SUMMARY OF BENEFITS Cigna Health and Life Insurance Co.

Heifer International
Health Savings Account Open Access Plus

General Services	In-Network	Out-of-Network
Physician office visit – Primary Care Physician (PCP)	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Physician Office Visit – Specialist	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Cigna Telehealth Connection Services • 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) • Telehealth services rendered by providers that are not contracted medical telehealth providers (as described on myCigna.com) are covered at the same benefit level as the same services would be if rendered in-person.	After the plan deductible is met, You pay 20% Plan pays 80%	Not Covered
Urgent care visit • All services including Lab & X-ray	After the plan deductible is met, You pay 20% Plan pays 80%	
Preventive Care **Birth through age 18**	You pay 0% Plan pays 100%	You pay 0% Plan pays 100%
Ages 19 and older	You pay 0% Plan pays 100%	After the plan deductible is met, You pay 40% Plan pays 60%
Preventive Services **Birth through age 18**	You pay 0% Plan pays 100%	You pay 0% Plan pays 100%
Ages 19 and older	You pay 0% Plan pays 100%	Lab & X-Ray: You pay 0% Plan pays 100% All other services: After the plan deductible is met, You pay 40% Plan pays 60%
Immunizations **Birth through age 18**	You pay 0% Plan pays 100%	You pay 0% Plan pays 100%
Ages 19 and older	You pay 0% Plan pays 100%	After the plan deductible is met, You pay 40% Plan pays 60%
Coinsurance	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%

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General Services	In-Network	Out-of-Network
Calendar year deductible • Entire Family deductible must be met before benefits will be paid. • In-network and out-of-network expenses do not cross accumulate. • Plan deductible always applies before any copay or coinsurance. • This plan includes a combined Medical/Pharmacy deductible.	Individual: $2,000 Family: $4,000	Individual: $4,000 Family: $8,000
Out-of-pocket annual maximum • Medical copays apply towards the out-of-pocket maximums • Medical deductibles apply towards the out-of-pocket maximums • Expenses do not cross accumulate between in-network and out-of-network out-of-pocket maximums • This plan includes a combined Medical/Pharmacy out-of-pocket maximum.	Individual: $4,000 Individual – In a Family: $7,900 Family: $8,000	Individual: $8,000 Individual – In a Family: $16,000 Family: $16,000
Lifetime maximum	Unlimited Per individual	
Out-of-network annual maximum		Unlimited Per individual
Emergency room care • All services rendered apply to ER benefit including Lab & X-ray	After the plan deductible is met, You pay 20% Plan pays 80%	
Ambulance	After the in-network plan deductible is met, You pay 20% Plan pays 80%	
Office surgery – PCP	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Office surgery – Specialist	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Other office services – laboratory	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services
Other office services – radiology	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services
Outpatient lab	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Outpatient radiology	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Independent lab	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Office advanced radiology imaging services • Includes MRI, MRA, PET, CT-Scan and Nuclear medicine	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%

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General Services	In-Network	Out-of-Network
Outpatient advanced radiology imaging services • Includes MRI, MRA, PET, CT-Scan and Nuclear medicine	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Durable medical equipment • Includes external prosthetic appliances • Does accumulate towards the out-of-pocket maximum	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60% External Prosthetic Appliances: After the plan deductible is met, You pay 20% Plan pays 80%
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	You pay 0% Plan pays 100%	After the plan deductible is met, You pay 40% Plan pays 60%

Benefits	In-Network	Out-of-Network
Hospital Services		
Inpatient hospital services	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists, Anesthesiologists, and Hospital Based Physician	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Outpatient hospital services	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Outpatient professional services • For services performed by Surgeons, Radiologists, Pathologists, Anesthesiologists	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Skilled nursing facility care • 30 days per calendar year maximum	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Hospice care	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Home health care • 40 visits per calendar year maximum • The limit is not applicable to mental health and substance use disorder conditions.	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Mental Health and Substance Use Disorder		
Inpatient mental health • Includes Residential Treatment	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Outpatient mental health – Physician's Office • Includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%

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Benefits	In-Network	Out-of-Network
Outpatient mental health – all other services • Includes Partial Hospitalization • Includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Inpatient substance use disorder • Includes Residential Treatment	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Outpatient substance use disorder – Physician's Office • Includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Outpatient substance use disorder – all other services • Includes Partial Hospitalization • Includes Individual, Intensive Outpatient, Behavioral Telehealth Consultation, and Group Therapy	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Therapy Services		
Outpatient physical therapy • 20 visits per calendar year • Limits are not applicable to mental health conditions	Covered same as plan's Physician Office Visit – Primary Care Physician (PCP)	Covered same as plan's Physician Office Visit – Primary Care Physician (PCP)
Outpatient speech therapy, hearing therapy and occupational therapy • 20 visits per calendar year • Limits are not applicable to mental health conditions for speech and occupational therapies	Covered same as plan's Physician Office Visit – Primary Care Physician (PCP)	Covered same as plan's Physician Office Visit – Primary Care Physician (PCP)
Chiropractic services • 12 visits per calendar year	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Acupuncture	Not Covered	Not Covered
Additional Services		
Medical Specialty Drugs Inpatient Facility • 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, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Medical Specialty Drugs Outpatient Facility • 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, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
Medical Specialty Drugs Physician's Office • 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, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%

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Benefits	In-Network	Out-of-Network
Medical Specialty Drugs Home • 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, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60%
PPACA Women's Health • Includes surgical services, such as tubal ligation (excludes reversals) • Contraceptive devices are included.	You pay 0% Plan pays 100%	Varies based on place of service
Family planning • Includes surgical services, such as vasectomy (excludes reversals)	Varies based on place of service	Varies based on place of service
Infertility • Includes non-experimental infertility treatment	Varies based on place of service	Varies based on place of service
Abortion • Includes non-elective procedures only	Varies based on place of service	Varies based on place of service
TMJ	Not Covered	Not Covered
Organ transplant • Services paid at network level if performed at Cigna LifeSOURCE Transplant Network® Facilities • Travel maximum $10,000 per transplant (only available if using Cigna LifeSOURCE Transplant Network® facility)	After the plan deductible is met, You pay 20% Plan pays 80%	After the plan deductible is met, You pay 40% Plan pays 60% Transplant Maximums: Heart - $150,000 Liver - $230,000 Bone Marrow - $130,000 Kidney - $80,000 Pancreas - $50,000 Kidney/Pancreas - $80,000 Heart/Lung - $185,000 Lung - $185,000
Hearing Aid • $1,400 maximum per device • Maximum of 2 devices (one per ear) per 3 years • Includes testing and fitting of hearing aid devices at Physician Office Visit cost share.	After the plan deductible is met, Plan pays 100%	After the plan deductible is met, Plan pays 100%
Pharmacy	**In-Network**	**Out-of-Network**
Cost Share and Supply		
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)	Once the medical deductible is met then the customer is responsible for the cost share **Retail:** You pay 20% Your plan pays 80% **Home Delivery:** You pay 20% Your plan pays 80%	Once the medical deductible is met then the customer is responsible for the coinsurance **Retail:** You pay 20% Your plan pays 80% **Home Delivery:** Same as Retail Out-of-Network

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Pharmacy	In-Network	Out-of-Network
• Retail drugs may be obtained In-Network at a wide range of pharmacies across the nation. • You can choose to fill your medications in a 30- or 90-day supply at any network pharmacy. • 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). • 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.		
Preventive Drugs: In-Network Generic Preventive drugs and products will not be subject to deductible and will be provided at no charge. In addition, Federally required preventive drugs will not be subject to deductible and will be provided at no charge. This applies to drugs for: • Hypertension, high cholesterol, diabetes, asthma, osteoporosis, stroke, prenatal nutrient deficiency		
Additional 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. • Oral Fertility drugs 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. • 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.		
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.		

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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.

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.

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

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.

Emergency Services Reimbursement Limit
Emergency services are covered at the In-Network cost-sharing level if services are received from a non-participating (Out-of-Network) provider. The allowable amount used in determining benefit payments for emergency services provided in the emergency department of a non-participating (Out-of-Network) hospital is the greatest of the following: (i) the median amount negotiated with In-Network providers for the emergency service (excluding 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 the applicable In-Network cost-sharing amounts, plus all charges in excess of the allowable amount.

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

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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.**

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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
- 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
- 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.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc. and HMO or service company subsidiaries of Cigna Health Corporation. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

EHB State: AR

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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.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., Cigna Health Management, Inc., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc. The Cigna name, logos, and other Cigna marks are owned by Cigna Intellectual Property, Inc. ATTENTION: If you 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). ATENCIÓN: 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 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).