



HELPING YOU CARE

FOR WHAT

MATTERS MOST

**A guide to your Weld County
Government health plan options.**

Plan year: 01/01/2017 - 12/31/2017

Together, all the way.®



Offered by Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company or their affiliates.

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Words to know



This guide was created to help you make important decisions about your health care. Before you begin, we think that understanding certain words will help you better understand the choices you need to make. So here are some definitions of words and phrases that you'll see in this guide.

Deductible: An annual amount you'll pay out-of-pocket before your health plan begins to pay for covered health care costs.

Copay: A pre-set amount you pay for your covered health care services. The health plan pays the rest.

Coinsurance: Your share of the cost of your covered health care services. The health plan pays the rest.

Out-of-pocket maximum: The most you pay before the health plan begins to pay 100% of covered charges. You'll still need to pay for any expenses the health plan doesn't count towards the limit.

Generics: Generic medications have the same active ingredients, dosage, and strength as their brand-name counterparts. You'll usually pay less for generic medications.

Preferred brand: Preferred brand medications will usually cost more than generics. But may cost less than a non-preferred brand on your plan.

In-network: Health care professionals and facilities that have contracts with Cigna to deliver services at a negotiated rate (discount). You pay a lower amount for those services.

Out-of-network: A health care professional or facility that doesn't participate in Cigna's network and doesn't provide services at a discounted rate. Using an out-of-network health care professional or facility will cost you more.

Non-preferred brands: Non-preferred brand medications generally have generic alternatives and/or one or more preferred brand options within the same drug class. You'll usually pay more for non-preferred brand medications.

Ways to get better health

Cigna wants to help you choose a health plan that fits your needs and keeps you healthy.

This year, **Weld County Government** offers you the following health plans:

- **Preferred Provider Organization**
- **Health Reimbursement Account**

Cigna plans offer the coverage, tools and resources you need to help you better manage your health – and health spending:

- Ways to compare costs, look at claims, search for health care providers, and more using myCigna - online or through the mobile app.
- Cost savings when using in-network providers.
- Enjoy discounts on health-related products and services.
- Take steps to maintain good health with annual wellness checkups and screenings.
- Access to board-certified doctors by phone or online video through telehealth.

At Cigna, we want to partner with you and support you in your health journey. We'll be there for you, every step of the way, so you don't have to go it alone.

Health care reform: Meeting the requirements

Coverage under your employer-sponsored health plan satisfies the health care reform requirement to maintain "minimum essential coverage" under the "individual mandate" provision of the Patient Protection and Affordable Care Act.

Each new year, Cigna, or your employer, will mail you a document confirming the coverage you were offered and were enrolled in, if applicable, during the prior calendar year. The form does not need to be filed your income tax return. It is provided for informational purposes only. The form will also include information for covered dependents, if applicable.

Please read all of the information in this brochure. Health plans may work differently, so it's important to use this along with your other enrollment materials as a guide to how your Cigna health plans work.

Call the preenrollment hotline at 1.800.Cigna24 (1.800.244.6224) if you have questions.

Understand your plan options

Option 1

Preferred Provider Organization (PPO): A health plan that gives you choice

Your Cigna PPO plan coverage for medical care, including visits to your doctor's office, hospital stays, mental health and substance use services, chiropractic treatment, physical therapy and other services.

You don't need to select a primary care doctor, and can see a specialist without a referral. You have the option to see any licensed health care professional; however, your costs will be lowest when you use the PPO network.

With health coverage, you pay a predetermined fee (copay) for certain covered health care expenses and the plan pays the rest. For other services, you pay a deductible then a percentage of the cost (coinsurance).*

Once you reach an annual limit on your payments (out-of-pocket maximum), the health plan pays your covered health care costs 100%.

* If you go out-of-network for care, your expenses may exceed the coinsurance amount because the doctor may bill you for charges not covered under the plan.

Important features:

- No referral is needed to see a specialist, although precertification may be required.
- Certain in-network preventive care services are covered at no added cost to you.
- 24-hour emergency care, in- or out-of-network.
- The amount you pay out-of-pocket is limited by your plan's out-of-pocket maximum. Once you spend the annual maximum amount, the health plan pays your covered health care costs at 100%.
- No claim paperwork necessary when you receive care in-network.

You can view highlights of this plan on pages 6-7. Remember, this brochure is a guide only. Make sure to read all your enrollment information. Plan details may vary.

How your PPO plan works

What's covered: Your medical care and prescription drugs. Certain in-network preventive care services are covered at no added cost to you.



Option 2

Cigna Choice Fund® Health Reimbursement Account (HRA): A health plan plus a health reimbursement account puts you in control

Your Cigna HRA plan combines a health plan with a health reimbursement account. Your employer funds the account to help pay for some of your covered health care costs.

Here's how the HRA works. At the start of your plan year, your employer will put a specific dollar amount into your HRA. Your HRA will be used to pay 100% of covered health care costs until the money is used up.

You'll pay an annual amount (deductible) before the health plan begins to pay for covered health care costs. Health care costs that were paid from your HRA typically count toward your deductible. With the health plan, you pay a predetermined fee (copay) for certain covered health care expenses and the plan pays the rest. For other services, you pay a deductible, then a percentage of the cost (coinsurance).

Once you reach an annual limit on your payments (out-of-pocket maximum), the health plan pays your covered health care costs at 100%.

Money not used this year can be spent next year if you reenroll in the HRA.

¹ Check your plan materials to verify expenses that will count toward your deductible.

² If you go out-of-network for care, your expenses may exceed the coinsurance amount because the doctor may bill you for charges not covered under the plan.

Key benefits of choosing an HRA:

- You have an employer-funded account to help you pay for out-of-pocket medical expenses and meet your annual deductible
- You decide how the money in your HRA is spent. The services you receive within your plan are up to you.
- Unused money will be available to you in the following year if you reenroll in the HRA plan.

Important features:

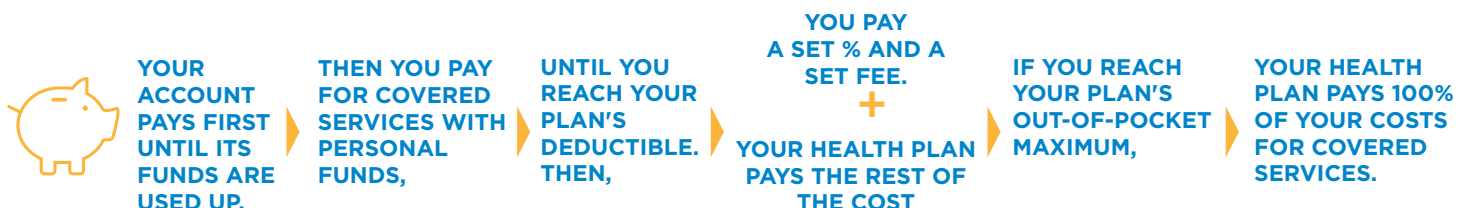
- Choose the in-network health care professional you want to see - no referral is needed to see a specialist.
- Certain in-network preventive care services are covered at no added cost to you.
- 24-hour emergency care, in- or out-of-network.
- The amount you pay out-of-pocket is limited by your plan's out-of-pocket maximum. Once you spend the annual maximum amount, the health plan pays covered health care costs at 100%.

You can view highlights of this plan on pages 6-7. Remember, this brochure is a guide only. Make sure to read all your enrollment information. Plan details may vary.

How your HRA works

How your HRA is funded: Money from your employer.

What's covered: Your medical care and prescription drugs. Certain in-network preventive care services are covered at no added cost to you.



If you reenroll in the HRA, money not used this year can be spent next year.

Review your plan options

Option 1

Option 2

	Preferred Provider Organization ²		Cigna Choice Fund [®] Health Reimbursement Account ²	
Medical Plan Highlights	Individual	Family	Individual	Family
Medical deductible-				
In-network	\$1,500	\$3,000	\$3,000	\$6,000
Out-of-network	\$5,000	\$10,000	\$6,000	\$12,000
Contribution from employer	\$0	\$0	\$1,000	\$1,000
Out-of-pocket maximum				
In-network ¹	\$4,000	\$8,000	\$3,500	\$7,000
Out-of-network	\$10,000	\$20,000	\$13,500	\$37,000

Prescription Medication Highlights	Retail (30-day supply)	Home Delivery (90-day supply)	Retail (30-day supply)	Home Delivery (90-day supply)
Pharmacy deductible	Not applicable	Not applicable	Not applicable	Not applicable
Generic	You pay \$15 copay	You pay \$30 copay	You pay \$15 copay	You pay \$30 copay
Preferred brand	You pay \$40 copay	You pay \$80 copay	You pay \$40 copay	You pay \$80 copay
Non-preferred brand	You pay \$70 copay	You pay \$140 copay	You pay \$70 copay	You pay \$140 copay
Out-of-network	100% then reimbursed 50%	100% then reimbursed 50%	100% then reimbursed 50%	100% then reimbursed 50%

Words to know:

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Copay: A preset amount you pay for your covered health care services. The health plan pays the rest.

Coinsurance: Your share of the cost of your covered health care services. The health plan pays the rest.

Out-of-pocket maximum: The most you pay before the health plan begins to pay 100% of covered charges. You will still need to pay for any expenses the health plan doesn't count towards the limit.

In-network: Many health care professionals and facilities that have a contract with Cigna to deliver services at a negotiated rate (discount). You pay a lower amount for those services.

Out-of-network: A health care professional or facility that doesn't participate in your Cigna plan's network and doesn't provide services at a discounted rate. Using an out-of-network health care professional or facility may cost you more.

Generics: Generic medications have the same active ingredients, dosage, and strength as their brand-name counterparts. You'll usually pay less for generic medications under your plan.

Preferred brands: Preferred brand medications will usually cost more than generics. But may cost less than non-preferred brands.

Non-preferred brands: Non-preferred brand medications generally have generic alternatives and/or one or more preferred brand options within the same drug class. You'll usually pay more for non-preferred brand medications.

Option 1

Option 2

	Preferred Provider Organization ²		Cigna Choice Fund® Health Reimbursement Account ²	
Office/Routine Care – What you will pay. If a deductible applies, it will be noted.				
	In-Network	Out-of-Network	In-Network	Out-of-Network
Adult preventive care ³	Plan pays 100%	You pay 50% after deductible is met	Plan pays 100%	You pay 50% after deductible is met
Office visit	You pay \$30 copay per visit	You pay 50% after deductible is met	You pay 0% after deductible is met	You pay 50% after deductible is met
Specialist visit	You pay \$30 copay per visit	You pay 50% after deductible is met	You pay 0% after deductible is met	You pay 50% after deductible is met
Prenatal care	You pay 20% after deductible is met	You pay 50% after deductible is met	You pay 0% after deductible is met	You pay 50% after deductible is met
Chiropractic	Not covered	Not covered	Not covered	Not covered
Physical, occupational and speech therapy	You pay 20% after deductible is met	You pay 50% after deductible is met	You pay 0% after deductible is met	You pay 50% after deductible is met
Well-child care ³	Plan pays 100%	You pay 50% after deductible is met	Plan pays 100%	You pay 50% after deductible is met
Lab, X-ray, diagnostic tests	You pay 20% after deductible is met	You pay 50% after deductible is met	You pay 0% after deductible is met	You pay 50% after deductible is met
Durable medical equipment	You pay 20% after deductible is met	You pay 50% after deductible is met	You pay 0% after deductible is met	You pay 50% after deductible is met
Hospital Care – What you'll pay once you meet your deductible				
Inpatient hospitalization	You pay 20% after deductible is met	You pay \$500 per admission, then 50%	You pay 0% after deductible is met	You pay 50% after deductible is met
Outpatient surgery	You pay 20% after deductible is met	You pay \$500 per admission, then 50%	You pay 0% after deductible is met	You pay 50% after deductible is met
Emergency room	You pay 20% after deductible is met	You pay 20% after deductible is met	You pay 0% after in-network deductible is met	You pay 0% after in-network deductible is met
Urgent care center	You pay \$30 per visit copay	You pay 50% after deductible is met	You pay 0% after deductible is met	You pay 50% after deductible is met
Ambulance	You pay 20% after deductible is met	You pay 20% after deductible is met	You pay 0% after in-network deductible is met	You pay 0% after in-network deductible is met
Mental Health and Substance Abuse – What you'll pay once you meet your deductible				
Inpatient (Unlimited day maximum)	You pay 20% after deductible is met	You pay \$500 per admission, then 50%	You pay 0% after deductible is met	You pay 50% after deductible is met
Outpatient	You pay \$30 copay per visit	You pay 50% after deductible is met	You pay 0% after deductible is met	You pay 50% after deductible is met

¹ This is the most a family (employees plus covered family members) will pay for in-network out-of-pocket expenses. It's important to note that each individual family member's out-of-pocket costs are capped at \$7,150 for 2017 health plans. To see examples of how this works, please visit www.InformedOnReform.com > Reform Topics Overview > Cost Sharing Limits, or Cigna.com/health-care-reform/embedded-oop-customer-impacts.

² What you'll pay after you meet your deductible. You'll pay 100% of the cost until you meet your deductible.

³ Certain in-network preventive care services and well-childcare services are covered at no added cost to you. You have no deductible to meet for these services.

These plans provides coverage for most medically necessary services. However, there are certain services and supplies that are not covered by the plan regardless of medical necessity. See the "What's Not Covered" section of this guide for examples of plan exclusions.

Get smarter about ways to stay healthy

Prescription drug coverage

Our prescription drug plans offer an extensive list of covered medications. Review your plan's drug list for a complete listing of covered prescription medications.

Choosing where to fill your medications should be easy, too. With thousands of pharmacies and Cigna Home Delivery PharmacySM in our network, you will have convenient access to your medications – whether you pick them up, or have them delivered right to your home.

If you need to purchase a prescription medication from a pharmacy not in our extensive network, you may pay more.

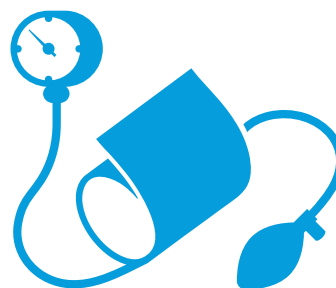
To help you stay healthy and manage the prescription medications you or your family may need, you'll have access to many online resources and tools on **myCigna**. You can:

- Review your specific pharmacy coverage details including your covered prescription list.
- Track your pharmacy expenses and claims.
- View real-time prescription drug prices.
- Learn more about Cigna Home Delivery Pharmacy. We do the work – we'll call your doctor's office to transfer the prescription to Cigna. You can order refills, track your shipments, and talk with your pharmacist at anytime, day or night.

Your plan covers contraceptives which include some selected products at no cost to you.

You can use telehealth for 24/7 care

See a doctor 24/7/365 with telehealth services. You will usually get an appointment in an hour or less, anytime, day or night. So, whether you're at home, at work or on vacation, and you can't see your doctor, a board-certified doctor will treat you by phone or online video chat for minor, non-emergency conditions like cold and flu symptoms, nausea and vomiting, sore throat, earache or sinus pain. The doctor can even prescribe most medications if appropriate. Prescriptions are not guaranteed to be written and telehealth may not be available in all areas, so see your enrollment materials for details.



Start saving today with Cigna Healthy Rewards^{®*}

Health and wellness discounts

Get discounts on the health products and programs you use every day for:

- Weight management and nutrition
- Fitness
- Mind/body
- Vision and hearing care
- Alternative medicine
- Healthy lifestyle

Just use your Cigna ID card when you pay and let the savings begin.

*Some Healthy Reward programs are not available in all states and programs may be discontinued at any time. If your Cigna plan includes coverage for any of these services, this program is in addition to, not instead of your plan benefits.

A discount program is NOT insurance, and you must pay the entire discounted charge.

Know your numbers

Staying healthy is important and knowing certain test results will help you and your doctor better understand your health. When you receive your results, here are some numbers you should keep in mind:

- **Blood pressure** ideally should be lower than 120/80.
- **Body Mass Index (BMI)** will vary by gender and age but, generally, falls between 18.5 and 24.9.
- **Glucose level** ideally should be between 70-110 mg/dl.
- **A healthy total cholesterol level** is a reading of less than 200 mg/dl.

If you find you need to work on any of these numbers, talk to your doctor. You may also benefit from some of the following suggestions:

- Increase your intake of fruits, vegetables, fish and fiber.
- Choose healthy carbohydrates and eat more foods that are low in saturated fat and high in soluble fiber.
- Eat small, more frequent meals - and never skip breakfast.
- Maintain a healthy body weight and exercise at least 30 minutes, five days a week.

Preventive care

Helping you stay well

Getting and staying healthy is important. That's why certain preventive care services are covered at no additional cost to you, when you receive them from a doctor who participates in your Cigna plan's network*.

Covered preventive care services can include, but are not limited to:

- Well visits
- Blood pressure screenings
- Cholesterol screenings
- Diabetes screenings
- Testing for colon cancer

Women's preventive care services are also covered at no additional cost, including:

- Annual well-woman visits
- Screenings for gestational diabetes
- HPV DNA testing for women 30 years and older
- Sexually-transmitted infection counseling
- HIV screening and counseling
- Screening and counseling for interpersonal and domestic violence
- Breast-feeding support, supplies and counseling

* Not all preventive care services are covered. For example, immunizations for travel are generally not covered. See your plan materials for a complete list of covered preventive care services

Make myCigna your Cigna

Nothing is more important than your good health. That's why there's **myCigna** – your online home for assessment tools, plan management, medical updates, and much more.

On **myCigna** you can:

- Find doctors and medical services
- View ID card information
- Review your coverage
- See your complete list of prescription medications covered under your plan.
- Manage and track claims
- Order refills at Cigna Home Delivery Pharmacy and track your orders 24/7.
- Compare cost and quality information for doctors and hospitals
- Access a variety of health and wellness tools and resources
- Sign up to receive alerts when new plan documents are

Make sure you read this important information

What's not covered*

Your benefit plan pays for health services that may help you stay well, treat illness or manage medical conditions, but all plans have exclusions and limitations. Following are examples of some services not covered by your employer's medical plan, unless required by law:

- Services provided through government programs
- Services that aren't medically necessary
- Experimental, investigational or unproven services
- Services for an injury or illness that occurs while working for pay or profit, including services covered by Worker's Compensation benefits
- Cosmetic services
- Dental care, unless due to accidental injury to sound natural teeth
- Reversal of sterilization procedures
- Genetic screenings
- Nonprescription and antiobesity drugs
- Custodial and other non-skilled services
- Weight-loss programs
- Hearing aids
- Treatment of sexual dysfunction
- Travel immunizations
- Telephone, email and internet consultations in the absence of a specific benefit
- Treatment of TMJ disorder
- Acupuncture
- Infertility services
- Obesity surgery and services
- Eyeglass lenses and frames, contact lenses and surgical vision correction

These services may not be covered under your medical plan. However, you may be able to pay for them using your health account (for example HRA, HSA or FSA) if you have one, if permitted under applicable federal tax regulations.

* This is a summary only and your plan's actual terms may vary. For a complete list of both covered and not-covered services, including benefits required by your state, please see your employer's insurance certificate or summary plan description – the official plan document. If there are any differences between the information in this brochure and the plan document, the information in the plan document takes precedence.

Important notice: special enrollment requirements

If you are declining enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because you have other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if:

- You or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If the other coverage is COBRA continuation coverage, you and your dependents must complete your entire COBRA coverage period before you can enroll in this plan, even if your former employer ceases contributions toward the COBRA coverage.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Effective April 1, 2009 or later, if you or your dependents lose eligibility for state Medicaid or Children's Health Insurance Program (CHIP) coverage or become eligible for assistance with group health plan premium payment under a state Medicaid or CHIP plan, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the state Medicaid or CHIP coverage ends or you are determined eligible for premium assistance.

To request special enrollment or obtain more information, call our Customer Service Team at 1.800.Cigna24 (1.800.244.6224).

Other late entrants

If you decide not to enroll in this plan now, then want to enroll later, you must qualify for special enrollment. If you do not qualify for special enrollment, you may have to wait until an open enrollment period, or you may not be able to enroll, depending on the terms and conditions of your benefit plan. Please contact your plan administrator for more information.

Women's Health and Cancer Rights Act (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance or copays applicable to other medical and surgical benefits provided under this plan as shown in the Summary of Benefits. If you would like more information on WHCRA benefits, call Customer Service at 1.800.Cigna24 (1.800.244.6224).

Notes

Notes

Enrollment checklist and choice deadline.



**This is one of the most important decisions you'll make this year.
These steps will help you choose wisely.**

- Think about your health history and health care needs.
How much do you spend, on average, for health care?
How might that change in the upcoming year?
- Check the online directory on **Cigna.com** to see if your doctor participates in our network.
- Visit **myCigna.com** to compare prescription drug prices or to see if your medicine is covered.

Call the preenrollment hotline at 1.800.Cigna24 (1.800.244.6224) if you have questions.



The information in this brochure is provided as a guide only. Make sure to read all your enrollment information thoroughly as plan details may vary. If you need more assistance, talk to your Human Resources representative.

Patient experience, quality designations, cost-efficiency and other ratings found in Cigna's online provider directories reflect a partial assessment of quality and should not be the sole basis for decision-making (as such measures have a risk of error). They are not a guarantee of the quality of care that will be provided to individual patients. Individuals are encouraged to consider all relevant factors and consult with their physician when selecting a health care facility. Health care professionals and facilities that participate in the Cigna network and the MDLive program are independent practitioners solely responsible for the treatment provided to their patients. They are not agents of Cigna.

Product availability may vary by location and plan type and is subject to change. All group insurance policies and group benefit plans may contain exclusions, limitations, reduction of benefits, and terms under which the policies or plans may be continued in force or discontinued. For costs and complete details of coverage, see your plan documents.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company (CHLIC), Connecticut General Life Insurance Company (CGLIC), Life Insurance Company of North America, Cigna Life Insurance Company of New York (New York, NY), Cigna Behavioral Health, Inc., Cigna Health Management, Inc., Cigna Onsite Health, LLC, Tel-Drug, Inc., Tel-Drug of Pennsylvania, L.L.C., and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc. "Cigna Home Delivery Pharmacy" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C. In Texas, Open Access Plus and LocalPlus plans are considered Preferred Provider Plans with certain managed care features, and Open Access Plus In-Network and LocalPlus IN plans are considered Exclusive Provider plans with certain managed care features. Cigna Group Accidental Injury, Critical Illness, and Hospital Care insurance policies are insured by Life Insurance Company of North America, except in NY, where Group Accidental Injury insurance policies are insured by Cigna Life Insurance Company of New York. Policy forms: OK Medical: HP-APP-1 et al (CHLIC), GM6000 C1 et al (CGLIC); OK Dental Indemnity/PPO: HP-POL99 (CHLIC), GM6000 ELI288 et al (CGLIC); OK DHMO: HP-POL115 (CHLIC), GM6000 DEN201V1 (CGLIC); TN Medical: HP-POL43/HC-CER1V1 et al (CHLIC); TN HMO: GSA-COVER, et al (Cigna HealthCare of Tennessee, Inc.); TN Dental Indemnity/PPO: HP-POL69/HC-CER2V1 et al (CHLIC); TN DHMO: HP-POL134/HC-CER17V1 et al (CHLIC); Accident Indemnity: GAI-00-1000, GAI-00-1000.OR; Critical Illness: GCI-00-1000, GCI-00-0000.OR; Hospital Indemnity: GHIP-00-100, GHIP-00-1000.ORa. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc.

A HEALTHIER PARTNERSHIP STARTS HERE.

Preparing for a doctor's visit is an important step in taking control of your own health. Spend time thinking about what questions you want to ask. Your doctor will welcome your active participation. Here are some simple steps you can take to make the most of your visit.



MAKE A LIST.

Prepare for your visit by writing down your most important questions and concerns. Put them in order of importance. This will help make sure you don't spend too much time talking about less important things - or run out of time before you get to what really matters to you.



PREPARE TO SHARE.

The best way for your doctor to get a full picture of your health is by examining you and then talking with you. Be prepared to share your basic health history. If you have a complex health history, bring the contact information of your other doctors.



DEAL WITH PAPERWORK EARLY.

If you need any paperwork completed - school physicals, disability forms, etc. - let your doctor know early in the visit. Lengthy paperwork often requires your input, too so plan for enough time during the visit to fill in the information.



UNDERSTAND YOUR INSURANCE.

Knowing how your health plan works can help your doctor get through the necessary paperwork quickly and efficiently. Also, don't forget to bring your Cigna ID card. It has the information your doctor will need to process any claims.



FIND THE RIGHT FIT.

You should leave your doctor's office feeling like your concerns were heard and addressed. Together, you and your doctor should come up with a health care plan that fits your needs.

**Develop a good relationship with your doctor.
It can help you live a healthier life.**

Together, all the way.®

