SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.
For - Dilmar Oil Company, Inc.
HSA OAP Plan

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.

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	
Plan Coinsurance	Plan pays 100%	Plan pays 70%
Maximum Reimbursable Charge	Not Applicable	110%
Plan Deductible	Individual: $3,500 Family: $7,000	Individual: $15,000 Family: $30,000

- 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.
- Plan deductible always applies before any benefit copay/deductible or coinsurance.
- After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan.
- This plan includes a combined Medical/Pharmacy plan deductible.

Note: Services where plan deductible applies are noted with a caret (^).

Plan Highlights	In-Network	Out-of-Network
Plan Out-of-Pocket Maximum	Individual: $6,650 Family: $13,300	Individual: $30,000 Family: $60,000

- 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.
- Plan deductible contributes towards your out-of-pocket maximum.
- All benefit copays/deductibles contribute towards your out-of-pocket maximum.
- 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.
- 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.
- 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	$35 copay, and plan pays 100% ^	Plan pays 70% ^
Specialty Care Physician Services/Office Visit	$70 copay, and plan pays 100% ^	Plan pays 70% ^
Surgery Performed in Physician's Office	Plan pays 100% ^	Plan pays 70% ^
Cigna Telehealth Connection Services	$35 copay, and plan pays 100% ^	Not Covered
• 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)		
Preventive Care		
Preventive Care Office Visit	Plan pays 100%	Not Covered
Preventive Services	Plan pays 100%	Not Covered
• Includes preventive Mammograms, Papanicolaou (Pap), Prostate Specific Antigen (PSA) tests and colorectal screenings. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.		
Immunizations	Plan pays 100%	Not Covered
Inpatient		
Inpatient Hospital Facility Services	Plan pays 100% ^	Plan pays 70% ^
Note: Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs		
Inpatient Hospital Physician's Visit/Consultation	Plan pays 100% ^	Plan pays 70% ^
Inpatient Professional Services	Plan pays 100% ^	Plan pays 70% ^
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists		
Outpatient		
Outpatient Facility Services	Plan pays 100% ^	Plan pays 70% ^

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.		
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Plan pays 100% ^	Plan pays 70% ^
Emergency Services		
Emergency Room • Includes ER Physician Charges, Lab and Radiology including Advanced Radiological Imaging (ARI) • Per visit copay is waived if admitted.	$250 copay, and plan pays 100% ^	
Urgent Care Facility Includes Physician Charges, Lab and Radiology	$70 copay, and plan pays 100% ^	Plan pays 70% ^
Ambulance	Plan pays 100% ^	
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 • Annual Limit: 100 days	Plan pays 100% ^	Plan pays 70% ^
Laboratory Services		
Physician's Services/Office Visit	Plan pays 100% ^	Covered same as Physician Services - Office Visit
Independent Lab	Plan pays 100% ^	Plan pays 70% ^
Outpatient Facility	Plan pays 100% ^	Plan pays 70% ^
Radiology Services		
Physician's Services/Office Visit	Plan pays 100% ^	Covered same as Physician Services - Office Visit
Outpatient Facility	Plan pays 100% ^	Plan pays 70% ^
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.	
Outpatient Facility	Plan pays 100% ^	Plan pays 70% ^
Physician's Services/Office Visit	Plan pays 100% ^	Plan pays 70% ^
Outpatient Short Term Rehabilitation		
Outpatient Physical Therapy, Speech Therapy, Hearing Therapy and Occupational Therapy	$70 copay, and plan pays 100% ^	Plan pays 70% ^
Annual Limits: • All Therapies Combined – Includes Physical, Speech, Hearing and Occupational Therapies – 60 visits • Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies. **Note:** Therapy visits, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy 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.		
Chiropractic Care	$70 copay, and plan pays 100% ^	Plan pays 70% ^
Annual Limit: • Chiropractic Care – 12 visits		
Hospice		
Inpatient Facilities	Plan pays 100% ^	Plan pays 70% ^
Outpatient Services	Plan pays 100% ^	Plan pays 70% ^
Note: Includes Bereavement counseling provided as part of a hospice program.		
Medical Specialty Drugs		
Outpatient Facility	Plan pays 100% ^	Plan pays 70% ^
Physician's Office	Plan pays 100% ^	Plan pays 70% ^
Home	Plan pays 100% ^	Plan pays 70% ^
Note: This benefit only applies to the cost of the Infusion Therapy drugs administered. This benefit does not cover the related Facility, Office Visit or Professional charges.		
Family Planning		
Women's Services	Plan pays 100%	Not Covered
In-Network includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals). Out-of-Network coverage is provided for contraceptive devices as ordered or prescribed by a physician.		
Men's Services	Coverage varies based on Place of Service	Not Covered
Includes surgical sterilization services, such as vasectomy (excludes reversals)		
Abortion		
Abortion Services	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Note: • Includes non-elective procedures • Includes elective procedures in-network only		
Infertility		
Infertility Treatment **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.		
Other Health Care Facilities/Services		

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.		
Home Health Care • Annual Limit: 40 visits (The limit is not applicable to mental health and substance use disorder conditions.)	Plan pays 100% ^	Not Covered
Organ Transplants • Services paid at in-network level if performed at Cigna LifeSOURCE Transplant Network® Facilities. • Travel Maximum – Cigna LifeSOURCE Transplant Network® Facility Only: $10,000 maximum per Transplant per Lifetime	Covered same as Inpatient benefit	Not Covered
Durable Medical Equipment and External Prosthetic Appliances • Annual Limit: Unlimited	Plan pays 100% ^	Plan pays 70% ^
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Plan pays 100%	Not Covered
Note: Services where plan deductible applies are noted with a caret (^).		
Mental Health and Substance Use Disorder		
Inpatient mental health	Plan pays 100% ^	Plan pays 70% ^
Outpatient mental health – Physician's Office	$70 copay, and plan pays 100% ^	Plan pays 70% ^
Outpatient mental health – all other services	Plan pays 100% ^	Plan pays 70% ^
Inpatient substance use disorder	Plan pays 100% ^	Plan pays 70% ^
Outpatient substance use disorder – Physician's Office	$70 copay, and plan pays 100% ^	Plan pays 70% ^
Outpatient substance use disorder – all other services	Plan pays 100% ^	Plan pays 70% ^
Annual Limits: • Unlimited maximum Notes: • Inpatient includes Acute Inpatient and Residential Treatment. • Outpatient - Physician's Office - includes Individual, family and group therapy, psychotherapy, medication management, etc. • Outpatient - All Other Services - includes Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy) and Behavioral Telehealth Consultation, etc.		
Pharmacy	**In-Network**	
Cost Share and Supply		

Pharmacy	In-Network
Med Pharmacy Cost Share • Retail – up to 90-day supply (except Specialty up to 30-day supply) • Home Delivery – up to 90-day supply (except Specialty up to 30-day supply) • If you receive a supply of 34 days or less at home delivery of a Specialty Prescription Drug, the Specialty home delivery cost share will be adjusted to reflect a Retail (per 30-day supply) cost share.	Once the medical deductible is met then the customer is responsible for the cost share **Retail (per 30-day supply):** Generic: You pay $10 ^ Preferred Brand: You pay $35 ^ Non-Preferred Brand: You pay $60 ^ **Retail and Home Delivery (per 30-day supply):** Specialty: You pay $100 ^ **Retail and Home Delivery (per 90-day supply):** Generic: You pay $25 ^ Preferred Brand: You pay $88 ^ 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.
- 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.
- 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).
- 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. Some exceptions may apply.
- 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.

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.

Clinical Outcome Programs:

- 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

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 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 if no amount is agreed to, the greater of the following: (i) the median amount negotiated with In-Network providers for the Emergency Service, excluding any In-Network copay or coinsurance; (ii) the Maximum Reimbursable Charge; or (iii) the amount payable under the Medicare program, not to exceed the provider's billed charges.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is also responsible for all 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.

Additional Information

Medicare Coordination
In accordance with the Social Security Act of 1965, this plan will pay as the Secondary plan 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, 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.

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.**

Out-of-Area Services • Coverage for services rendered outside a network area • ER and Ambulance paid the same as network services • Preventive care services covered at 100% for Out-of-Area • In-Network Deductible and Out-of-Pocket maximums apply	For all other services, plan pays 80% after the in-network deductible is met

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.

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

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 (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 workers' compensation or similar law
- Services provided by government health plans

Exclusions

- 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
- 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, 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.

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).