

## BENEFIT SUMMARY



**Cigna Health and Life Insurance Co.**  
**For - County of Albany**  
**OAP Plan**  
**HDHPQ Choice**  
**Effective - 08/01/2021**

**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](http://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](http://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
<b>Lifetime Maximum</b>	Unlimited	Unlimited
<b>Plan Year Accumulation</b>	Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a calendar year basis unless otherwise stated. In addition, all plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted.	
<b>Plan Coinsurance</b>	Plan pays 90%	Plan pays 70%
<b>Maximum Reimbursable Charge</b>	Not Applicable	110%
<b>Plan Deductible</b>	Individual - Employee Only: \$2,800 Individual - within a Family: \$2,800 Family Maximum: \$5,600	Individual - Employee Only: \$5,600 Individual - within a Family: \$5,600 Family Maximum: \$11,200
<ul style="list-style-type: none"> <li>• 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.</li> <li>• Plan deductible always applies before any benefit copay/deductible or coinsurance.</li> <li>• Plan deductible does not apply to in-network preventive services.</li> <li>• 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.</li> <li>• This plan includes a combined Medical/Pharmacy plan deductible.</li> </ul>		
<b>Note:</b> Services where plan deductible applies are noted with a caret (^).		

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Plan Highlights	In-Network	Out-of-Network
<b>Plan Out-of-Pocket Maximum</b>	Individual - Employee Only: \$3,200 Individual - within a Family: \$3,200 Family Maximum: \$6,400	Individual - Employee Only: \$6,400 Individual - within a Family: \$6,400 Family Maximum: \$12,800
<ul style="list-style-type: none"> <li>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.</li> <li>Plan deductible contributes towards your out-of-pocket maximum.</li> <li>All benefit copays/deductibles contribute towards your out-of-pocket maximum.</li> <li>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.</li> <li>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.</li> <li>This plan includes a combined Medical/Pharmacy out-of-pocket maximum.</li> </ul>		
Benefit	In-Network	Out-of-Network
<b>Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.</b>		
<b>Physician Services - Office Visits</b>		
<b>Primary Care Physician (PCP) Services/Office Visit</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Specialty Care Physician Services/Office Visit</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Surgery Performed in Physician's Office</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Cigna Telehealth Connection Services (Virtual Care)</b>	Plan pays 90% ^	Not Covered
<ul style="list-style-type: none"> <li>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.</li> <li>Virtual Wellness Screenings are available for individuals 18 and older and are covered same as Preventive Care (see Preventive Care Section).</li> </ul>		
<b>Preventive Care</b>		
<b>Preventive Care Office Visit</b>	Plan pays 100%	Not Covered
<b>Preventive Services</b>	Plan pays 100%	Not Covered
<ul style="list-style-type: none"> <li>Includes preventive Mammograms, Papanicolaou (Pap), Prostate Specific Antigen (PSA) tests and colorectal screenings.</li> <li>Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.</li> </ul>		
<b>Immunizations</b>	Plan pays 100%	Not Covered
<b>Inpatient</b>		
<b>Inpatient Hospital Facility Services</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Note: Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs</b>		
<b>Inpatient Hospital Physician's Visit/Consultation</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Inpatient Professional Services</b>	Plan pays 90% ^	Plan pays 70% ^
<ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>		
<b>Outpatient</b>		

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Benefit	In-Network	Out-of-Network
<b>Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.</b>		
<b>Outpatient Facility Services</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Outpatient Professional Services</b>	Plan pays 90% ^	Plan pays 70% ^
<ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>		
<b>Emergency Services</b>		
<b>Emergency Room</b>	Plan pays 90% ^	
<ul style="list-style-type: none"> <li>Includes ER Physician Charges, Lab and Radiology including Advanced Radiological Imaging (ARI)</li> </ul>		
<b>Urgent Care Facility</b>	Plan pays 90% ^	Plan pays 70% ^
<ul style="list-style-type: none"> <li>Includes Physician Charges, Lab and Radiology</li> </ul>		
<b>Ambulance</b>	Plan pays 90% ^	
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.		
<b>Inpatient Services at Other Health Care Facilities</b>		
<b>Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities</b>	Plan pays 90% ^	Plan pays 70% ^
<ul style="list-style-type: none"> <li>Annual Limit: 60 days</li> </ul>		
<b>Laboratory Services</b>		
<b>Physician's Services/Office Visit</b>	Plan pays 90% ^	Covered same as Physician Services - Office Visit
<b>Independent Lab</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Outpatient Facility</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Radiology Services</b>		
<b>Physician's Services/Office Visit</b>	Plan pays 90% ^	Covered same as Physician Services - Office Visit
<b>Outpatient Facility</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Advanced Radiological Imaging (ARI)</b>	Includes MRI, MRA, CAT Scan, PET Scan, etc.	
<b>Outpatient Facility</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Physician's Services/Office Visit</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Outpatient Therapy Services</b>		
<b>Outpatient Physical Therapy</b>	Plan pays 90% ^	Plan pays 70% ^
Annual Limits: <ul style="list-style-type: none"> <li>Physical Therapy – 20 visits</li> <li>Limits are not applicable to mental health conditions.</li> </ul>		
<b>Note: Therapy visits, provided as part of an approved Home Health Care plan, accumulate to the applicable Home Health Care maximum.</b>		

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Benefit	In-Network	Out-of-Network
<b>Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.</b>		
<b>Outpatient Speech Therapy, Hearing Therapy and Occupational Therapy</b> Annual Limits: <ul style="list-style-type: none"> <li>Speech, Hearing and Occupational Therapies – 40 visits</li> <li>Limits are not applicable to mental health conditions for Speech and Occupational Therapies.</li> </ul>	Plan pays 90% ^	Plan pays 70% ^
<b>Note: Therapy visits, provided as part of an approved Home Health Care plan, accumulate to the applicable Home Health Care maximum.</b>		
<b>Chiropractic Care</b> Annual Limit: <ul style="list-style-type: none"> <li>Chiropractic Care – 20 visits</li> </ul>	Plan pays 90% ^	Not Covered
<b>Hospice</b>		
<b>Inpatient Facilities</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Outpatient Services</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Note: Includes Bereavement counseling provided as part of a hospice program.</b>		
<b>Medical Specialty Drugs</b>		
<b>Outpatient Facility</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Physician's Office</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Home</b>	Plan pays 90% ^	Plan pays 70% ^
<b>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.</b>		
<b>Family Planning</b>		
<b>Women's Services</b>	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.		
<b>Men's Services</b>	Coverage varies based on Place of Service	Not Covered
Includes surgical sterilization services, such as vasectomy (excludes reversals)		
<b>Abortion</b>		
<b>Abortion Services</b>	Coverage varies based on Place of Service	Coverage varies based on Place of Service
<b>Note: Non-elective procedures only</b>		

Benefit	In-Network	Out-of-Network
<b>Note: Services where plan deductible applies are noted with a caret (^). Plan deductible always applies before benefit copays/deductibles.</b>		
<b>Infertility</b>		
<b>Infertility Treatment</b>		
<b>Note:</b> 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.		
<b>Other Health Care Facilities/Services</b>		
<b>Home Health Care</b>	Plan pays 90% ^	Plan pays 70% ^
<ul style="list-style-type: none"> <li>Annual Limit: 60 visits (The limit is not applicable to mental health and substance use disorder conditions.)</li> </ul>		
<b>Organ Transplants</b>	Covered same as Inpatient benefit	Not Covered
<ul style="list-style-type: none"> <li>Services paid at in-network level if performed at Cigna LifeSOURCE Transplant Network® Facilities.</li> <li>Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility Only: After the plan deductible is met, \$10,000 maximum per Transplant per Lifetime</li> </ul>		
<b>Durable Medical Equipment and External Prosthetic Appliances</b>	Plan pays 90% ^	Plan pays 70% ^
<ul style="list-style-type: none"> <li>Annual Limit: Unlimited</li> </ul>		
<b>Breast Feeding Equipment and Supplies</b>	Plan pays 100%	Not Covered
<ul style="list-style-type: none"> <li>Limited to the rental of one breast pump per birth as ordered or prescribed by a physician</li> <li>Includes related supplies</li> </ul>		
<b>Note: Services where plan deductible applies are noted with a caret (^).</b>		
<b>Mental Health and Substance Use Disorder</b>		
<b>Inpatient Mental Health</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Outpatient Mental Health – Physician’s Office</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Outpatient Mental Health – All Other Services</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Inpatient Substance Use Disorder</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Outpatient Substance Use Disorder – Physician’s Office</b>	Plan pays 90% ^	Plan pays 70% ^
<b>Outpatient Substance Use Disorder – All Other Services</b>	Plan pays 90% ^	Plan pays 70% ^
Annual Limits:		
<ul style="list-style-type: none"> <li>Unlimited maximum</li> </ul>		
<u>Notes:</u>		
<ul style="list-style-type: none"> <li>Inpatient includes Acute Inpatient and Residential Treatment.</li> <li>Outpatient - Physician's Office - may include Individual, family and group therapy, psychotherapy, medication management, etc.</li> <li>Outpatient - All Other Services - may include Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy), etc.</li> </ul>		
<b>Pharmacy</b>		<b>In-Network</b>
<b>Cost Share and Supply</b>		

## Pharmacy

### 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.

## In-Network

Once the medical deductible is met then the customer is responsible for the cost share

### Retail:

You pay 10% ^  
Your plan pays 90% ^

### Home Delivery:

You pay 10% ^  
Your plan pays 90% ^

- 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 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.
- 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 upon your first 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.

### Preventive Drugs:

Federally required preventive drugs will not be subject to deductible and will be provided at no charge. In addition, In-Network Generic preventive drugs and products 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 Performance Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. 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.
- Prescription smoking cessation 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.
- 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.

### 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

### Cigna Diabetes Prevention Program in collaboration with Omada

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

## 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.

### 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.**

### 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-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



## 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 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
- 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
- Smoking cessation programs
- Non-emergency services incurred outside the United States
- Bariatric surgery
- Infertility services
- Treatment of TMJ disorders and craniofacial muscle disorders

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**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.

*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: WY

# 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](mailto: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](mailto: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).

## 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 연락해주시십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주시십시오.

**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 deyè 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せん。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).