# SUMMARY OF BENEFITS Cigna Health and Life Insurance Co.

**Dilmar Oil Company, Inc.**
**Health Savings Account Open Access Plus**


| General Services | In-Network | Out-of-Network |
|---|---|---|
| **Physician office visit – Primary Care Physician (PCP)** | After plan deductible is met, you pay $35 per visit copay, then plan pays 100% | After the plan deductible is met, You pay 30% Plan pays 70% |
| **Physician Office Visit – Specialist** | After plan deductible is met, you pay $70 per visit copay, then plan pays 100% | After the plan deductible is met, You pay 30% Plan pays 70% |
| **Cigna Telehealth Connection services**<br>• Includes charges for the delivery of medical and health-related consultations via secure telecommunications technologies, telephones and internet only when delivered by contracted medical telehealth providers (see details on myCigna.com) | After plan deductible is met, you pay $35 per visit copay, then plan pays 100% | Not Covered |
| **Urgent care visit**<br>• All services including Lab & X-ray | After plan deductible is met, you pay $70 per visit copay, then plan pays 100% | After the plan deductible is met, You pay 30% Plan pays 70% |
| **Preventive Care** | Plan pays 100%, no copay, no deductible | Not Covered |
| **Preventive Services** | Plan pays 100%, no copay, no deductible | Not Covered |
| **Immunizations** | Plan pays 100%, no copay, no deductible | Not Covered |
| **Coinsurance** | After the plan deductible is met, You pay 0% Plan pays 100% | After the plan deductible is met, You pay 30% Plan pays 70% |
| **Calendar year deductible**<br>• Benefits for an individual within a family are paid once the individual deductible has been met.<br>• In-network and out-of-network expenses do not cross accumulate.<br>• Plan deductible always applies before any copay or coinsurance. | Individual: $3,500 Family: $7,000 | Individual: $7,500 Family: $15,000 |
| **Out-of-pocket annual maximum**<br>• Medical copays apply towards the out-of-pocket maximums<br>• Medical deductibles apply towards the out-of-pocket maximums<br>• Expenses do not cross accumulate between in-network and out-of-network out-of-pocket maximums | Individual: $6,400 Family: $12,800 | Individual: $10,000 Family: $20,000 |
| **Lifetime maximum** | Unlimited Per individual | |
| **Out-of-network annual maximum** | | Unlimited Per individual |

| General Services | In-Network | Out-of-Network |
|---|---|---|
| **Emergency room care**<br>• All services rendered apply to ER benefit including Lab & X-ray | After the plan deductible is met,<br>You pay $250 per visit copay (waived if admitted),<br>then plan pays 100% | |
| **Ambulance** | After the in-network plan deductible is met,<br>You pay 0%<br>Plan pays 100% | |
| **Office surgery – PCP** | After the plan deductible is met,<br>You pay 0%<br>Plan pays 100% | After the plan deductible is met,<br>You pay 30%<br>Plan pays 70% |
| **Office surgery – Specialist** | After the plan deductible is met,<br>You pay 0%<br>Plan pays 100% | After the plan deductible is met,<br>You pay 30%<br>Plan pays 70% |
| **Other office services – laboratory** | After the plan deductible is met,<br>You pay 0%<br>Plan pays 100% | Covered same as plan's<br>Physician's Office Services |
| **Other office services – radiology** | After the plan deductible is met,<br>You pay 0%<br>Plan pays 100% | Covered same as plan's<br>Physician's Office Services |
| **Outpatient lab** | After the plan deductible is met,<br>Plan pays 100% | After the plan deductible is met,<br>You pay 30%<br>Plan pays 70% |
| **Outpatient radiology** | After the plan deductible is met,<br>Plan pays 100% | After the plan deductible is met,<br>You pay 30%<br>Plan pays 70% |
| **Independent lab** | After the plan deductible is met,<br>Plan pays 100% | After the plan deductible is met,<br>You pay 30%<br>Plan pays 70% |
| **Office advanced radiology imaging services**<br>• Includes MRI, MRA, PET, CT-Scan and Nuclear medicine | After the plan deductible is met,<br>You pay 0%<br>Plan pays 100% | After the plan deductible is met,<br>You pay 30%<br>Plan pays 70% |
| **Outpatient advanced radiology imaging services**<br>• Includes MRI, MRA, PET, CT-Scan and Nuclear medicine | After the plan deductible is met,<br>You pay 0%<br>Plan pays 100% | After the plan deductible is met,<br>You pay 30%<br>Plan pays 70% |
| **Durable medical equipment**<br>• Includes external prosthetic appliances<br>• Does accumulate towards the out-of-pocket maximum | After the plan deductible is met,<br>You pay 0%<br>Plan pays 100% | After the plan deductible is met,<br>You pay 30%<br>Plan pays 70% |
| **Breast Feeding Equipment and Supplies**<br>• Limited to the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies | Plan pays 100%,<br>no copay,<br>no deductible | Not Covered |

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| **Hospital Services** | | |
| **Inpatient hospital services** | After the plan deductible is met,<br>You pay 0%<br>Plan pays 100% | After the plan deductible is met,<br>You pay 30%<br>Plan pays 70% |
| **Inpatient Professional Services**<br>• For services performed by Surgeons, Radiologists, Pathologists, Anesthesiologists, and Hospital Based Physician | After the plan deductible is met,<br>You pay 0%<br>Plan pays 100% | After the plan deductible is met,<br>You pay 30%<br>Plan pays 70% |

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| **Outpatient hospital services** | After the plan deductible is met,<br>You pay 0%<br>Plan pays 100% | After the plan deductible is met,<br>You pay 30%<br>Plan pays 70% |
| **Outpatient professional services**<br>• For services performed by Surgeons, Radiologists, Pathologists, Anesthesiologists | After the plan deductible is met,<br>You pay 0%<br>Plan pays 100% | After the plan deductible is met,<br>You pay 30%<br>Plan pays 70% |
| **Skilled nursing facility care**<br>• 100 days per calendar year maximum | After the plan deductible is met,<br>You pay 0%<br>Plan pays 100% | After the plan deductible is met,<br>You pay 30%<br>Plan pays 70% |
| **Hospice care** | After the plan deductible is met,<br>You pay 0%<br>Plan pays 100% | After the plan deductible is met,<br>You pay 30%<br>Plan pays 70% |
| **Home health care**<br>• 40 visits per calendar year maximum | After the plan deductible is met,<br>You pay 0%<br>Plan pays 100% | Not Covered |
| **Mental Health and Substance Use Disorder** | | |
| **Inpatient mental health**<br>• Includes Residential Treatment | After the plan deductible is met,<br>Plan pays 100% | After the plan deductible is met,<br>You pay 30%<br>Plan pays 70% |
| **Outpatient mental health – Physician's Office**<br>• Includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy | You pay $70 copay<br>after the plan deductible | After the plan deductible is met,<br>You pay 30%<br>Plan pays 70% |
| **Outpatient mental health – all other services**<br>• Includes Partial Hospitalization<br>• Includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy | After the plan deductible is met,<br>Plan pays 100% | After the plan deductible is met,<br>You pay 30%<br>Plan pays 70% |
| **Inpatient substance use disorder**<br>• Includes Residential Treatment | After the plan deductible is met,<br>Plan pays 100% | After the plan deductible is met,<br>You pay 30%<br>Plan pays 70% |
| **Outpatient substance use disorder – Physician's Office**<br>• Includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy | You pay $70 copay<br>after the plan deductible | After the plan deductible is met,<br>You pay 30%<br>Plan pays 70% |
| **Outpatient substance use disorder – all other services**<br>• Includes Partial Hospitalization<br>• Includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy | After the plan deductible is met,<br>Plan pays 100% | After the plan deductible is met,<br>You pay 30%<br>Plan pays 70% |
| **Therapy Services** | | |
| **Outpatient physical therapy, speech therapy, hearing therapy and occupational therapy**<br>• 60 visits per calendar year | Covered same as plan's Physician Office Visit – Specialist | Covered same as plan's Physician Office Visit – Specialist |
| **Chiropractic services**<br>• 12 visits per calendar year | Covered same as Specialist's Office Visit | Covered same as Specialist's Office Visit |
| **Acupuncture** | Not Covered | Not Covered |
| **Additional Services** | | |

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| **Medical Specialty Drugs Inpatient Facility**<br>• This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges. | After the plan deductible is met,<br>You pay 0%<br>Plan pays 100% | After the plan deductible is met,<br>You pay 30%<br>Plan pays 70% |
| **Medical Specialty Drugs Outpatient Facility**<br>• This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges. | After the plan deductible is met,<br>You pay 0%<br>Plan pays 100% | After the plan deductible is met,<br>You pay 30%<br>Plan pays 70% |
| **Medical Specialty Drugs Physician's Office**<br>• This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician's Office. This benefit does not cover the related Office Visit or Professional charges. | After the plan deductible is met,<br>You pay 0%<br>Plan pays 100% | After the plan deductible is met,<br>You pay 30%<br>Plan pays 70% |
| **Medical Specialty Drugs Home**<br>• This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient's home. This benefit does not cover the related Professional charges. | After the plan deductible is met,<br>You pay 0%<br>Plan pays 100% | After the plan deductible is met,<br>You pay 30%<br>Plan pays 70% |
| **PPACA Women's Health**<br>• Includes surgical services, such as tubal ligation (excludes reversals)<br>• Contraceptive devices are included. | Plan pays 100%,<br>no copay,no deductible | Not Covered |
| **Family planning**<br>• Includes surgical services, such as vasectomy (excludes reversals)<br>• Includes infertility testing for diagnosis only | Varies based on place of service | Not Covered |
| **Infertility** | Not Covered | Not Covered |
| **Abortion**<br>• Includes non-elective procedures<br>• Includes elective procedures in-network only | Varies based on place of service | Varies based on place of service |
| **TMJ** | Not Covered | Not Covered |
| **Organ transplant**<br>• Services paid at network level if performed at Cigna LifeSOURCE Transplant Network® Facilities<br>• Travel maximum $10,000 per lifetime (only available if using Cigna LifeSOURCE Transplant Network® facility) | After the plan deductible is met,<br>You pay 0%<br>Plan pays 100% | Not Covered |
| **Out-of-area services**<br>• Coverage for services rendered outside a network area<br>• ER and Ambulance paid the same as network services<br>• Preventive care services covered at 100% for out of area<br>• In-network deductible and out-of-pocket maximums apply | For all other services<br>You pay 20%<br>Plan pays 80%<br>after the network deductible is met | |
| **Pharmacy** | **In-Network** | |
| **Cost Share and Supply** | | |

| Pharmacy | In-Network |
|---|---|
| **Med 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)<br>• If you receive a supply of 34 days or less at home delivery, the home delivery pharmacy cost share will be adjusted to reflect a 30-day supply. | Once the medical deductible is met then the customer is responsible for the cost share<br><br>**Retail (per 30-day supply):**<br>Generic: You pay $10<br>Preferred Brand: You pay $35<br>Non-Preferred Brand: You pay $60<br><br>**Retail and Home Delivery (per 30-day supply):**<br>Specialty: You pay $100<br><br>**Retail and Home Delivery (per 90-day supply):**<br>Generic: You pay $25<br>Preferred Brand: You pay $88<br>Non-Preferred Brand: You pay $150 |

- 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.
- 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.
- You can elect brand or generic with no penalty (MAC C).
- 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 Cigna Home Delivery. If you choose to fill a 90-day prescription, it must be filled at a 90-day network retail pharmacy or Cigna Home Delivery to be covered by the plan.
- Exclusive specialty home delivery: Specialty medications must be filled through home delivery; otherwise you pay the entire cost of the prescription after 1 Retail fill.
- 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.

## Drugs Covered

**Prescription Drug List:**
Your Cigna Advantage 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:

- Coverage includes Self Administered injectable drugs, but excludes infertility drugs.
- 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.
- Non-Sedating Anti-histamines are not covered.
- Ulcer Drugs (Proton Pump Inhibitors/PPI) are not covered.

## Pharmacy Program Information

**Pharmacy Clinical Management and Prior Authorization**

- Your plan includes access to the TheraCare® program which works with customers to help them better understand their condition, medications and their side effects in addition to why it's important to take their medications exactly as prescribed by a physician.
- Prior authorization is required on specialty medications and quantity limits may apply.

**Pharmacy Cost Management Program**
**Step Therapy:** Your plan is subject to rules for certain classes of drugs that may require you to try Generic and/or Preferred Brand drugs before use of a Non-Preferred Brand will be approved.

- Please refer to the Prescription Drug Price Quote tool on myCigna.com or call Customer Service at the phone

| Pharmacy Program Information |
| --- |
| number listed on your ID card to determine whether any of your medications require Step Therapy. Medications requiring Step Therapy are identified on the prescription drug list with an "ST" suffix. |
| **Clinical Outcome Programs:**<br>• Your plan includes Narcotic Therapy Management to identify unusual medication use patterns and offers physicians a comprehensive view of your overall treatment history. |

## Additional Information

**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.

**Out of Pocket Maximum**

Once you reach the individual or family out-of-pocket maximum (non-covered benefits are excluded from this total) in any one calendar year, covered services will be payable at 100% for the remainder of the year.

- Medical copays apply towards the out-of-pocket maximums
- Medical deductibles apply towards the out-of-pocket maximums

**Plan Coverage for Out-of-Network Providers**

- 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 at 110% of a fee schedule 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 supply or the amount charged for that service by 80% of the health care professionals in the geographic area where it is received. Out-of-network services are subject to a calendar year deductible and maximum reimbursable charge limitations.

**Complete Care Management**

Pre-authorization is required on all inpatient admissions and selected outpatient procedures, diagnostic testing, and outpatient surgery. Network providers are contractually obligated to perform pre-authorization on behalf of their customers. For an out-of-network provider, the customer is responsible for following the pre-authorization procedures. If a customer does not follow requirements for obtaining pre-treatment authorization, a $750 penalty will be applied.

**General Notice of Preexisting Condition Exclusion**

- Not applicable

**Medicare Coordination**

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 as permitted by the Social Security Act of 1965** as follows:
(a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent, or an Employee's Domestic Partner who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);
(b) an Employee, a former Employee, an Employee's Dependent, or former Employee's Dependent, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

This plan will pay as the Secondary Plan to Medicare Part A and B **regardless if the person seeks care at a Medicare Provider or not for Medicare covered services.**

## Exclusions

**What's Not Covered (This Is Not All Inclusive; check your plan documents for a complete list)**

- Services that aren't medically necessary
- Experimental or investigational treatments, except for routine patient care costs related to qualified clinical trials as described in your plan document
- Accidental injury that occurs while working for pay or profit
- Sickness for which benefits are paid or payable under any Worker's Compensation or similar law
- Services provided by government health plans
- Cosmetic surgery, unless it corrects deformities resulting from illness, breast reconstruction surgery after a mastectomy, or congenital defects of a newborn or adopted child or child placed for adoption
- Dental treatments and implants
- Custodial care
- Surgical procedures for the improvement of vision that can be corrected through the use of glasses or contact lenses
- Vision therapy or orthoptic treatment
- Hearing aids
- Reversal of sterilization procedures
- Nonprescription drugs or anti-obesity drugs
- Gene manipulation therapy
- Smoking cessation programs
- Non-emergency services incurred outside the United States
- Bariatric surgery
- Infertility services
- Treatment of TMJ disorders and craniofacial muscle disorders

**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 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.



EHB State: SC

# DISCRIMINATION IS AGAINST THE LAW

## Medical coverage

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

Cigna:

- 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.

If you believe that Cigna 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
Nondiscrimination Complaint Coordinator
PO 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
http://www.hhs.gov/ocr/office/file/index.html.




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## Proficiency of Language Assistance Services

**English** – ATTENTION: 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).

**Spanish** – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. 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).

**Chinese** – 注意：我們可為您免費提供語言協助服務。對於 Cigna 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, 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 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, 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, 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 الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna 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 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, 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 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 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 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-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 می‌شود. برای مشتریان فعلی Cigna، 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 شماره‌گیری کنید).