SCHEDULE OF BENEFITS

Cigna Healthcare℠ Small Group Arizona Silver $4,250
Open Access Plus 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 Plan 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 70%	Plan pays 50%
Maximum Reimbursable Charge (see "Additional Information")	Not Applicable	110%
Plan Deductible	Individual: $4,250 Family: $8,500	Individual: $7,500 Family: $15,000

- 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.
- 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.

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

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Plan Highlights	In-Network	Out-of-Network
Plan Out-of-Pocket Maximum	Individual:$12,000 Family $24,000	Individual: $20,000 Family: $40,000

- 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	$55 copay, and plan pays 100%	Plan pays 50% ^
Specialty Care Physician Services/Office Visit	$85 copay, and plan pays 100%	Plan pays 50% ^
Surgery Performed in Physician's Office	Covered same as Physician Services - Office Visit	Plan pays 50%^
Virtual Care		
Dedicated Virtual Providers - MDLIVE		
MDLIVE Urgent Virtual Care Services	Plan pays 100%	Not Covered
MDLIVE Primary Care Services	$55 copay, and plan pays 100%	Not Covered
MDLIVE Specialty Care Services	$85 copay, and plan pays 100%	Not Covered

- Primary Care cost share applies to routine care. Virtual wellness screenings are payable under Preventive Care.
- For MDLIVE Behavioral Services, please refer to the Mental Health and Substance Use Disorder section (below).
- Lab services supporting a virtual visit must be obtained through dedicated labs.
- 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	$55 copay, and plan pays 100%	Plan pays 50% ^
Specialty Care Physician Services/Office Visit	$85 copay, and plan pays 100%	Plan pays 50% ^

- Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services).
- 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.

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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.		
Preventive Care		
Preventive Care Office Visit	Plan pays 100%	Plan pays 50% ^
Preventive Services • Includes preventive Mammograms, preventative breast cancer screening, 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.	Plan pays 100%	Plan pays 50% ^
Immunizations	Plan pays 100%	Plan pays 50% ^
Breast Health Imaging		
Routine	Plan pays 100%	Plan pays 50%
Diagnostic/Supplemental breast examinations (including but not limited to Mammograms, molecular breast imaging (MBI), breast ultrasound screening and MRIs)	Plan pays 100%	Plan pays 50%
Inpatient		
Inpatient Hospital Facility Services **Note:** Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs	Plan pays 70% ^	Plan pays 50% ^
Inpatient Hospital Physician's Visit/Consultation	Plan pays 70% ^	Plan pays 50% ^
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Plan pays 70% ^	Plan pays 50% ^
Outpatient		
Outpatient Facility Services	Plan pays 70% ^	Plan pays 50% ^
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Plan pays 70% ^	Plan pays 50% ^
Emergency Services		
Emergency Room • Includes ER Physician Charges, Lab and Radiology including Advanced Radiological Imaging (ARI)	$800 copay, and plan pays 100%^	
Urgent Care Facility • Includes Physician Charges, Lab and Radiology	$90 copay, and plan pays 100%	Plan pays 50% ^
Ambulance - Medical Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.	Plan pays 70% ^	
Ambulance - Mental Health and Substance Use Disorder Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.	Plan pays 100% ^	

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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 Services at Other Health Care Facilities		
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities • Annual Limit: 100 days	Plan pays 70% ^	Plan pays 50% ^
Laboratory Services		
Physician's Services/Office Visit	Plan pays 100%	Plan pays 50% ^
Independent Lab	Plan pays 100%	Plan pays 50% ^
Outpatient Facility	Plan pays 70% ^	Plan pays 50% ^
Radiology Services		
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit	Plan pays 50% ^
Outpatient Facility	Plan pays 70% ^	Plan pays 50% ^
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.	
Outpatient Facility	Plan pays 70% ^	Plan pays 50% ^
Physician's Services/Office Visit	Plan pays 70% ^	Plan pays 50% ^
Outpatient Therapy Services		
Outpatient Physical Therapy, Speech Therapy and Occupational Therapy Annual Limits: • All Therapies Combined – Includes Physical, Speech 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 Home Health Care maximum.	$85 copay, and plan pays 100%	Plan pays 50% ^
Chiropractic Care Annual Limit: • Chiropractic Care – Unlimited • Including Spinal Manipulation and Subluxation Services	$35 copay, and plan pays 100%	Plan pays 50% ^
Cardiac & Pulmonary Rehabilitation Annual Limit: • Cardiac Rehabilitation - 36 visits • Pulmonary Rehabilitation - Unlimited	Plan pays 70% ^	Plan pays 50% ^
Hospice		
Inpatient Facilities	Plan pays 70% ^	Plan pays 50% ^
Outpatient Services **Note:** Includes Bereavement counseling provided as part of a hospice program.	Plan pays 70% ^	Plan pays 50% ^

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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.		
Medical Pharmaceutical Drugs		
Cigna Pathwell Specialty℠ Medical Pharmaceuticals	**Cigna Pathwell Specialty℠ Network:** Plan pays 70% ^	Plan pays 50% ^
Other Medical Pharmaceuticals	Plan pays 70% ^	Plan pays 50% ^
Note: 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.		
Family Planning		
Women's Services	Plan pays 100%	Coverage varies based on Place of Service
Includes contraceptive devices as ordered or prescribed by a physician and surgical sterilization services, such as tubal ligation (excludes reversals)		
Men's Services	Coverage varies based on Place of Service	Coverage varies based on Place of Service
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: Non-elective procedures 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.		
Transplant Services		
Cigna LifeSOURCE Transplant Network® Facility	Plan pays 100%	Not Covered
Travel Benefit (Only available through Cigna LifeSOURCE Transplant Network® Facility) Includes a $10,000 Travel maximum/per transplant		
Non-LifeSOURCE Participating Facility specifically contracted to perform Transplant Services	Plan pays 70% ^	Not Covered
Participating Facilities NOT specifically contracted to perform Transplant Services and Non-Participating Facilities	Plan pays 50% ^	Plan pays 50% ^

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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.		
Nutritional Formulas		
Medical Foods to treat inherited metabolic disorders	Plan pays 70% ^	Plan pays 50% ^
Amino Acid Based formula to treat Eosinophilic Gastrointestinal Disorder	Plan pays 70% ^	Plan pays 50% ^
Other Health Care Facilities/Services		
Home Health Care • Annual Limit: 42 visits	Plan pays 70% ^	Plan pays 50% ^
Durable Medical Equipment and External Prosthetic Appliances • Annual Limit: Unlimited	Plan pays 70% ^	Plan pays 50% ^
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%	Plan pays 50% ^
Temporomandibular Joint Disorder (TMJ) • Annual Limit: Unlimited for Surgical and Non-Surgical treatment **Note:** Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment.	Coverage varies based on Place of Service	Coverage varies based on Place of Service
Hearing Aids • Maximum of 1 per ear, per benefit period. • Includes testing and fitting of hearing aid devices	Plan pays 70% ^	Plan pays 50% ^

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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.		
Pediatric Dental and Vision Services		
Pediatric Dental Care (up to age 19) Preauthorization required for orthodontics and major services		
Diagnostic and Preventive Care • One (1) visit per 6 months	Plan pays 100%	Plan pays 50% ^
Basic Services	Plan pays 80% ^	Plan pays 50% ^
Major Services	Plan pays 50% ^	Plan pays 50% ^
Orthodontics	Plan pays 50% ^	Plan pays 50% ^
Pediatric Vision Care (up to age 19) Performed by an ophthalmologist or optometrist for an Insured Person, through the end of the month in which the Insured Person turns 19 years of age. Please be aware that the pediatric vision network is different from the network of your medical benefits.		
Comprehensive Eye Exam • Limited to one exam per Plan Year	Plan pays 100%	Plan pays 70% ^
Eyeglasses for Children • Limited to one pair per Plan Year from pediatric frame collection. • Pediatric Frames, Single Vision, Lined Bifocals, Lined Trifocal or Standard Progressive and Lenticular Lenses.	Plan pays 100%	Plan pays 70% ^
Contact Lenses for Children • Plan Year limits apply	Plan pays 100%	Plan pays 70% ^
Low Vision Services and Aids • Plan Year limits apply	Plan pays 100%	Plan pays 70% ^

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

Mental Health and Substance Use Disorder

Inpatient Mental Health	Plan pays 70% ^	Plan pays 50% ^
Outpatient Mental Health – Physician's Office	$55 copay, and plan pays 100%	Plan pays 50% ^
Outpatient Mental Health - MDLIVE Behavioral Services	$55 copay, and plan pays 100%	Not Covered
Outpatient Mental Health – All Other Services	Plan pays 70% ^	Plan pays 50% ^
Inpatient Substance Use Disorder	Plan pays 70% ^	Plan pays 50% ^
Outpatient Substance Use Disorder – Physician's Office	$55 copay, and plan pays 100%	Plan pays 50% ^
Outpatient Substance Use Disorder - MDLIVE Behavioral Services	$55 copay, and plan pays 100%	Not Covered
Outpatient Substance Use Disorder – All Other Services	Plan pays 70% ^	Plan pays 50% ^

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.

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."

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Pharmacy	In-Network	Out-of-Network
Cost Share and Supply		
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)	**Retail (per 30-day supply):** Generic: You pay $25 Preferred Brand: You pay $40 Non-Preferred Brand: You pay $60 **Retail and Home Delivery (per 90-day supply):** Generic: You pay $75 Preferred Brand: You pay $120 Non-Preferred Brand: You pay $180	**Retail:** You pay 50% Your plan pays 50% **Home Delivery:** Not Covered

- **Cigna 90 Now Walgreens:** 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. CVS 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.
- 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 you request a brand drug, you pay 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) (MAC B).
- Your pharmacy benefits share an out-of-pocket maximum with the medical/behavioral benefits.

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.

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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 only count toward meeting your out-of-pocket maximum.
- Any discount provided by a pharmaceutical manufacturer for these medications only count toward meeting your out-of-pocket maximum.

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. If a Medicare based fee schedule is unavailable, 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 Plan 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.

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Additional Information

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 preauthorization procedures. If a customer does not follow requirements for obtaining pre-treatment authorization, a $750 penalty will be applied.

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.
Plan Year - the 12-month period in which Your Plan begins and ends.

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: AZ

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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.

cigna healthcare

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**

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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 - ATENCION: Hay servicios de asistencia de idiomas, sin cargo, a su disposici6n. Si es un cliente actual de Cigna Healthcare, !lame al numero que figura en el reverso de su tarjeta de identificaci6n. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese - i±: ft{rraJf,Sf:9e.JftJHJ:t!t ia.l=l}Jij f£ ◦ It Cigna Healthcare EfJJJi P , rlfi&fflf Efl ID -t1r®Ef1 ◦ {-g 1.800.244.6224 C lr!H!H,i : ffti 711) ◦

Vietnamese - XIN LU'U Y: Quy vi dU'Q'C c p djch v1,1 trQ' giup v ng6n ngQ> mien phi. Danh cha khach hang hi(m tc;1i cua Cigna Healthcare, vui long goi s6 mc;it sau the Hoi vien. Cac tmcmg hQ'p khac xin goi s6 1.800.244.6224 (TTY: Quay s6 711).

Korean - -?l: J Oj J..§-o J..l:= . <2! Oj 7'1 J..i 1 A 1f-E£ Ol-§-o "? LIq_ XH Cigna Healthcare 7'fl 7' a 7JllJ..i := ID 7' 121011 := 2 te:!.2.£ '2:! oH-? J..12.. 7IE q 011:= 1.800.244.6224 (TTY: qo1 711)te:! £ 2 0H-? J..l2..

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. 0 kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian - BHv1MAHv1E: BaM MoryT npeAOCTaBt,1Tb 6ecnnaTHble ycnyrn nepeBOAa. Ecm1 Bbl y)f{e y4acTByeTe B nnaHe Cigna Healthcare, no3BOHll1Te no HOMepy, yKa3aHHOMY Ha o6paTHO CTOpOHe Bawe 111A8HTll1q:>111Kal...\1110HHO KapTO4Kll1 y4aCTHll1Ka nnaHa. Ecn111 Bbl He f!BmleTeCb y4aCTHIIIKOM OAHOro 1113 HaWIIIX nnaHOB, no3BOHll1Te no HOMepy 1.800.244.6224 (TTY: 711).

Arabic .(711 '-,-l :TTY) 1.800.244.6224 '-:-l .Jl

French Creole - ATANSYON: Gen sevis ed nan lang ki disponib gratis pou ou. Pou kliyan Cigna Healthcare yo, rele nimewo ki deye kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French - ATTENTION: Des services d'aide linguistique vous sont proposes gratuitement. Si vous etes un client actuel de Cigna Healthcare, veuillez appeler le numero indique au verso de votre carte d'identite. Sinon, veuillez appeler le numero 1.800.244.6224 (ATS : composez le numero 711).

Portuguese - ATENCAO: Tern ao seu dispor servi<;:os de assistencia lingufstica, totalmente gratuitos. Para clientes Cigna Healthcare atuais, ligue para o numero que se encontra no verso do seu cartao de identifica<;:ao. Caso contrario, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish - UWAGA: w celu skorzystania z dost pnej, bezpfatnej pomocy j zykowej, obecni klienci firmy Cigna Healthcare mog9 dzwonic pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese - 51$:I:.W : 87$:iR7;£-it n -g-, *{O) iRsz::titt-I::'A7;£-c'f1JffII,'tctdt*9 IJH'IO)Cigna HealthcareO)S J;;t:_ ID:b- t- :' jijO) it:ffl: *c\ s it,LZc'Ji(tc. l,' f-O){{Q0)7J i, 1.800.244.6224 (TTY: 711) *c\ s it,LZc'Ji(tc. l,'

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

German - ACHTUNG: Die Leistungen der Sprachunterstotzung stehen Ihnen kostenlos zur Verfugung. Wenn Sie gegenwartiger Cigna Healthcare-Kunde sind, rufen Sie bitte die Nummer auf der Ruckseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wahlen Sie 711).

Persian (Farsi) c..J"w ...:..w,w <.s:iL....W w) S ,-, •·J .J.l c.S'•.Jw 4 i.il:.J ,Cigna Healthcare ui...y:;,.. c.Sl..>i ..l_,.!, <S'° \) w uK;I.J -:....J_,....,, •u-i4j wl.. :ji- .(.I:¢ c.S..>P-• .Jw 1.J 711 •.Jw :u\.ol w •y,_, •.JW) c..J"w 1.800.244.6224 •.Jw 4 W.J1 Y.F .J.l -