Warren County R-III School District

REQUEST FOR PROPOSAL

Title: Benefit Broker/Consultant Services
Issue Date: March 13, 2020

Contact Person: Shelley Kinder
Phone #: (636) 456-6901
E-mail: kinderml@warrencor3.k12.mo.us

RETURN PROPOSAL NO LATER THAN: March 27, 2020 at 12:00 Noon, CST

RETURN PROPOSAL AND ADDENDA TO:

Warren County R-III School District
ATTN: Shelley Kinder
385 West Veterans Memorial Parkway
Warrenton, MO 63383

The Proposer hereby declares understanding, agreement and certification of compliance to provide the items and/or services, at the prices quoted, in accordance with all terms and conditions, requirements and specifications of the original Request for Proposal (RFP) and as modified by any addenda thereto.

SIGNATURE REQUIRED

Authorized Signature		Date
Printed Name		Title
Company Name		
Mailing Address		
City, State Zip		
Phone #:	Fax #:	E-Mail Address

STATEMENT OF INTENT

The Warren County R-III School District is requesting proposals for Benefit Broker/Consultant Services to assist in evaluating options for its employee benefits plans, as well as assisting with the ongoing administration of such plans.

Please include pricing on the district's current plan structure with the HAS's meeting all current deductible requirements. The final pages of this document include information about the district's current coverage.

GENERAL CONDITIONS

1. The Board of Education of the Warren County R-III School District (hereafter "District") will receive sealed Proposals from qualified brokers/benefit consultant firms (hereafter "Company") for providing **Benefit Broker/Consultant Services** for an initial term from July 1, 2020 until June 30, 2021 with options to renew for two additional one-year periods.

2. The Company must submit a complete Proposal covering all requirements identified in this RFP package in order to be considered. All Proposals will be carefully scrutinized to ensure that such requirements can be met. Proposals submitted must be the original work product of the Company.

3. The Company must submit one (1) original and three (3) copies of the Proposal in sealed envelopes plainly marked with the name "Benefit Broker/Consultant Proposal." Proposals should be delivered to:

   Shelley Kinder, Director of Finance
   Warren County R-III School District
   385 West Veterans Memorial Pkwy
   Warrenton, MO 63383

4. Proposals will be received until **12:00 Noon, CST, March 27, 2020.** Electronic or facsimile offers will not be considered in response to this RFP, nor will modifications by electronic or facsimile notice be accepted.

5. The District is not responsible for lateness or non-delivery by the US Postal Service or other carrier to the District. The time and date recorded by the District shall be the official time of receipt.

6. Proposals may be modified or withdrawn by written notice or in person by the Company or its authorized representative, provided its identity is disclosed on the envelope containing the Proposal and such person signs a receipt for the Proposal, but only if the withdrawal is made prior to the deadline.

7. The information presented in the RFP is not to be construed as a commitment of any kind on the part of the District. There is no expressed or implied obligation for the District to reimburse responding firms for any expenses incurred in preparing Proposals in response to this request.

8. All Proposals must be submitted on the District forms as attached with this specification. Proposals submitted on forms other than the enclosed may be rejected. No alternate Proposals that significantly deviate or modify the concept and ultimate objectives of this Proposal will be considered. Non-compliance with RFP specifications will disqualify Proposals from further consideration.

9. Any explanation or statement that the Company wishes to make must be contained with the Proposal but shall be written separately and independently of the Proposal proper and attached thereto. Unless the Company so indicates, it is understood that the Company has proposed in strict accordance with the RFP requirements.

in connection with the Request for Proposal of the Warren County R-III School District shall not be used nor disclosed except for evaluation purposes, provided that, if a Contract is awarded to this Company as a result of or in connection with the submission of this Proposal, Warren County R-III School District shall have the right to use or disclose technical data to substantiate the award of a Contract."

20. The above restriction does not limit the District's rights to use or disclose without the Company's permission any technical data obtained independently from another source. Proposals shall not contain any restrictive language different from the above legend. Proposals submitted with restrictive legends or statements which differ from the above will be treated under the terms of the above legend. The District assumes no liability for disclosure or use of unmarked technical data and may use or disclose the data for any purpose.

21. The Company shall not, under penalty of law and immediate disqualification of the Proposal, offer or give any gratuities, favors or anything of monetary value to an officer, employee, agent, or Board of Education member of the District for the purpose of influencing favorable disposition toward a submitted Proposal or for any reason while a Proposal is pending or during the evaluation process.

22. No Company shall engage in any activity or practice, by itself or with other Companies, the result of which may be to restrict or eliminate competition or otherwise restrain trade. Violation of this instruction will result in immediate rejection of the Company's Proposal.

23. The District may accept one part, aspect or phase, or any combination thereof, of any Proposal unless the Company specifically qualifies its offer by stating that the Proposal must be taken as a whole.

24. The District may award a contract based upon the initial Proposals received without discussion of such Proposals. Accordingly, each initial Proposal should be submitted with the most favorable price and service standpoint.

25. To facilitate consideration of the Proposals, the District may, at its option, conduct interviews after receipt of the Proposal. If this is necessary, the Company will be contacted to arrange a time for an interview.

26. The District reserves the right to hold negotiations in an attempt to clarify and qualify terms of any Proposal.

27. The District reserves the right to negotiate final contract terms with any Company, regardless of whether such Company was interviewed or submitted a best and final Proposal.

28. The District may accept any Proposal as submitted whether or not negotiations have been conducted between the parties.

29. Neither the commencement nor cessation of negotiations shall constitute rejection of the Proposal or a counteroffer on the part of the District.

30. The District reserves the right to withdraw the award to a successful Company within 30

the Agreement by providing written notice to the successful Company and the District will thereby be relieved from all further obligations under the Agreement.

38. Initial Proposals may not be withdrawn for 90 calendar days from the due date for Proposals except with the express written consent of the District. If a Proposal is accepted as submitted, the negotiated final Agreement shall consist of the Agreement, this RFP, plus any addenda thereto, and the Company's Proposal.

39. In the event the Agreement initially awarded by the District is terminated for any reason within 120 days of the due date for Proposals, the District reserves the right to negotiate and accept any other submitted Proposals.

40. The District shall not be responsible for any pre-Agreement expenses of any Company, including the successful Company, incurred prior to the commencement of the Agreement.

41. By submitting a Proposal, the Company certifies that it is not currently barred or otherwise prohibited from submitting proposals for contracts to any political subdivision or agency of the State of Missouri and it is not an agent of a person or entity that is currently barred or otherwise prohibited from submitting proposals for contracts by any political subdivision or agency of the State of Missouri.

42. The District is exempt from the payment of city, state and federal taxes. Such taxes must not be included in the Proposal price.

43. It is understood that the Company is an independent contractor supplying services to the District. Neither the Company nor its employees shall represent themselves to be employees, agents, representatives, partners or joint ventures of the District for any purposes whatsoever. The Company shall comply with all federal, state and local laws, regulations and ordinances, including but not limited to, the compliance with all employment tax requirements for withholding and all applicable state and federal employment and workers' compensation laws. The District shall not withhold taxes from the Company's compensation. The District shall not be construed to be the Company's employer, nor be held liable for any obligation as an employer.

44. Although the District cannot bind future governing bodies, it is anticipated that the Company selected to provide Benefit Broker/Consultant services will be retained for a 3-year period with annual evaluations made of its services.

SCOPE OF SERVICES

I. Assist in the development of employee communication tools, including the design and preparation of printed material, on-site employee meetings, etc.

J. Consult with the District on all benefit regulatory compliance issues and assist in the preparation of reporting requirements. The successful vendor must be able to provide direction to the District on implementation of all applicable aspects of the Affordable Care Act.

K. Assist claimants throughout the plan year as claim discrepancies occur.

L. Conduct renewal negotiations with the carrier(s) utilized and prepare a complete and detailed accounting of all claim costs, provider access fees, administrative expenses, risk charges, investment performances, etc.

M. Provide industry and geographical comparative data for the purpose of attracting and retaining quality employees.

N. Conduct an annual plan review to determine success, areas of focus, as well as reduction of liability.

PROPOSAL FORMAT AND EVALUATION

3. Total resources of the Company that can be applied to the advantage of the District.

4. The scope of services offered and the extent to which they meet or exceed the requirements of the District.

5. The total cost of the services offered to the District

PROPOSAL FORMAT AND EVALUATION

Attachment 2 References and Experience

Each Company must submit a minimum of five (5) references. Each reference must be presently using services similar to those requested in this RFP. No reference may be an affiliate of the Company or the Company's officers, directors, shareholders or partners.

List as primary references any current contracts for broker/consultant services currently in force with public school districts; include contacts and telephone numbers for each reference. Use additional pages for additional contracts.

1) Company Name: _____
   Business Address: _____
   Name and Title of Contact: _____
   Phone Number of Contact: _____

2) Company Name: _____
   Business Address: _____
   Name and Title of Contact: _____
   Phone Number of Contact: _____

3) Company Name: _____
   Business Address: _____
   Name and Title of Contact: _____
   Phone Number of Contact: _____

4) Company Name: _____
   Business Address: _____
   Name and Title of Contact: _____
   Phone Number of Contact: _____

5) Company Name: _____
   Business Address: _____
   Name and Title of Contact: _____
   Phone Number of Contact: _____

Attachments 3 & 4 Federal Work Authorization Program Addendum and Affidavit

FEDERAL WORK AUTHORIZATION PROGRAM ("E-VERIFY") ADDENDUM

Pursuant to Missouri Revised Statute 285.530, all business entities awarded any contract in excess of five thousand dollars ($5,000) with a Missouri public school district must, as a condition to the award of any such contract, be enrolled and participate in a federal work authorization program with respect to the employees working in connection with the contracted services being provided, or to be provided, to the District (to the extent allowed by E-Verify). In addition, the business entity must affirm the same through sworn affidavit and provision of documentation. In addition, the business entity must sign an affidavit that it does not knowingly employ any person who is an unauthorized alien in connection with the services being provided, or to be provided, to the District.

Accordingly, your company:

a) agrees to have an authorized person execute the attached "Federal Work Authorization Program Affidavit" attached hereto as Exhibit A and deliver the same to the District prior to or contemporaneously with the execution of its contract with the District;

b) affirms it is enrolled in the "E-Verify" (formerly known as "Basic Pilot") work authorization program of the United States, and are participating in E-Verify with respect to your employees working in connection with the services being provided (to the extent allowed by E-Verify), or to be provided, by your company to the District;

c) affirms that it is not knowingly employing any person who is an unauthorized alien in connection with the services being provided, or to be provided, by your company to the District;

d) affirms you will notify the District if you cease participation in E-Verify, or if there is any action, claim or complaint made against you alleging any violation of Missouri Revised Statute 285.530, or any regulations issued thereto;

e) agrees to provide documentation of your participation in E-Verify to the District prior to or contemporaneously with the execution of its contract with the District (or at any time thereafter upon request by the District), by providing to the District an E-Verify screen print-out (or equivalent documentation) confirming your participation in E-Verify;

f) agrees to comply with any state or federal regulations or rules that may be issued subsequent to this addendum that relate to Missouri Revised Statute 285.530; and

g) agrees that any failure by your company to abide by the requirements a) through f) above will be considered a material breach of your contract with the District.

By: _____
(Signature)

Printed Name and Title: _____

For and on behalf of: _____
(Company Name)

Warren County R-III School District

REQUEST FOR PROPOSAL

Title: Benefit Broker/Consultant Services
Issue Date: March 13, 2020

Contact Person: Shelley Kinder
Phone #: (636) 456-6901
E-mail: kinderml@warrencor3.k12.mo.us

RETURN PROPOSAL NO LATER THAN: March 27, 2020 at 12:00 Noon, CST

RETURN PROPOSAL AND ADDENDA TO:
Warren County R-III School District
ATTN: Shelley Kinder
385 West Veterans Memorial Parkway
Warrenton, MO 63383

The Proposer hereby declares understanding, agreement and certification of compliance to provide the items and/or services, at the prices quoted, in accordance with all terms and conditions, requirements and specifications of the original Request for Proposal (RFP) and as modified by any addenda thereto.

SIGNATURE REQUIRED

Authorized Signature		Date
Printed Name		Title
Company Name		
Mailing Address		
City, State Zip		
Phone #:	Fax #:	E-Mail Address

STATEMENT OF INTENT

The Warren County R-III School District is requesting proposals for Benefit Broker/Consultant Services to assist in evaluating options for its employee benefits plans, as well as assisting with the ongoing administration of such plans.

GENERAL CONDITIONS

1. The Board of Education of the Warren County R-III School District (hereafter "District") will receive sealed Proposals from qualified brokers/benefit consultant firms (hereafter "Company") for providing **Benefit Broker/Consultant Services** for an initial term from July 1, 2020 until June 30, 2021 with options to renew for two additional one-year periods.

2. The Company must submit a complete Proposal covering all requirements identified in this RFP package in order to be considered. All Proposals will be carefully scrutinized to ensure that such requirements can be met. Proposals submitted must be the original work product of the Company.

3. The Company must submit one (1) original and three (3) copies of the Proposal in sealed envelopes plainly marked with the name "Benefit Broker/Consultant Proposal." Proposals should be delivered to:

   Shelley Kinder, Director of Finance
   Warren County R-III School District
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   Warrenton, MO 63383

4. Proposals will be received until **12:00 Noon, CST, March 27, 2020.** Electronic or facsimile offers will not be considered in response to this RFP, nor will modifications by electronic or facsimile notice be accepted.

5. The District is not responsible for lateness or non-delivery by the US Postal Service or other carrier to the District. The time and date recorded by the District shall be the official time of receipt.

6. Proposals may be modified or withdrawn by written notice or in person by the Company or its authorized representative, provided its identity is disclosed on the envelope containing the Proposal and such person signs a receipt for the Proposal, but only if the withdrawal is made prior to the deadline.

7. The information presented in the RFP is not to be construed as a commitment of any kind on the part of the District. There is no expressed or implied obligation for the District to reimburse responding firms for any expenses incurred in preparing Proposals in response to this request.

8. All Proposals must be submitted on the District forms as attached with this specification. Proposals submitted on forms other than the enclosed may be rejected. No alternate Proposals that significantly deviate or modify the concept and ultimate objectives of this Proposal will be considered. Non-compliance with RFP specifications will disqualify Proposals from further consideration.

9. Any explanation or statement that the Company wishes to make must be contained with the Proposal but shall be written separately and independently of the Proposal proper and attached thereto. Unless the Company so indicates, it is understood that the Company has proposed in strict accordance with the RFP requirements.

GENERAL CONDITIONS

10. The District reserves the right to reject any or all Proposals and to waive informalities and minor irregularities in Proposals received. The District, in its sole discretion, will determine whether an irregularity is minor.

11. The District reserves the right to decline any or all Proposal submissions, or to cancel the RFP call, in whole or in part, at any time prior to making an award, for any reason, or no reason, without liability being incurred by the District to any Company for any expense, cost, loss or damage incurred or suffered by the Company as a result of such withdrawal.

12. All Proposals shall be deemed final, conclusive and irrevocable and no Proposal shall be subject to correction or amendment for any error or miscalculation. No Proposal shall be withdrawn without the consent of the District after the scheduled closing time for the receipt of Proposals.

13. Proposals, prices, terms and conditions shall remain firm for a period of ninety (90) days from the due date for Proposals or until that time when the District takes official action on the Proposals.

14. While the District has used considerable efforts to ensure an accurate representation of information in this RFP document, the information contained herein is contained solely as a guideline for proposers. The information is not guaranteed or warranted to be accurate by the District, nor is it necessarily comprehensive or exhaustive. Nothing in this RFP document is intended to relieve proposers from forming their own opinions and conclusions with respect to the matters addressed in the RFP document.

15. The Company is responsible for its own verification of all information provided to it. The Company must satisfy itself, upon examination of this RFP, as to the intent of the specifications. After the submission of the Proposal, no complaint or claim that there was any misunderstanding will be entertained.

16. No oral interpretation will be made to any Company as to the meaning of the RFP. Any oral communication will be considered unofficial and non-binding on the District. Unauthorized contact by the Company with other District employees or Board members regarding the RFP may result in disqualification.

17. Requests for interpretation must be made in writing to the Director of Finance at the Warren County R-III School District no later than **4:00 p.m. on March 20, 2020**. Responses to Requests for interpretation will be posted to the District website as an addendum to the RFP by **2:00 P.M. on March 23, 2020**. The Company should rely only on written statements issued by the District in the form of an addendum to the RFP.

18. The District reserves the right to modify the specifications prior to the Proposal submission deadline and will endeavor to notify all potential Companies that have received a copy of the specifications, but failure to notify shall impose no obligation or liability on the District.

19. Proposals may contain data that the Company does not want used or disclosed for any purpose other than evaluation of the Proposal. The use and disclosure of such data may be so restricted, provided the Company marks the cover sheet of the Proposal with the following legend: **"Technical data contained on pages _____ and _____ in this Proposal furnished**

in connection with the Request for Proposal of the Warren County R-III School District shall not be used nor disclosed except for evaluation purposes, provided that, if a Contract is awarded to this Company as a result of or in connection with the submission of this Proposal, Warren County R-III School District shall have the right to use or disclose technical data to substantiate the award of a Contract."

20. The above restriction does not limit the District's rights to use or disclose without the Company's permission any technical data obtained independently from another source. Proposals shall not contain any restrictive language different from the above legend. Proposals submitted with restrictive legends or statements which differ from the above will be treated under the terms of the above legend. The District assumes no liability for disclosure or use of unmarked technical data and may use or disclose the data for any purpose.

21. The Company shall not, under penalty of law and immediate disqualification of the Proposal, offer or give any gratuities, favors or anything of monetary value to an officer, employee, agent, or Board of Education member of the District for the purpose of influencing favorable disposition toward a submitted Proposal or for any reason while a Proposal is pending or during the evaluation process.

22. No Company shall engage in any activity or practice, by itself or with other Companies, the result of which may be to restrict or eliminate competition or otherwise restrain trade. Violation of this instruction will result in immediate rejection of the Company's Proposal.

23. The District may accept one part, aspect or phase, or any combination thereof, of any Proposal unless the Company specifically qualifies its offer by stating that the Proposal must be taken as a whole.

24. The District may award a contract based upon the initial Proposals received without discussion of such Proposals. Accordingly, each initial Proposal should be submitted with the most favorable price and service standpoint.

25. To facilitate consideration of the Proposals, the District may, at its option, conduct interviews after receipt of the Proposal. If this is necessary, the Company will be contacted to arrange a time for an interview.

26. The District reserves the right to hold negotiations in an attempt to clarify and qualify terms of any Proposal.

27. The District reserves the right to negotiate final contract terms with any Company, regardless of whether such Company was interviewed or submitted a best and final Proposal.

28. The District may accept any Proposal as submitted whether or not negotiations have been conducted between the parties.

29. Neither the commencement nor cessation of negotiations shall constitute rejection of the Proposal or a counteroffer on the part of the District.

30. The District reserves the right to withdraw the award to a successful Company within 30

days of the award if, in the opinion of the District, the successful Company is unable or unwilling to enter into a form of contract satisfactory to the District. The District shall be entitled to do so without any liability being incurred by the District to the Company.

31. In the event of a conflict between the Proposal and the RFP, the District shall resolve any inconsistency in favor of the RFP. Additionally, the District shall in good faith decide all inconsistencies and/or disputes pertaining to the RFP and the Proposal. The Company agrees to abide by the decisions of the District. Any ambiguity in the Proposal because of omissions, error, lack of clarity or noncompliance by the Company with specifications, instructions and all conditions of bidding shall be construed in the favor of the District.

32. All of the terms and conditions of this RFP are deemed to be accepted by the Company and incorporated into the Company's Proposal submission. The terms and conditions stated in this RFP and the successful Company's response to this RFP shall be incorporated into the contract between the District and the successful Company.

33. The successful Company must not at any time assign any portion of its contract with the District nor shall it assign the contract without the written permission of the District. The successful Company must not, at any time, change sub-consultants approved by the District without written permission of the District, other than as listed in the proposal submission.

34. The Company agrees that in any resulting contract both the District or its duly authorized representative shall have access to, and the right to examine and copy any directly pertinent books, documents, papers, and records of the Company involving transactions related to any resultant contract. This obligation shall expire three years after the final payment for the final service performed because of any and all contract(s) awarded pursuant to this solicitation. The Company will provide reasonable access to all necessary documents and upon demand provide copies of documents if so required by the District or its representative(s).

35. The District reserves the right to terminate any resulting contract with 30 days written notice if, in its opinion, the successful Company fails to meet the terms and conditions of the Request for Proposal. Notwithstanding the termination of the contract, the successful Company shall remain responsible for its obligations under any resulting contract up to the date of termination. The District reserves the right to commence an action in a court of competent jurisdiction against the successful Company for damages that result from the breach of the terms and conditions of the contract, by the successful Company.

36. The District may terminate any resulting contract immediately without further cost or liability in the event of the occurrence of any of the following: insolvency of successful Company; liquidation or dissolution of successful Company; the institution of any voluntary or involuntary bankruptcy proceeding by or against the successful Company; assignment by successful Company for the benefit of creditors; or the appointment of a receiver or trustee to manage the property of the successful Company.

37. In the event the Board of Education of the District fails to approve the appropriation of funds sufficient to provide for the District's obligations under the Agreement, or if the funds are not appropriated due to federal, state or local action, the District shall have the right to terminate

the Agreement by providing written notice to the successful Company and the District will thereby be relieved from all further obligations under the Agreement.

38. Initial Proposals may not be withdrawn for 90 calendar days from the due date for Proposals except with the express written consent of the District. If a Proposal is accepted as submitted, the negotiated final Agreement shall consist of the Agreement, this RFP, plus any addenda thereto, and the Company's Proposal.

39. In the event the Agreement initially awarded by the District is terminated for any reason within 120 days of the due date for Proposals, the District reserves the right to negotiate and accept any other submitted Proposals.

40. The District shall not be responsible for any pre-Agreement expenses of any Company, including the successful Company, incurred prior to the commencement of the Agreement.

41. By submitting a Proposal, the Company certifies that it is not currently barred or otherwise prohibited from submitting proposals for contracts to any political subdivision or agency of the State of Missouri and it is not an agent of a person or entity that is currently barred or otherwise prohibited from submitting proposals for contracts by any political subdivision or agency of the State of Missouri.

42. The District is exempt from the payment of city, state and federal taxes. Such taxes must not be included in the Proposal price.

43. It is understood that the Company is an independent contractor supplying services to the District. Neither the Company nor its employees shall represent themselves to be employees, agents, representatives, partners or joint ventures of the District for any purposes whatsoever. The Company shall comply with all federal, state and local laws, regulations and ordinances, including but not limited to, the compliance with all employment tax requirements for withholding and all applicable state and federal employment and workers' compensation laws. The District shall not withhold taxes from the Company's compensation. The District shall not be construed to be the Company's employer, nor be held liable for any obligation as an employer.

44. Although the District cannot bind future governing bodies, it is anticipated that the Company selected to provide Benefit Broker/Consultant services will be retained for a 3-year period with annual evaluations made of its services.

SCOPE OF SERVICES

Issue Date:.....March 13, 2020

Line of Service:.....Benefit Broker/Consultant Services

Current Benefits: .....Self-Insured Medical/Prescription, Self-Insured Dental, Fully Funded Dental, Fully Funded Vision, Term Life, STD, LTD, Section 125 Administration, Employee Assistance Program

Participation:.....Approximately 463 eligible employees and 588 eligible retirees & dependents

Proposal Due Date: .....12:00 Noon, CST, March 27, 2020

Declining the RFP:.....Companies declining to offer a proposal for coverage should submit a formal letter of declination to the District.

The scope of service expected is as follows:

A. Assist with the review and evaluation of the District's benefit components, specifically in the area of plan design, funding, cost and administration. This will include a review of current and proposed plan features and rate structures.

B. Review current carrier plans and performance, and provide written report on findings.

C. Propose recommendations to include comparative alternatives, plan design changes, new products and compliance with all appropriate tax codes, as well as state and federal regulations governing benefit plans.

D. Perform statistical analysis and claim reserve studies on the claims and utilization of the benefit plans, and make recommendations for appropriate rate structures based on this analysis.

E. Review current legal plan documents for benefit plans and advise on recommended changes.

F. Provide projections of benefit trends for the next five years and identify areas of potential concerns.

G. Attend meetings called by the District for purposes of discussion, review, and evaluation of the District's benefit plans.

H. Assist in the development of the request for proposal for administrator and underwriter selection, analysis of proposals, and recommendations of plan design and funding methods to be employed.

SCOPE OF SERVICES

I. Assist in the development of employee communication tools, including the design and preparation of printed material, on-site employee meetings, etc.

J. Consult with the District on all benefit regulatory compliance issues and assist in the preparation of reporting requirements. The successful vendor must be able to provide direction to the District on implementation of all applicable aspects of the Affordable Care Act.

K. Assist claimants throughout the plan year as claim discrepancies occur.

L. Conduct renewal negotiations with the carrier(s) utilized and prepare a complete and detailed accounting of all claim costs, provider access fees, administrative expenses, risk charges, investment performances, etc.

M. Provide industry and geographical comparative data for the purpose of attracting and retaining quality employees.

N. Conduct an annual plan review to determine success, areas of focus, as well as reduction of liability.

PROPOSAL FORMAT AND EVALUATION

1. Proposals must be concise and in outline format. Pertinent supplemental information should be referenced and included as attachments. All Proposals must be organized and tabbed to allow for easy reference.

2. The Proposal shall include a **Letter of Transmittal** that provides an introduction to the Company and includes an expression of the Company's ability and desire to meet the requirements of the RFP. The Letter of Transmittal should be under the signature of a Company officer.

3. The Proposal shall include an **Executive Summary** that briefly describes the Company's approach to meeting the District's requirements as outlined in the RFP, indicates any major requirements than cannot be met, and highlights the major features of the Proposal. The reader should be able to determine generally how well the Proposal meets the District's requirements by reading the Executive Summary.

4. The Proposal shall include a **Summary of Compensation** that describes the Company's manner of compensation and discloses any and all fees and commissions, payable by either the District or individual carriers.

5. The Company shall complete Attachment 1, "**Company Identification Form.**"

6. The Company shall complete Attachment 2, "**References and Experience,**" thereby providing the District a listing of all Missouri school districts for which the company currently provides broker/consultant services. The references should include at least one contract currently in force with a district similar in size and population to the Francis Howell School District. The Company shall additionally provide the District a listing of all public school clients that have discontinued service from the Company in the past five years due to poor performance or non-performance.

7. The Company shall complete Attachment 3, "**Federal Work Authorization Program Addendum.**"

8. The Company shall complete Attachment 4, "**Federal Work Authorization Program Affidavit.**"

9. The Company shall provide proof of Registration with Missouri Secretary of State. Contract Awards are contingent upon the Company providing the District, prior to the execution of the contract, a current Annual Registration Report from the Missouri Secretary of the State's Office, showing the company is in good standing to conduct business in Missouri.

Proposals will be evaluated by the District and designated staff. The following will serve as the basic criteria for the selection of the consultant eventually chosen.

1. Understanding of the work required by the Company as evidenced by the Proposal.

2. The qualifications of the Company and the team assigned to the District.

PROPOSAL FORMAT AND EVALUATION

3. Total resources of the Company that can be applied to the advantage of the District.

4. The scope of services offered and the extent to which they meet or exceed the requirements of the District.

5. The total cost of the services offered to the District

PROPOSAL FORMAT AND EVALUATION

Attachment 1: Company Identification Form

Designate one individual as the Company's representative to the District during the term of the Agreement. The representative will be contacted to solve any and all problems that may arise concerning the Proposal during the evaluation period. The undersigned Company hereby agrees to be bound by the terms of the RFP and that the enclosed Proposal is submitted in accordance therewith. Once completed and returned, this Proposal becomes the primary basis for evaluation and selection of the Company to provide the services required by the District for the specified period. By signing this Company Identification Form, the Company certifies that there are no "PARTIES OF INTEREST" or "CONFLICTS OF INTEREST", as defined by state and/or federal regulations, existing between the Company and the District or any of its employees, agents or Board of Education members.

Legal name | Representative's Name | Title

Address | City/State/Zip | Telephone # | Fax #

E-mail Address

Years in Operation | Years under current structure and/or under previous structure

1) Name of Company's Officers:

NAME	TITLE

2) The undersigned hereby acknowledges the receipt of the following addenda:

Addendum Number	Date Issued	Date Acknowledged	Signature

3) The undersigned hereby acknowledges that the Company has read and agrees to the terms and conditions set forth in the RFP, and that the terms and conditions set forth in the Proposal will remain open for at least 90 days from the deadline for submission of Proposals

Company Officer's Name

Signature **Date**

PROPOSAL FORMAT AND EVALUATION

Attachment 2 References and Experience

Each Company must submit a minimum of five (5) references. Each reference must be presently using services similar to those requested in this RFP. No reference may be an affiliate of the Company or the Company's officers, directors, shareholders or partners.

List as primary references any current contracts for broker/consultant services currently in force with public school districts; include contacts and telephone numbers for each reference. Use additional pages for additional contracts.

1) Company Name: _____
   Business Address: _____
   Name and Title of Contact: _____
   Phone Number of Contact: _____

2) Company Name: _____
   Business Address: _____
   Name and Title of Contact: _____
   Phone Number of Contact: _____

3) Company Name: _____
   Business Address: _____
   Name and Title of Contact: _____
   Phone Number of Contact: _____

4) Company Name: _____
   Business Address: _____
   Name and Title of Contact: _____
   Phone Number of Contact: _____

5) Company Name: _____
   Business Address: _____
   Name and Title of Contact: _____
   Phone Number of Contact: _____

PROPOSAL FORMAT AND EVALUATION

References and Experience (continued)

All Contracts **terminated for default** within the last five (5) years should be noted below. Termination for default is defined as notice to stop performance due to Company's nonperformance or poor performance. Submit full details of all terminations for default experienced. The District will evaluate the facts and may at its sole discretion reject the Company's Proposal if the facts discovered indicate that the completion of a Contract resulting from this RFP may be jeopardized by selection of the Company. If the Company has experienced no such terminations for default in the past five (5) years, so indicate.

TERMINATED CONTRACTS WITHIN THE LAST FIVE (5) YEARS.

	#1	#2	#3
Company Name			
Business Address			
Name of Contact			
Title of Contact			
Telephone Number of Contact			
Contract Length			

PROPOSAL FORMAT AND EVALUATION

Attachments 3 & 4 Federal Work Authorization Program Addendum and Affidavit

FEDERAL WORK AUTHORIZATION PROGRAM ("E-VERIFY") ADDENDUM

Pursuant to Missouri Revised Statute 285.530, all business entities awarded any contract in excess of five thousand dollars ($5,000) with a Missouri public school district must, as a condition to the award of any such contract, be enrolled and participate in a federal work authorization program with respect to the employees working in connection with the contracted services being provided, or to be provided, to the District (to the extent allowed by E-Verify). In addition, the business entity must affirm the same through sworn affidavit and provision of documentation. In addition, the business entity must sign an affidavit that it does not knowingly employ any person who is an unauthorized alien in connection with the services being provided, or to be provided, to the District.

Accordingly, your company:

a) agrees to have an authorized person execute the attached "Federal Work Authorization Program Affidavit" attached hereto as Exhibit A and deliver the same to the District prior to or contemporaneously with the execution of its contract with the District;

b) affirms it is enrolled in the "E-Verify" (formerly known as "Basic Pilot") work authorization program of the United States, and are participating in E-Verify with respect to your employees working in connection with the services being provided (to the extent allowed by E-Verify), or to be provided, by your company to the District;

c) affirms that it is not knowingly employing any person who is an unauthorized alien in connection with the services being provided, or to be provided, by your company to the District;

d) affirms you will notify the District if you cease participation in E-Verify, or if there is any action, claim or complaint made against you alleging any violation of Missouri Revised Statute 285.530, or any regulations issued thereto;

e) agrees to provide documentation of your participation in E-Verify to the District prior to or contemporaneously with the execution of its contract with the District (or at any time thereafter upon request by the District), by providing to the District an E-Verify screen print-out (or equivalent documentation) confirming your participation in E-Verify;

f) agrees to comply with any state or federal regulations or rules that may be issued subsequent to this addendum that relate to Missouri Revised Statute 285.530; and

g) agrees that any failure by your company to abide by the requirements a) through f) above will be considered a material breach of your contract with the District.

By: _____
(Signature)

Printed Name and Title: _____

For and on behalf of: _____
(Company Name)

EXHIBIT A

FEDERAL WORK AUTHORIZATION PROGRAM AFFIDAVIT

I, _____, being of legal age and having been duly sworn upon my oath, state the following facts are true:

1. I am more than twenty-one years of age; and have first-hand knowledge of the matters set forth herein.

2. I am employed by _____ (hereinafter "Company") and have authority to issue this affidavit on its behalf.

3. Company is enrolled in and participating in the United States E-Verify (formerly known as "Basic Pilot") federal work authorization program with respect to Company's employees working in connection with the services Company is providing to, or will provide to, the District, to the extent allowed by E-Verify.

4. Company does not knowingly employ any person who is an unauthorized alien in connection with the services Company is providing to, or will provide to, the District.

FURTHER AFFIANT SAYETH NOT.

By: _____ (individual signature)

For _____ (company name)

Title: _____

Subscribed and sworn to before me on this _____ day of _____ 2016.

_____
NOTARY PUBLIC

My commission expires:

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. 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 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: **$3,500**/individual or **$10,500**/family For out-of-network providers: **$3,500**/individual or **$10,500**/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care & immunizations, diagnostic mammogram, office visits, emergency room visits, in-network urgent care facility visits. Out-of-network immunization for children through age 5.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes, **$200**/individual for in-network prescription drugs; **$200**/individual for out-of-network prescription drugs **does not apply to generic prescription drugs There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For in-network providers **$7,150**/individual or **$14,300**/family For out-of-network providers **$21,450**/individual or **$42,900**/family Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See **www.myCigna.com or call 1-800-Cigna24** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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 provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit Deductible does not apply	50% coinsurance	None
	Specialist visit	$50 copay/visit Deductible does not apply	50% coinsurance	None
	Preventive care/ screening/ immunization	No charge/visit** No charge/screening** No charge/immunizations** **Deductible does not apply	50% coinsurance/visit 50% coinsurance/screening 50% coinsurance/ immunizations	None None No charge for out of network immunizations for children through age 5. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	In-network diagnostic mammogram - No Charge
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	$750 penalty for no 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)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myCigna.com	Generic drugs (Tier 1)	$10 copay/prescription (retail 30 days), $30 copay/prescription (retail 90 days); $10 copay/prescription (home delivery 90 days) Deductible does not apply	50% coinsurance/prescription (retail); Not covered (home delivery)	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail and home delivery) for Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.
	Preferred brand drugs (Tier 2)	$35 copay/prescription (retail 30 days), $105 copay/prescription (retail 90 days); $90 copay/prescription (home delivery 90 days)	50% coinsurance/prescription (retail); Not covered (home delivery)	
	Non-preferred brand drugs (Tier 3)	$75 copay/prescription (retail 30 days), $225 copay/prescription (retail 90 days); $225 copay/prescription (home delivery 90 days)	50% coinsurance/prescription (retail); Not covered (home delivery)	
	Specialty drugs (Tier 4)	25% coinsurance up to a maximum of $150/prescription (retail 30 days); 25% coinsurance up to a maximum of $150/prescription (home delivery 30 days)	50% coinsurance/prescription (retail); Not covered (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	$750 penalty for no precertification.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	$750 penalty for no precertification.
If you need immediate medical attention	Emergency room care	$250 copay/visit Deductible does not apply	$250 copay/visit Deductible does not apply	Per visit copay is waived if admitted
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$50 copay/visit Deductible does not apply	50% coinsurance	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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	$750 penalty for no precertification.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	$750 penalty for no precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/office visit** 20% coinsurance/all other services **Deductible does not apply	50% coinsurance/office visit 50% coinsurance/all other services	$750 penalty if no precert of non-routine services (i.e., partial hospitalization, IOP, etc.).
	Inpatient services	20% coinsurance	50% coinsurance	$750 penalty for no precertification.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	

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 need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	$750 penalty for no precertification. Coverage is limited to 90 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	$30 copay/PCP visit** $50 copay/Specialist visit** **Deductible does not apply	50% coinsurance/PCP visit 50% coinsurance/Specialist visit	$750 penalty for failure to precertify speech therapy services. Coverage is limited to annual max of: 20 days each for Pulmonary rehab and Cognitive therapy services; 20 days each for Physical and Occupational therapies; 36 days for Cardiac rehab services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	$30 copay/PCP visit** $50 copay/Specialist visit** **Deductible does not apply	50% coinsurance/PCP visit 50% coinsurance/Specialist visit	$750 penalty for failure to precertify speech therapy services. Services are covered when Medically Necessary to treat a mental health condition (e.g. autism). Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Skilled nursing care	20% coinsurance	50% coinsurance	$750 penalty for no precertification. Coverage is limited to 90 days annual max for Skilled Nursing, Sub-Acute Facility and 60 days annual max for Rehabilitation Hospital

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)	
	Durable medical equipment	20% coinsurance	50% coinsurance	$750 penalty for no precertification.
	Hospice services	20% coinsurance/inpatient; 20% coinsurance/outpatient services	50% coinsurance/inpatient; 50% coinsurance/outpatient services	$750 penalty for no precertification.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Chiropractic care (first 26 visits per year without referral, additional visits if medically necessary)
- Private-duty nursing (82 days maximum per Calendar Year; 164 days maximum per lifetime)

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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 to submit a claim, appeal, or a grievance for any reason to your plan. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. 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. Additionally, a consumer assistance program can help you file your appeal. Contact the program for this plan's situs state: Missouri Division of Insurance at (800) 735-2966 (toll-free). However, for information regarding your own state's consumer assistance program refer to www.healthcare.gov.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

----------*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	$3,500
■ 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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$50
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$5,360**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	$3,500
■ 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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$130
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$1,330**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ The plan's overall deductible	$3,500
■ 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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$630
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,030**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: OAP 3500 **Ben Ver:** 14 **Plan ID:** 8399330

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

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Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224 (TTY: 711)まで、お電話にてご連絡ください。

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

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).

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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. 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 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: **$6,550**/individual or **$13,100**/family For out-of-network providers: **$6,550**/individual or **$13,100**/family Combined medical/behavioral and pharmacy deductible	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care & immunizations. Out-of-network immunization for children through age 5.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers **$6,550**/individual or **$13,100**/family For out-of-network providers **$19,650**/individual or **$39,300**/family Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See **www.myCigna.com or call 1-800-Cigna24** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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 provider's office or clinic	Primary care visit to treat an injury or illness	No charge/visit	30% coinsurance	None
	Specialist visit	No charge/visit	30% coinsurance	None
	Preventive care/ screening/ immunization	No charge/visit** No charge/screening** No charge/immunizations** **Deductible does not apply	30% coinsurance/visit 30% coinsurance/screening 30% coinsurance/ immunizations	None None No charge for out of network immunizations for children through age 5. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	$750 penalty for no 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)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myCigna.com	Generic drugs (Tier 1)	No charge/prescription (retail 30 days), No charge/prescription (retail 90 days); No charge/prescription (home delivery 90 days)	30% coinsurance/prescription (retail); Not covered (home delivery)	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail and home delivery) for Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits. In-network Federally required preventive drugs will be provided at no charge
	Preferred brand drugs (Tier 2)	No charge/prescription (retail 30 days), No charge/prescription (retail 90 days); No charge/prescription (home delivery 90 days)	30% coinsurance/prescription (retail); Not covered (home delivery)	
	Non-preferred brand drugs (Tier 3)	No charge/prescription (retail 30 days), No charge/prescription (retail 90 days); No charge/prescription (home delivery 90 days)	30% coinsurance/prescription (retail); Not covered (home delivery)	
	Specialty drugs (Tier 4)	No charge/prescription (retail 30 days);No charge/prescription (home delivery 30 days)	30% coinsurance/prescription (retail); Not covered (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	$750 penalty for no precertification.
	Physician/surgeon fees	No charge	30% coinsurance	$750 penalty for no precertification.
If you need immediate medical attention	Emergency room care	No charge/visit	No charge/visit	None
	Emergency medical transportation	No charge	No charge	None
	Urgent care	No charge/visit	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% coinsurance	$750 penalty for no precertification.
	Physician/surgeon fees	No charge	30% coinsurance	$750 penalty for no 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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge/office visit No charge/all other services	30% coinsurance/office visit 30% coinsurance/all other services	$750 penalty if no precert of non-routine services (i.e., partial hospitalization, IOP, etc.).
	Inpatient services	No charge/admission	30% coinsurance	$750 penalty for no precertification.
If you are pregnant	Office visits	No charge	30% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	30% coinsurance	
	Childbirth/delivery facility services	No charge	30% coinsurance	

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 need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	$750 penalty for no precertification. Coverage is limited to 100 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	No charge/visit	30% coinsurance/visit	$750 penalty for failure to precertify speech therapy services. Coverage is limited to annual max of: 20 days each for Pulmonary rehab and Cognitive therapy services; 20 days each for Physical and Occupational therapies; 36 days for Cardiac rehab services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	No charge/visit	30% coinsurance/visit	$750 penalty for failure to precertify speech therapy services. Services are covered when Medically Necessary to treat a mental health condition (e.g. autism). Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Skilled nursing care	No charge	30% coinsurance	$750 penalty for no precertification. Coverage is limited to 90 days annual max for Skilled Nursing, Sub-Acute Facility and 60 days annual max for Rehabilitation Hospital

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)	
	Durable medical equipment	No charge	30% coinsurance	$750 penalty for no precertification.
	Hospice services	No charge/inpatient; No charge/outpatient services	30% coinsurance/inpatient; 30% coinsurance/outpatient services	$750 penalty for no precertification.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Chiropractic care (first 26 visits per year without referral, additional visits if medically necessary)
- Private-duty nursing (82 days maximum per Calendar Year; 164 days maximum per lifetime)

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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 to submit a claim, appeal, or a grievance for any reason to your plan. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. 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. Additionally, a consumer assistance program can help you file your appeal. Contact the program for this plan's situs state: Missouri Division of Insurance at (800) 735-2966 (toll-free). However, for information regarding your own state's consumer assistance program refer to www.healthcare.gov.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

----------*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** **$6,550**
- **Specialist coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$6,550
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$6,560**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$6,550**
- **Specialist coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$6,480
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$6,680**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$6,550**
- **Specialist coinsurance** **0%**
- **Hospital (facility) coinsurance** **0%**
- **Other coinsurance** **0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: HSA 6550 **Ben Ver:** 14 **Plan ID:** 8399323

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

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Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224 (TTY: 711) まで、お電話にてご連絡ください。

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

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).

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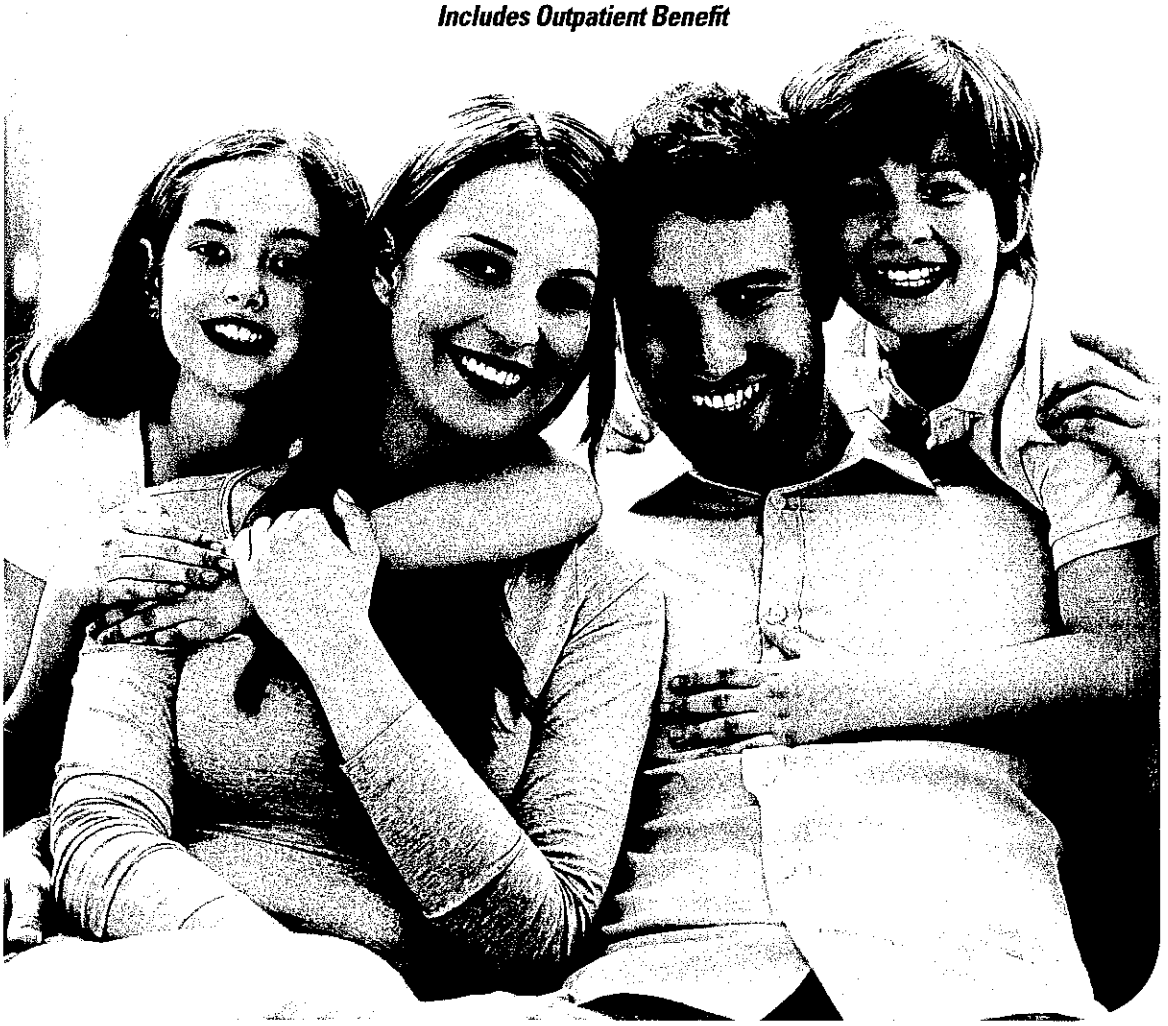
For Your School District and Staff

A Path to Affordable Health Care When You Need It Most

Hospital Helper Plus™

Supplemental Medical Expense Insurance

Includes Outpatient Benefit



#7828FSL

Don't Let an Unexpected Medical Bill Cripple Your Future

Health-care costs are outpacing inflation again. That has led to higher deductibles and co-payments for most insurance plans. With the average cost of a 3-day hospital stay around $30,000* coupled with the increasing popularity of high deductible health plans, it doesn't take long before your out-of-pocket expenses can become a significant financial burden.

Hospital Helper Plus™ Can Significantly Reduce Your Financial Exposure When Facing Medical Treatment, Saving Your Hard-Earned Money and Increasing Your Peace of Mind.

But here's the good news. You now have the option to choose **Hospital Helper Plus™**, a supplemental hospital confinement insurance policy that could substantially reduce your out-of-pocket expenses if you happen to suffer a serious injury or illness. Hospital Helper™ Plus provides "gap benefits," reimbursing much of what you pay out of pocket before your insurance covers the rest.

** HealthCare.gov, 2018*

How It Works

Your District purchased Hospital Helper Plus™ as part of your benefit package. Your District Health Plan is your primary coverage and has its own deductible and out-of-pocket maximums. Each benefit period, you pay the first $1,500 of covered expenses (inpatient or outpatient or both), and then Hospital Helper Plus™ benefits are available for inpatient or outpatient care, or both. For outpatient care, you get reimbursed up to $2,000 after your initial $1,500 expense for deductibles and coinsurance. For inpatient care, there's a reimbursement up to $4,000 after the initial $1,500 expense. So over the course of your benefit period, Hospital Helper Plus™ could save you up to $6,000 in medical expenses. Covered charges begin after the insured person's effective date.

Hospital Helper Plus Guidelines

Inpatient Benefit

Benefits are payable for covered charges if the insured person is hospital confined due to an injury or sickness and is under the regular care and attendance of a physician and the expenses are covered by the insured person's medical plan. Benefits are payable for covered charges for treatment in a hospital emergency room, transportation by ambulance to a hospital due to an injury or sickness, and for durable medical equipment received by the insured person while hospital confined.

Hospital confinement is payable for covered charges for the insured person's newborn children from the moment of birth until discharged from the hospital if the expenses are covered by the insured's medical plan. Covered charges are subject to the inpatient maximum benefit.

HOSPITAL HELPER PLUS™ Features and Benefits

Benefit	Benefit Option	Benefit Period Maximums*
Inpatient Care	Per Person ($1,500 deductible)	Up to $4,000 per insured
	Per Family ($3,000 deductible)	Up to $8,000 per family
Outpatient Care	Per Person ($1,500 deductible)	Up to $2,000 per insured
	Per Family ($3,000 deductible)	Up to $4,000 per family

Other benefits include:

- **Emergency Room.** Benefits are payable for covered charges for treatment in a hospital emergency room if the insured person is hospital confined within 24 hours of the hospital emergency room treatment.
- **Durable Medical Equipment.** Benefits are payable for covered charges for durable medical equipment received by the insured person while hospital confined.
- **Ambulance.** Benefits are payable for covered charged if an insured person requires ambulance transportation to a hospital for an injury or sickness, and the insured person is hospital confined within 24 hours of being transported to the hospital.

Inpatient Maximum Benefit *– Up to $4,000 per insured, per benefit period; up to $8,000 per family, per benefit period.*

Outpatient Benefit Rider

Benefits are payable for covered charges for outpatient treatment due to an injury or sickness. Covered charges are subject to the outpatient maximum benefit shown in the schedule of benefits.

This benefit includes covered charges for treatment in a hospital emergency and transportation by ambulance to a hospital for injury or sickness, and the insured person is not hospital confined within 24 hours of treatment or transport.

Benefits are also payable for covered charges for outpatient durable medical equipment received by the insured person.

This benefit does not include expenses incurred for an examination of an insured person by a physician in the physician's office or urgent care facility.

Outpatient benefits are in lieu of any inpatient benefits.

Outpatient Maximum Benefit *– Up to $2,000 per insured, per benefit period; up to $4,000 per family, per benefit period.*

The Benefits of Hospital Helper Plus™:

- Less money coming out of your pocket if you face a significant medical procedure.
- May allow you to change to a higher deductible HSA plan at your annual Group Health Plan enrollment, and be eligible for District contributions to your HSA account and your own tax-free contributions up to annual IRS maximums.
- Reimbursement benefits are paid directly to the member, or the reimbursement can be assigned to the Health Care Provider.
- Underwritten by Fidelity Security Life Insurance Company (FSL), a sister company of Forrest T. Jones & Company (FTJ), the plan's administrator.

Premiums (See separate Rate Sheet)

The employee premium is paid by the District as part of the benefit package that includes Hospital Helper Plus™. Dependent rates are provided to your District human resources department and are also available at FTJ Connect (www.ftjconnect.com). For employees covering dependents who meet the $3,000 annual family deductible, you can receive up to $8,000 in annual reimbursements per family. For outpatient care, you can receive reimbursements annually up to $4,000 per family.

How to Use This Valuable Benefit

If you prefer benefits be paid directly to you, please follow the instructions on the top of the FSL claim form, which will be mailed to your home address after your initial enrollment.

If you prefer to assign benefits to your provider, they will assist you with the initial claim filing process.

** See Limitations and Exclusions page regarding Hospital Helper Plus™ coverage.*

Hospital Helper Plus™

Policy MG157
Underwritten by Fidelity Security Life Insurance Company

Limitations and Exclusions

Limitations

Medical Plan. If an insured person did not have a medical plan on the insured person's effective date under the policy, the company's sole obligation will then be to refund all premiums paid for that insured person.

Exclusions

The Policy does not provide any benefits for the following:

1. *any Expenses Incurred during any period the Insured Person does not have coverage under a Medical Plan;*
2. *war, declared or undeclared;*
3. *suicide or any attempt thereat, while sane or insane (in Colorado, Missouri or Montana, while sane);*
4. *any intentionally self-inflicted Injury or Sickness, while sane or insane (in Colorado, Missouri or Montana, while sane);*
5. *any loss while the Insured Person is in the service of the Armed Forces of any country. Orders to active military service for training purposes of two months or less will not constitute service in the Armed Forces. Upon notice to the Company of entering the Armed Forces, the Company will return to the Insured Person pro rata any premium paid, less any benefits paid, for any period during which the Insured Person is in such service;*
6. *any expense for which there is no legal obligation to pay, no charge is made or in the absence of coverage, no charge would be made;*
7. *drugs or medicines, except medicines prescribed and taken while Hospital Confined;*
8. *dental or vision services unless:*
   a. *resulting from an Injury occurring while the Insured Person's coverage under the Policy is in force; or*
   b. *due to congenital disease or anomaly of a Dependent newborn child;*
9. *mental illness or functional or organic nervous disorders, regardless of the cause;*
10. *treatment of alcoholism, drug addiction or complications thereof;*
11. *any Injury that occurs while an Insured Person has been determined to be intoxicated:*
    a. *by judicial or administrative judgment or order;*
    b. *by evidence of an alcohol concentration in the Insured Person's blood, breath or urine which equals or exceeds the limits set by applicable motor vehicle laws; or*
    c. *by other evidence demonstrating the Insured Person was under the influence of any alcohol, narcotic, barbiturate or hallucinatory drug, unless the same was administered on the advice of a Physician and was taken according to the prescribed dosage; and the use of such substance was a proximate cause of the Injury;*
12. *any treatment, services or supplies for Wellness Services. For this exclusion, "Wellness Services" means treatment, services or supplies provided for routine health care, including, but not limited to, routine health or check-up examinations, routine well child visits, mammograms and other charges incurred during the course of a routine physical examination or checkup;*
13. *Injury or Sickness for which compensation is payable under any Workers' Compensation Law, any Occupational Disease Law or similar legislation, or if the Policyholder opts out of such requirements, any similar coverage purchased or self-funded by the Policyholder to cover work-related Injuries or Sicknesses;*
14. *any loss for which the Insured Person is not required to pay a Deductible, Copayment and/or Coinsurance under the Insured Person's Medical Plan;*
15. *any expense for which benefits are excluded under the Insured Person's Medical Plan; or*
16. *an Insured Person engaging in any act or occupation which is a violation of the law of the jurisdiction where the loss or cause of loss occurred. A violation of law includes both misdemeanor and felony violations.*

Coverage will continue as long as the policy remains in force, the required premium is paid, and the insured remains qualified for coverage.

Fidelity Security Life Insurance Company
3130 Broadway
Kansas City, MO 64111

Hospital Helper Plus™

2018 RATES

Benefits per Calendar Year	
Individual Deductible	$1,500
Family Deductible	3,000
Inpatient Maximum	4,000
Outpatient Maximum	2,000
Physician Office Visit	0

Monthly Rates	
Employee (District Paid)	$32.05
Spouse	25.64
Children	30.45
Spouse & children	56.09

Administered by:

Forrest T. Jones & Company™
800.821.7303, ext. 1179
www.ftj.com

Underwritten by:

Fidelity Security Life Insurance Company
3130 Broadway
Kansas City, MO 64111

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. 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 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: **$4,000**/individual or **$8,000**/family For out-of-network providers: **$4,000**/individual or **$8,000**/family Combined medical/behavioral and pharmacy deductible	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care & immunizations. Out-of-network immunization for children through age 5.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers **$5,000**/individual or **$10,000**/family For out-of-network providers **$15,000**/individual or **$30,000**/family Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See **www.myCigna.com or call 1-800-Cigna24** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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 provider's office or clinic	Primary care visit to treat an injury or illness	No charge/visit	30% coinsurance	None
	Specialist visit	No charge/visit	30% coinsurance	None
	Preventive care/ screening/ immunization	No charge/visit** No charge/screening** No charge/immunizations** **Deductible does not apply	30% coinsurance/visit 30% coinsurance/screening 30% coinsurance/ immunizations	None None No charge for out of network immunizations for children through age 5. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	$750 penalty for no 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)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myCigna.com	Generic drugs (Tier 1)	$15 copay/prescription (retail 30 days), $45 copay/prescription (retail 90 days); $15 copay/prescription (home delivery 90 days) No charge/preventive drugs** **Deductible does not apply	50% coinsurance/prescription (retail); Not covered (home delivery)	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail and home delivery) for Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.
	Preferred brand drugs (Tier 2)	$45 copay/prescription (retail 30 days), $135 copay/prescription (retail 90 days); $112 copay/prescription (home delivery 90 days) No charge/preventive drugs** **Deductible does not apply	50% coinsurance/prescription (retail); Not covered (home delivery)	
	Non-preferred brand drugs (Tier 3)	$75 copay/prescription (retail 30 days), $225 copay/prescription (retail 90 days); $225 copay/prescription (home delivery 90 days) No charge/preventive drugs** **Deductible does not apply	50% coinsurance/prescription (retail); Not covered (home delivery)	
	Specialty drugs (Tier 4)	25% coinsurance up to a maximum of $400/prescription (retail 30 days); 25% coinsurance up to a maximum of $400/prescription (home delivery 30 days)	50% coinsurance/prescription (retail); Not covered (home delivery)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	$750 penalty for no precertification.
	Physician/surgeon fees	No charge	30% coinsurance	$750 penalty for no 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)	
If you need immediate medical attention	Emergency room care	No charge/visit	No charge/visit	None
	Emergency medical transportation	No charge	No charge	None
	Urgent care	No charge/visit	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% coinsurance	$750 penalty for no precertification.
	Physician/surgeon fees	No charge	30% coinsurance	$750 penalty for no precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge/office visit No charge/all other services	30% coinsurance/office visit 30% coinsurance/all other services	$750 penalty if no precert of non-routine services (i.e., partial hospitalization, IOP, etc.).
	Inpatient services	No charge/admission	30% coinsurance	$750 penalty for no precertification.
If you are pregnant	Office visits	No charge	30% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	30% coinsurance	
	Childbirth/delivery facility services	No charge	30% coinsurance	

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 need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	$750 penalty for no precertification. Coverage is limited to 100 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	No charge/visit	30% coinsurance/visit	$750 penalty for failure to precertify speech therapy services. Coverage is limited to annual max of: 20 days each for Pulmonary rehab and Cognitive therapy services; 20 days each for Physical and Occupational therapies; 36 days for Cardiac rehab services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	No charge/visit	30% coinsurance/visit	$750 penalty for failure to precertify speech therapy services. Services are covered when Medically Necessary to treat a mental health condition (e.g. autism). Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Skilled nursing care	No charge	30% coinsurance	$750 penalty for no precertification. Coverage is limited to 90 days annual max for Skilled Nursing, Sub-Acute Facility and 60 days annual max for Rehabilitation Hospital

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)	
	Durable medical equipment	No charge	30% coinsurance	$750 penalty for no precertification.
	Hospice services	No charge/inpatient; No charge/outpatient services	30% coinsurance/inpatient; 30% coinsurance/outpatient services	$750 penalty for no precertification.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Chiropractic care (first 26 visits per year without referral, additional visits if medically necessary)
- Private-duty nursing (82 days maximum per Calendar Year; 164 days maximum per lifetime)

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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 to submit a claim, appeal, or a grievance for any reason to your plan. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. 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. Additionally, a consumer assistance program can help you file your appeal. Contact the program for this plan's situs state: Missouri Division of Insurance at (800) 735-2966 (toll-free). However, for information regarding your own state's consumer assistance program refer to www.healthcare.gov.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

----------*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**	**$4,000**
■ **Specialist coinsurance**	**0%**
■ **Hospital (facility) coinsurance**	**0%**
■ **Other coinsurance**	**0%**

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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,000
Copayments	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$4,040**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ **The plan's overall deductible**	**$4,000**
■ **Specialist coinsurance**	**0%**
■ **Hospital (facility) coinsurance**	**0%**
■ **Other coinsurance**	**0%**

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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$4,000
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$4,900**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ **The plan's overall deductible**	**$4,000**
■ **Specialist coinsurance**	**0%**
■ **Hospital (facility) coinsurance**	**0%**
■ **Other coinsurance**	**0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: HSA 4000 **Ben Ver:** 14 **Plan ID:** 8399314

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

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Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224 (TTY: 711)まで、お電話にてご連絡ください。

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

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شمارهگیری کنید).

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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. 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 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers: **$2,700**/individual or **$5,000**/family For out-of-network providers: **$2,700**/individual or **$5,000**/family Combined medical/behavioral and pharmacy deductible	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care & immunizations. Out-of-network immunization for children through age 5. In-Network preventive prescription drugs.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers **$5,000**/individual or **$10,000**/family For out-of-network providers **$15,000**/individual or **$30,000**/family Combined medical/behavioral and pharmacy out-of-pocket limit	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See **www.myCigna.com or call 1-800-Cigna24** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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 provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance/visit	40% coinsurance	None
	Specialist visit	20% coinsurance/visit	40% coinsurance	None
	Preventive care/ screening/ immunization	No charge/visit** No charge/screening** No charge/immunizations** **Deductible does not apply	40% coinsurance/visit 40% coinsurance/screening 40% coinsurance/ immunizations	None None No charge for out of network immunizations for children through age 5. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	$750 penalty for no 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)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myCigna.com	Generic drugs (Tier 1)	20% coinsurance/prescription (retail 30 days), 20% coinsurance/prescription (retail 90 days); 10% coinsurance/prescription (home delivery 90 days) No charge/preventive drugs** **Deductible does not apply	40% coinsurance/prescription (retail); Not covered (home delivery)	Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail and home delivery) for Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.
	Preferred brand drugs (Tier 2)	20% coinsurance/prescription (retail 30 days), 20% coinsurance/prescription (retail 90 days); 10% coinsurance/prescription (home delivery 90 days) No charge/preventive drugs** **Deductible does not apply	40% coinsurance/prescription (retail); Not covered (home delivery)	
	Non-preferred brand drugs (Tier 3)	20% coinsurance/prescription (retail 30 days), 20% coinsurance/prescription (retail 90 days); 10% coinsurance/prescription (home delivery 90 days) No charge/preventive drugs** **Deductible does not apply	40% coinsurance/prescription (retail); Not covered (home delivery)	
	Specialty drugs (Tier 4)	20% coinsurance/prescription (retail 30 days); 10% coinsurance/prescription (home delivery 30 days)	40% coinsurance/prescription (retail); Not covered (home delivery)	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	$750 penalty for no precertification.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	$750 penalty for no precertification.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	$750 penalty for no precertification.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	$750 penalty for no precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance/office visit 20% coinsurance/all other services	40% coinsurance/office visit 40% coinsurance/all other services	$750 penalty if no precert of non-routine services (i.e., partial hospitalization, IOP, etc.).
	Inpatient services	20% coinsurance	40% coinsurance	$750 penalty for no precertification.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

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 need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	$750 penalty for no precertification. Coverage is limited to 100 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	Rehabilitation services	20% coinsurance/visit	40% coinsurance/visit	$750 penalty for failure to precertify speech therapy services. Coverage is limited to annual max of: 20 days each for Pulmonary rehab and Cognitive therapy services; 20 days each for Physical and Occupational therapies; 36 days for Cardiac rehab services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Habilitation services	20% coinsurance/visit	40% coinsurance/visit	$750 penalty for failure to precertify speech therapy services. Services are covered when Medically Necessary to treat a mental health condition (e.g. autism). Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	Skilled nursing care	20% coinsurance	40% coinsurance	$750 penalty for no precertification. Coverage is limited to 90 days annual max for Skilled Nursing, Sub-Acute Facility and 60 days annual max for Rehabilitation Hospital.

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)	
	Durable medical equipment	20% coinsurance	40% coinsurance	$750 penalty for no precertification.
	Hospice services	20% coinsurance/inpatient; 20% coinsurance/outpatient services	40% coinsurance/inpatient; 40% coinsurance/outpatient services	$750 penalty for no precertification.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Eye care (Children)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Chiropractic care (first 26 visits per year without referral, additional visits if medically necessary)
- Private-duty nursing (82 days maximum per Calendar Year; 164 days maximum per lifetime)

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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 to submit a claim, appeal, or a grievance for any reason to your plan. For questions about your rights, this notice, or assistance, you can contact Cigna Customer service at 1-800-Cigna24. 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. Additionally, a consumer assistance program can help you file your appeal. Contact the program for this plan's situs state: Missouri Division of Insurance at (800) 735-2966 (toll-free). However, for information regarding your own state's consumer assistance program refer to www.healthcare.gov.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-800-244-6224.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-244-6224.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-244-6224.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-244-6224.

----------*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	$2,700
Specialist coinsurance	20%
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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,700
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$4,710**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,700
Specialist coinsurance	20%
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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,700
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$3,700**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,700
Specialist coinsurance	20%
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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Plan Name: HSA 2700 **Ben Ver:** 14 **Plan ID:** 8399325

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

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Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224 (TTY: 711) まで、お電話にてご連絡ください。

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

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).

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