

BENEFIT SUMMARY

Administered by - Cigna Health and Life Insurance Co.  
For - Ditta Enterprises, Inc.  
Open Access Plus Plan  
OAP  
Effective - 09/01/2024



**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
Lifetime Maximum	Unlimited	Unlimited
Plan Year Accumulation	Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a calendar year basis unless otherwise stated. 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 80%	Plan pays 60%
Maximum Reimbursable Charge	Not Applicable	110%
Plan Deductible	Individual: \$1,500 Family: \$3,000	Individual: \$4,500 Family: \$9,000
<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>Benefit copays/deductibles always apply before plan deductible and coinsurance.</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></ul>		
<b>Note:</b> Services where plan deductible applies are noted with a caret (^).		

Plan Highlights		In-Network	Out-of-Network
<b>Plan Out-of-Pocket Maximum</b>		Individual: \$5,500 Family: \$11,000	Individual: \$11,000 Family: \$22,000
<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 (^). Benefit copays/deductibles always apply before plan deductible.</b>			
<b>Physician Services - Office Visits</b>			
<b>Primary Care Physician (PCP) Services/Office Visit</b>		\$30 copay, and plan pays 100%	Plan pays 60% ^
<b>Specialty Care Physician Services/Office Visit</b>		\$50 copay, and plan pays 100%	Plan pays 60% ^
<b>Surgery Performed in Physician's Office</b>		Covered same as Physician Services - Office Visit	Covered same as Physician Services - Office Visit
<b>Virtual Care</b>			
<b>Dedicated Virtual Providers - MDLIVE</b>			
<b>MDLIVE Urgent Virtual Care Services</b>		Plan pays 100%	Not Covered
<b>MDLIVE Primary Care Services</b>		Plan pays 100%	Not Covered
<b>MDLIVE Specialty Care Services</b>		\$50 copay, and plan pays 100%	Not Covered
<ul style="list-style-type: none"><li>Primary Care cost share applies to routine care. Virtual wellness screenings are payable under Preventive Care.</li><li>For MDLIVE Behavioral Services, please refer to the Mental Health and Substance Use Disorder section (below).</li><li>Lab services supporting a virtual visit must be obtained through dedicated labs.</li><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></ul>			
<b>Virtual Physician Services - Office Visits</b>			
<b>Primary Care Physician (PCP) Services/Office Visit</b>		\$30 copay, and plan pays 100%	Plan pays 60% ^
<b>Specialty Care Physician Services/Office Visit</b>		\$50 copay, and plan pays 100%	Plan pays 60% ^
<ul style="list-style-type: none"><li>Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services).</li><li>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.</li></ul>			

Benefit	In-Network	Out-of-Network
<b>Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.</b>		
<b>Convenience Care Clinic</b>		
Convenience Care Clinic	\$30 copay, and plan pays 100%	Plan pays 60% ^
<b>Preventive Care</b>		
Preventive Care Office Visit	Plan pays 100%	Not Covered
Preventive Services	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>		
Immunizations	Plan pays 100%	Not Covered
<b>Inpatient</b>		
Inpatient Hospital Facility Services	Plan pays 80% ^	Plan pays 60% ^
<b>Note:</b> Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs		
Inpatient Hospital Physician's Visit/Consultation	Plan pays 80% ^	Plan pays 60% ^
Inpatient Professional Services	Plan pays 80% ^	Plan pays 60% ^
<ul style="list-style-type: none"><li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li></ul>		
<b>Outpatient</b>		
Outpatient Facility Services	Plan pays 80% ^	Plan pays 60% ^
Outpatient Professional Services	Plan pays 80% ^	Plan pays 60% ^
<ul style="list-style-type: none"><li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li></ul>		
<b>Emergency Services</b>		
Emergency Room	Plan pays 80% ^	
<ul style="list-style-type: none"><li>Includes ER Physician Charges, Lab and Radiology including Advanced Radiological Imaging (ARI)</li></ul>		
Urgent Care Facility	\$50 copay, and plan pays 100%	Plan pays 60% ^
<ul style="list-style-type: none"><li>Includes Physician Charges, Lab and Radiology</li></ul>		
Ambulance	Plan pays 80% ^	
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>		
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities	Plan pays 80% ^	Plan pays 60% ^
<ul style="list-style-type: none"><li>Annual Limit: 60 days</li></ul>		
<b>Laboratory Services</b>		
Physician's Services/Office Visit	Plan pays 80% ^	Covered same as Physician Services - Office Visit

Benefit	In-Network	Out-of-Network
<b>Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.</b>		
<b>Independent Lab</b>	Plan pays 80% ^	Plan pays 60% ^
<b>Outpatient Facility</b>	Plan pays 80% ^	Plan pays 60% ^
<b>Radiology Services</b>		
<b>Physician's Services/Office Visit</b>	Plan pays 80% ^	Covered same as Physician Services - Office Visit
<b>Outpatient Facility</b>	Plan pays 80% ^	Plan pays 60% ^
<b>Advanced Radiological Imaging (ARI)</b>	Includes MRI, MRA, CAT Scan, PET Scan, etc.	
<b>Outpatient Facility</b>	Plan pays 80% ^	Plan pays 60% ^
<b>Physician's Services/Office Visit</b>	Plan pays 80% ^	Plan pays 60% ^
<b>Outpatient Therapy Services</b>		
<b>Outpatient Physical Therapy</b>	\$50 copay, and plan pays 100%	Plan pays 60% ^
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:</b> Therapy visits, provided as part of an approved Home Health Care plan, accumulate to the applicable Home Health Care maximum.		
<b>Outpatient Speech Therapy, Hearing Therapy and Occupational Therapy</b>	\$50 copay, and plan pays 100%	Plan pays 60% ^
Annual Limits:		
<ul style="list-style-type: none"> <li>Speech, Hearing and Occupational Therapies – 20 visits</li> <li>Limits are not applicable to mental health conditions for Speech and Occupational Therapies.</li> </ul>		
<b>Note:</b> Therapy visits, provided as part of an approved Home Health Care plan, accumulate to the applicable Home Health Care maximum.		
<b>Chiropractic Care</b>	Plan pays 80% ^	Plan pays 60% ^
Annual Limit:		
<ul style="list-style-type: none"> <li>Chiropractic Care – 12 visits</li> </ul>		
<b>Hospice</b>		
<b>Inpatient Facilities</b>	Plan pays 80% ^	Plan pays 60% ^
<b>Outpatient Services</b>	Plan pays 80% ^	Plan pays 60% ^
<b>Note:</b> Includes Bereavement counseling provided as part of a hospice program.		

Benefit	In-Network	Out-of-Network
<b>Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.</b>		
<b>Medical Pharmaceutical Drugs</b>		
<b>Cigna Pathwell Specialty<sup>SM</sup> Medical Pharmaceuticals</b>	<b>Cigna Pathwell Specialty<sup>SM</sup> Network:</b> Plan pays 80% ^	Not Covered
	<b>All other medical network providers:</b> Not Covered	
<b>Other Medical Pharmaceuticals</b>	Plan pays 80% ^	Not Covered
<b>Note:</b> 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.		
<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>	Not Covered	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:</b> Non-elective procedures only		
<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.		

Benefit	In-Network	Out-of-Network
<b>Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.</b>		
<b>Outpatient Dialysis Services</b>		
<b>Physician's Services/Office Visit</b>	Covered same as Physician Services - Office Visit	Not Covered
<b>Home Dialysis</b> <b>Note:</b> Dialysis visits will not accumulate to Home Health Care maximum	Covered same as plan's Home Health Care benefit	Not Covered
<b>Outpatient Facility Services</b>	Covered same as plan's Outpatient Facility Services benefit	Not Covered
<b>Outpatient Professional Services</b>	Covered same as plan's Outpatient Professional Services benefit	Not Covered
<b>Other Health Care Facilities/Services</b>		
<b>Home Health Care</b> <ul style="list-style-type: none"> <li>Annual Limit: 40 visits (The limit is not applicable to mental health and substance use disorder conditions.)</li> </ul>	Plan pays 80% ^	Plan pays 60% ^
<b>Organ Transplants</b> <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: \$10,000 maximum per Transplant per Lifetime</li> </ul>	Covered same as Inpatient benefit	Not Covered
<b>Condition-Specific Care</b> <ul style="list-style-type: none"> <li>Must be enrolled in the Condition-Specific Care program for orthopedic treatment prior to surgery and receive care from a specifically designated provider in order to qualify.</li> <li>Includes specific services for surgery, including Facility and Professional charges from admission through discharge. Some limitations may apply.</li> <li>Travel Maximum - \$600 per procedure</li> </ul>	Plan pays 100%	Not Applicable
<b>Durable Medical Equipment and External Prosthetic Appliances</b> <ul style="list-style-type: none"> <li>Annual Limit: Unlimited</li> </ul>	Plan pays 80% ^	Not Covered
<b>Breast Feeding Equipment and Supplies</b> <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>	Plan pays 100%	Not Covered
<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 80% ^	Plan pays 60% ^
<b>Outpatient Mental Health – Physician's Office</b>	\$50 copay, and plan pays 100%	Plan pays 60% ^
<b>Outpatient Mental Health - MDLIVE Behavioral Services</b>	\$50 copay, and plan pays 100%	Not Covered
<b>Outpatient Mental Health – All Other Services</b>	Plan pays 80% ^	Plan pays 60% ^
<b>Inpatient Substance Use Disorder</b>	Plan pays 80% ^	Plan pays 60% ^
<b>Outpatient Substance Use Disorder – Physician's Office</b>	\$50 copay, and plan pays 100%	Plan pays 60% ^

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<b>Note: Services where plan deductible applies are noted with a caret (^).</b>		
<b>Outpatient Substance Use Disorder - MDLIVE Behavioral Services</b>	\$50 copay, and plan pays 100%	Not Covered
<b>Outpatient Substance Use Disorder – All Other Services</b>	Plan pays 80% ^	Plan pays 60% ^
Annual Limits: <ul style="list-style-type: none"><li>Unlimited maximum</li></ul>		
Notes: <ul style="list-style-type: none"><li>Inpatient includes Acute Inpatient and Residential Treatment.</li><li>Outpatient - Physician's Office and MDLIVE Behavioral Services - 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>Important Note on Mental Health and Substance Use Disorder Coverage:</b> 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.”		
<b>Pharmacy</b>		<b>In-Network</b>
<b>Cost Share and Supply</b>		
<b>Pharmacy Cost Share</b> <ul style="list-style-type: none"><li>Retail – up to 90-day supply (except Specialty up to 30-day supply)</li><li>Home Delivery – up to 90-day supply (except Specialty up to 30-day supply)</li><li>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.</li></ul>	<b>Retail (per 30-day supply):</b> Generic: You pay \$15 Preferred Brand: You pay \$45 Non-Preferred Brand: You pay \$65  <b>Retail and Home Delivery (per 30-day supply):</b> Specialty: You pay \$130  <b>Retail and Home Delivery (per 90-day supply):</b> Generic: You pay \$30 Preferred Brand: You pay \$90 Non-Preferred Brand: You pay \$130	



## Pharmacy

## In-Network

- **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.
- 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.
- 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).
- 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.
- If you use a manufacturer coupon to pay for some or all of the cost of a medication, the value of the coupon may not apply towards meeting your plan deductible or out-of-pocket maximum, if any.
- **SaveOn Specialty Program:** Certain specialty pharmacy drugs may be considered non-essential health benefits and may fall outside of the deductible and out-of-pocket limits. All drugs in this program are potentially subject to a higher cost share than amounts set forth above. If you participate in the program, cost share may be paid through a manufacturer copay assistance program and your out-of-pocket cost may be reduced to \$0. If you do not participate in the program, then you will be responsible for the payment of the cost share for these medications and payment will not be applied towards your deductible and out-of-pocket maximums. See your plan documents for more specific information.
- Your pharmacy benefits share an out-of-pocket maximum with the medical/behavioral benefits.

### Preventive Drugs:

Federally required preventive drugs will not be subject to deductible and will be provided at no charge. In addition, In-Network Generic and Preferred Brand preventive drugs and products included in the Preventive Plus Package will be provided at no charge. This may apply to drugs for:

Asthma, Cholesterol Lowering, Depression, Diabetes (including diabetic supplies and continuous glucose monitor supplies), Heart Disease and Stroke, High Blood Pressure, Osteoporosis, Smoking Cessation, Prenatal Vitamins, Prescription Vitamins

## 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%.



## 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

### 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 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.

Medicare Coordination

In accordance with the Social Security Act of 1965, this plan will pay Secondary 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 Spouse and/or Dependent Child(ren), including a former Employee's Domestic Partner, or a COBRA continuant (whose insurance is continued for any reason), and who is also eligible for Medicare due to age or disability;

(b) an Employee's Domestic Partner who is also eligible for Medicare due to age;

(c) an Employee, a former Employee, an Employee's or former Employee's Dependent Spouse and/or Dependent Child(ren), an Employee's Dependent, including a Domestic Partner, 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

<div><ul style="list-style-type: none"><li>Coverage for services rendered outside a network area</li><li>ER and Ambulance paid the same as network services</li><li>Preventive care services covered at 100% for Out-of-Area</li><li>Out-of-Network Deductible and Out-of-Pocket maximums apply</li></ul></div>	<div>For all other services, plan pays 80% after the out-of-network deductible is met</div>
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Additional Information	
<p><b>Complete Care Management</b></p> <p>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.</p>	
<p><b>Pre-Existing Condition Limitation (PCL)</b> does not apply.</p>	
<p><b>Well-Being Solution: Core Plus</b></p> <ul style="list-style-type: none"><li>• Health assessment</li><li>• Device/app integration</li><li>• Personalized online content and data-driven actions</li><li>• Social connections/challenges</li></ul>	
Definitions	
<p><b>Coinsurance</b> - 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.</p> <p><b>Copay</b> - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.</p> <p><b>Deductible</b> - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.</p> <p><b>Out-of-Pocket Maximum</b> - 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.</p> <p><b>Place of Service</b> - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.</p> <p><b>Prescription Drug List</b> - The list of prescription brand and generic drugs covered by your pharmacy plan.</p> <p><b>Professional Services</b> - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists</p> <p><b>Transition of Care</b> - 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.</p>	
Exclusions	
<p><b>What's Not Covered (This Is Not All Inclusive; check your plan documents for a complete list)</b></p> <ul style="list-style-type: none"><li>• Services that aren't medically necessary</li><li>• Experimental or investigational treatments, except for routine patient care costs related to qualified clinical trials as described in your plan document</li><li>• Accidental injury that occurs while working for pay or profit</li><li>• Sickness for which benefits are paid or payable under any workers' compensation or similar law</li><li>• Services provided by government health plans</li><li>• 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</li><li>• Dental treatments and implants</li><li>• Custodial care</li><li>• Surgical procedures for the improvement of vision that can be corrected through the use of glasses or contact lenses</li><li>• Vision therapy or orthoptic treatment</li><li>• Hearing aids</li><li>• Reversal of sterilization procedures</li><li>• Nonprescription drugs or anti-obesity drugs</li></ul>	

Exclusions

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

These are only the highlights

This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate, 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.

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EHB State: AR

**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay for Covered Services  
**Ditta Enterprises, Inc.: Open Access Plus**

**Coverage Period:** 09/01/2024 - 08/31/2025  
**Coverage for:** Individual/Individual + Family | **Plan Type:** OAP



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is **only a summary**. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at [www.cigna.com/sp](http://www.cigna.com/sp). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-866-494-2111 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	For <a href="#">in-network providers</a> : \$1,500/individual or \$3,000/family For <a href="#">out-of-network providers</a> : \$4,500/individual or \$9,000/family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. In-network <a href="#">preventive care</a> & immunizations, office visits, <a href="#">prescription drugs</a> , in-network <a href="#">urgent care</a> facility visits.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <a href="#">in-network providers</a> : \$5,500/individual or \$11,000/family For <a href="#">out-of-network providers</a> : \$11,000/individual or \$22,000/family Combined medical/behavioral and pharmacy <a href="#">out-of-pocket limit</a>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Penalties for failure to obtain <a href="#">pre-authorization</a> for services, certain drug coupon amounts, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.cigna.com">www.cigna.com</a> or call 1-866-494-2111 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> /office visit** No charge/MDLIVE visit**  ** <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening</a> /immunization	No charge <a href="#">Deductible</a> does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a> at an outpatient facility 20% <a href="#">coinsurance</a> in the office	40% <a href="#">coinsurance</a> at an outpatient facility 40% <a href="#">coinsurance</a> in the office	\$750 penalty for no out-of-network precertification.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.cigna.com">www.cigna.com</a>	Generic drugs (Tier 1)	\$15 <a href="#">copay</a> /prescription (retail 30 days), \$30 <a href="#">copay</a> /prescription (retail & home delivery 90 days) <a href="#">Deductible</a> does not apply	Not covered	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail and home delivery) for <a href="#">Specialty drugs</a> . Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.  For drugs in the Cigna Patient Assurance Program you may pay less than the noted retail or home delivery cost share amounts.  In-network Federally required preventive drugs will be provided at no charge.
	Preferred brand drugs (Tier 2)	\$45 <a href="#">copay</a> /prescription (retail 30 days), \$90 <a href="#">copay</a> /prescription (retail & home delivery 90 days) <a href="#">Deductible</a> does not apply	Not covered	
	Non-preferred brand drugs (Tier 3)	\$65 <a href="#">copay</a> /prescription (retail 30 days), \$130 <a href="#">copay</a> /prescription (retail & home delivery 90 days) <a href="#">Deductible</a> does not apply	Not covered	
	<a href="#">Specialty drugs</a> (Tier 4)	\$130 <a href="#">copay</a> /prescription (retail & home delivery 30 days) <a href="#">Deductible</a> does not apply	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	\$750 penalty for no out-of-network precertification.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	\$750 penalty for no out-of-network precertification.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Out-of-network services are paid at the in-network cost share and <a href="#">deductible</a> .
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Out-of-network air ambulance services are paid at the in-network cost share and <a href="#">deductible</a> .
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	\$750 penalty for no out-of-network precertification.



Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	\$750 penalty for no out-of-network precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$50 <a href="#">copay</a> /office visit** 20% <a href="#">coinsurance</a> /all other services ** <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a> /office visit 40% <a href="#">coinsurance</a> /all other services	\$750 penalty if no precert of out-of-network non-routine services (i.e., partial hospitalization, etc.). Includes medical services for MH/SA diagnoses.
	Inpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	\$750 penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses.
If you are pregnant	Office visits	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Primary Care or <a href="#">Specialist</a> benefit levels apply for initial visit to confirm pregnancy. <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	\$750 penalty for no out-of-network precertification. Coverage is limited to 40 visits annual max. (The limit is not applicable to mental health and substance use disorder conditions.)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Rehabilitation services</a>	\$50 <a href="#">copay</a> /visit for Physical, Speech, Hearing & Occupational therapy**  20% <a href="#">coinsurance</a> /visit for Chiropractic care ** <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a> /visit for Physical, Speech, Hearing & Occupational therapy  40% <a href="#">coinsurance</a> /visit for Chiropractic care	\$750 penalty for failure to precertify out-of-network speech therapy. Coverage is limited to an annual max of 20 visits for Physical therapy and 20 visits for Speech, Hearing & Occupational therapy and 12 visits annual max for Chiropractic care services.  Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	<a href="#">Habilitation services</a>	\$50 <a href="#">copay</a> /visit for Physical, Speech, Hearing & Occupational therapy** ** <a href="#">Deductible</a> does not apply	40% <a href="#">coinsurance</a> /visit for Physical, Speech, Hearing & Occupational therapy	\$750 penalty for failure to precertify out-of-network speech therapy. Services are covered when <a href="#">Medically Necessary</a> to treat a mental health condition (e.g. autism) or a congenital abnormality.  Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	\$750 penalty for no out-of-network precertification. Coverage is limited to 60 days annual max.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	Not covered	None
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a> /inpatient services 20% <a href="#">coinsurance</a> /outpatient services	40% <a href="#">coinsurance</a> /inpatient services 40% <a href="#">coinsurance</a> /outpatient services	\$750 penalty for no out-of-network precertification.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	Not covered	Not covered	None

### Excluded Services & Other Covered Services:

**Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)**

- |   |  |  |
|---|--|--|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Dental care (Children)</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside of the U.S.</li> <li>• Private-duty nursing</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Routine eye care (Children)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
|---|--|--|

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- Chiropractic care (12 visits)

### Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Cigna at 1-866-494-2111, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

### Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#) or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-866-494-2111. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your [appeal](#). Contact: Arkansas Insurance Department, Consumer Services Division at (800) 282-9134.

### Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

### Does this plan meet the Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-494-2111.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-494-2111.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-494-2111.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-494-2111.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and excluded services under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$40
<a href="#">Coinsurance</a>	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$3,760</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$120
<a href="#">Copayments</a>	\$900
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$40
<b>The total Joe would pay is</b>	<b>\$1,060</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

# 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.



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** – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna Healthcare, 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 Healthcare 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 Healthcare, 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 Healthcare 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주시고. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주시고.

**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. 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 Healthcare, 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 Healthcare 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 Healthcare 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 Healthcare, 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 Healthcare 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 Healthcare 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 Healthcare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 Healthcare 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 Healthcare-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 می شود. برای مشتریان فعلی Cigna Healthcare، لطفاً با شماره ای 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 شماره گیری کنید).