines that a provider or Pharmacy did not bill you for is or has waived, reduced, or forgiven any portion of its charges and/or any portion of any Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for an otherwise Covered Expense (as shown on The Schedule) without Cigna's express consent.
    - charges of a non-Participating Provider who has agreed to charge you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.

      In the event that Cigna determines that this exclusion applies, then Cigna in its sole discretion shall have the right to:
        - require you and/or any provider or Pharmacy submitting claims on your behalf to provide proof sufficient to Cigna that you have made your required cost-share payment(s) prior to the payment of any benefits by Cigna;
        - reduce the payment of benefits in connection with the Covered Expense, regardless of whether the provider or the Pharmacy represents that you remain responsible for any amounts that your plan does not cover; or
        - reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover.
- Charges or payment for healthcare-related services that violate state or federal law.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies,


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## Exclusions

supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:

- Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
- Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
- The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or
- The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.
- In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines. The plan or policy shall not deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed and is recognized for the treatment of the prescribed indication for charges for a drug prescribed for treatment of life-threatening illnesses such as cancer, AIDs and coronary heart disease solely because the drug has not received FDA approval for that specific type of condition. A drug must be recognized as safe and effective for treatment of that specific type of condition in any of the standard reference compendia (American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, or the United States Pharmacopoeia Dispensing Information) or in medical literature will not be denied. A claim would not be denied solely on the basis that the person was a participant in a clinical trial.

- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- The following services are excluded from coverage regardless of clinical indications: macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics and casts. However, charges made for a continual course of dental treatment for an Injury to teeth are covered. Also, facility charges and charges for general anesthesia or deep sedation which cannot be administered in a dental office are covered when Medically Necessary for a child under the age of 8. Additionally, charges made by a Physician for any of the following surgical procedures are covered: TMJ, CMJ, jaw surgery, excision of unerupted impacted wisdom tooth, including removal of alveolar bone and sectioning of tooth; removal of residual root (when performed by a Dentist other than the one who extracted the tooth).
- For medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations, unless otherwise covered under this plan.
- Court-ordered treatment or hospitalization, unless treatment is prescribed by a Physician and is a covered service or supply under this plan.
- Infertility services including 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 sperm, eggs or embryos is also excluded from coverage.
- Reversal of male and female voluntary sterilization procedures.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile


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## Exclusions

dysfunction (including penile implants), anorgasmy, and premature ejaculation.

- Medical and Hospital care and costs for the child of your Dependent child, unless the child is otherwise eligible under this plan.
- Non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs, and driver safety courses.
- 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 "Home Health Care Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Care Services provision.
- 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 an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- Except as shown in the Covered Expenses section, hearing aids, for individuals who are 18 years of age or older, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- Eyeglass lenses and frames, contact lenses and associated services (exams and fittings), except the initial set after treatment of keratoconus or following cataract surgery.
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Acupuncture.
- All non-injectable prescription drugs unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Products and supplies associated with the administration of medications that are available to be covered under the Prescription Drug Benefit. Such products and supplies include but are not limited to therapeutic Continuous Glucose Monitor (CGM) sensors and transmitters and insulin pods.
- Routine foot care, including the paring and removing of corns and calluses and toenail maintenance. However, foot care services for diabetes, peripheral neuropathies and peripheral vascular disease are covered.
- Membership costs and fees associated with health clubs, weight loss programs or smoking cessation programs.
- 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.
- Dental implants for any condition.
- Fees associated with the collection, storage or donation of blood or blood products, except for autologous donation in anticipation of scheduled services when medical management review determines 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.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Health and beauty aids, cosmetics and dietary supplements.
- All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism except for special dietary formulas that are Medically Necessary for the therapeutic treatment of PKU (phenylketonuria).
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Charges related to an Injury or Sickness payable under worker’s compensation or similar laws.
- Massage therapy.
- Elective and non-elective abortions, unless a Physician certifies in writing that the pregnancy would endanger the life of the mother, the fetus is not viable, or


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## Exclusions

the expenses are incurred to treat medical complications due to elective and non-elective abortions. Abortions for plans utilizing state funds are not excluded when pregnancy is the result of an act of rape or incest.

**These are only the highlights**
This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate, service agreement or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.

*Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Evernorth Care Solutions, Inc. and HMO or service company subsidiaries of Cigna Health Corporation.*

EHB State: TN

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# Discrimination is against the law.

## Medical coverage

Cigna Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna Healthcare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

**Cigna Healthcare:**

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

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If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to **ACAGrievance@Cigna.com** or by writing to the following address:

**Cigna Healthcare**
Nondiscrimination Complaint Coordinator
P.O. Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to **ACAGrievance@Cigna.com**. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

**U.S. Department of Health and Human Services**

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
**1.800.368.1019, 800.537.7697 (TDD)**

Complaint forms are available at
**https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html**

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Evernorth Care Solutions, Inc. and HMO or service company subsidiaries of Cigna Health Corporation, including Cigna HealthCare of Arizona, Inc., Cigna HealthCare of California, Inc., Cigna HealthCare of Colorado, Inc., Cigna HealthCare of Connecticut, Inc., Cigna HealthCare of Florida, Inc., Cigna HealthCare of Georgia, Inc., Cigna HealthCare of Illinois, Inc., Cigna HealthCare of Indiana, Inc., Cigna HealthCare of St. Louis, Inc., Cigna HealthCare of North Carolina, Inc., Cigna HealthCare of New Jersey, Inc., Cigna HealthCare of South Carolina, Inc., Cigna HealthCare of Tennessee, Inc., and Cigna HealthCare of Texas, Inc. ATTENTION: If ycu speak languages other than English, language assistance services, free of charge are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711). ATENCION: Si usted habla un idioma que no sea inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

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## Proficiency of Language Assistance Services

**English** – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna Healthcare customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

**Spanish** – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna Healthcare, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

**Chinese** – 注意：我們可爲您免費提供語言協助服務。對於 Cigna Healthcare 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

**Vietnamese** – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna Healthcare, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

**Korean** – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna Healthcare 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

**Tagalog** – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna Healthcare, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

**Russian** – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna Healthcare, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

**Arabic** – برجاء الانتباة خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna Healthcare الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية.
او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

**French Creole** – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna Healthcare yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

**French** – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna Healthcare, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

**Portuguese** – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna Healthcare atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

**Polish** – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna Healthcare mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

**Japanese** – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCigna Healthcareのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

**Italian** – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna Healthcare attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

**German** – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna Healthcare-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

**Persian (Farsi)** – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می شود. برای مشتریان فعلی Cigna Healthcare، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شمار ه‌گیری کنید).