MANAGED HEALTH CARE TRUST FUND

February 9, 2022

TO: All Eligible Participants

FROM: La Verne Thompson, Executive Director

We wish you a safe and healthy 2022 to you and your family from the MILA Co-Chairmen, Benny Holland, Jr., and David F. Adam, as well as all of the MILA Trustees and the MILA staff.

The current Summary Plan Description (SPD) for the MILA National Health Plan was effective as of October 2020. The Board of Trustees amends the Plan from time to time and informs you of changes. The information in this document summarizes any changes made to the SPD during 2021. In addition, it provides some important Notices and Reminders as well as clarifications that pertain to the SPD and the administration of the Plan. Please keep this letter with your SPD and other plan documents for future reference. If you have any questions, please contact the MILA Plan Office. To provide you with important information concerning the operation of the MILA National Health Plan, we are enclosing:

- Important Notice – Change of Address
- New Cigna (Medical) and CVS Caremark (Drugs) I.D. Cards
- The MILA National Health Plan Summary Annual Report, which summarizes MILA's 2020 annual financial filing with the government
- Summary of Material Modifications
- MILA Substance Use Disorder Treatment Program
- Notice of Grandfathered Plan under the Affordable Care Act
- Notice Regarding Form 1095-B
- Important Reminders, including but not limited to:
    - Urgent Care vs. Emergency Room Care
    - Telehealth Medicine
    - Employee Assistance Program (EAP)
    - Women's Health and Cancer Rights Act of 1998 (WHCRA)
    - Newborn's and Mothers' Health Protection Act Annual Notice Reminder
    - Mandatory Notification of Divorce
    - Information for Retirees
    - Notice of Non-Discrimination
    - Medical Treatment for On-the-Job Injuries
- Additional Information:
    - MILA Board of Trustees
    - Free Language Assistance

If you have any questions about any of these documents, please contact the MILA office.

Enc.

cc: MILA-MHCTF Trustees
Local Port Administrators
William Spelman, Esq.
John Sheridan, Esq.
James Campbell, Esq.
Nicholas Graziano, Esq.

55 Broadway, 27th Floor
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Tel. (212) 766-5700 ♦ Fax. (212) 766-0844/45
E-Mail: info@milamhctf.com ♦ Website: milamhctf.com

IMPORTANT NOTICE

From
111 Broadway, Suite 502
New York, New York 10006

TO

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New York, New York 10006-1901
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EFFECTIVE JANUARY 1, 2022

NEW CIGNA AND CVS CAREMARK I.D. CARDS

The new Cigna and CVS I.D. Cards will now list the copays and the deductibles for an individual or family:

- In-Network Deductible (INN DED)
- Out-of-Network Deductible (OON DED)
- In-Network Out-of-Pocket Maximum (INN OOP)
- Out-of Network Out-of-Pocket (OON OOP)

MYOELECTRIC PROSTHETIC DEVICES

Effective January 1, 2022, MILA has expanded its coverage of prosthetic devices to cover certain myoelectric prosthetic devices that are medically necessary.

KIDNEY DIALYSIS

Effective January 1, 2022, MILA will provide coverage for kidney dialysis at in-network providers only. Treatment at out-of-network providers will no longer be covered by MILA.

NO SURPRISES ACT

Effective January 1, 2022, the following provisions go into effect in accordance with the Consolidated Appropriations Act, 2020:

Emergency Services MILA will cover Emergency Services

a. Without the need for a prior authorization determination, even if the services are provided by Out-of-Network providers;
b. Without regard to whether the health care provider furnishing the Emergency Services is a Network Provider or Emergency facility, as applicable, with respect to the services;
c. Without imposing any administrative requirement or limitation on Out-of-Network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from Network Providers and Emergency facilities;
d. By calculating the cost-sharing requirement for out-of-network Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services and;
e. The cost-sharing amount for Emergency Services from Network Providers will be based upon the lessor of (i) billed charges from the Provider or (ii) the Qualifying Payment Amount.

Non-Emergency Services MILA will cover non-Emergency services or items provided by an Out-of-Network Provider at an In-Network facility if those non-Emergency services or items are otherwise covered by MILA. The cost-sharing requirement for those services or items will be no greater than the cost-sharing requirement that would have applied had those services or items been furnished by a Network Provider and will be calculated as though the total amount that would have been charged by a Network Provider for those services or items were equal to the Recognized Amount for those services or items.

However, non-Emergency services or items performed by an Out-of-Network Provider at an In-Network facility will be covered based on Out-of-Network coverage if at least 72 hours before the day of the appointment (or three hours in advance of services rendered in the case of a same-day appointment), the Participant is supplied with a written notice, as required by federal law, stating that (1) the Provider is an Out of-Network Provider with respect to the Plan, (2) the estimated charges for treatment and any advance limitations that the Plan may put on treatment, (3) the names of any Network Providers at the facility, and (4) the Participant may elect to be referred to one of the Network providers listed in the notice; and the Participant gives informed consent to continued treatment by the Out-of-Network Provider, acknowledging that the Participant understands that continued treatment by the Out-of-Network Provider may result in greater cost to the Participant.

Air Ambulance Services MILA will cover medically necessary Emergency Air Ambulance Services from an Out-of-Network Provider. The cost-sharing requirement for those services will be no greater than the cost-sharing requirement that would have applied had the services been furnished by a Network Provider and will be calculated as though the total amount that would have been charged by a Network Provider for those services were equal to the lesser of (i) the Qualifying Payment Amount or (ii) the billed amount for those services.

Initial Payment or Notice of Denial MILA will make an initial payment or notice of denial of payment for (i) Emergency Services, (ii) non-Emergency Services at In-Network facilities performed by Out-of-Network Providers, or (iii) Air Ambulance Services within 30 calendar days of receiving a clean claim (a complete claim submission as determined by the Claims Manager) from the Out-of-Network Provider. The 30-day period begins on the date the Plan receives the information necessary to decide a claim for payment for the services. MILA will pay directly to the Out-of-Network provider an amount that is equal to the amount by which the out-of-network rate for the services exceeds the cost-sharing amount for the services, less any initial payment amount.

External Review Process MILA will implement an external-review process under the NSA for denied claims related to Emergency Services, non-Emergency services provided by an Out-of-Network Provider at a Network facility, and Air Ambulances Services.

Continuing Care Patients If a Participant is a Continuing Care Patient and the contract with the Participant's Network Provider or facility terminates, or the Participant's benefits under the Plan are terminated because of a change in terms of the Providers' and/or facilities' participation in the Plan, the Participant will be notified in a timely manner of (i) the termination of the contract and (ii) the Participant's right to elect continued transitional care from the Provider or facility. The Participant will be allowed up to 90 days of continued coverage at Network cost sharing to allow for a transition of care to a Network Provider.

MILA National Health Plan
Summary Annual Report

This is a summary of the annual report of the MILA National Health Plan (Employer Identification Number 13-3968546), a collectively bargained multi-employer health and welfare plan, for the twelve months ending December 31, 2020. The annual report has been filed with the Department of Labor as required under the Employee Retirement Income Security Act of 1974 (ERISA).

All benefits payable under this plan are being provided on an uninsured basis. The Management-ILA Managed Health Care Trust Fund has committed itself to pay all claims incurred under the terms of the plan.

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the plan, was $1,179,036,530 as of December 31, 2020, compared to $1,048,597,919 as of January 1, 2020. During the plan year the plan experienced an increase in its net assets of $130,438,611. This increase includes unrealized appreciation and depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the plan had total income of $801,977,880, including employer and other contributions of $611,792,289, gains on the sale of assets of $1,853,840, unrealized gains from investments of $105,000,593, and interest and dividend income of $8,360,551. Plan expenses were $671,539,269. These expenses included $7,128,829 in administrative expenses, and $664,410,440 in benefits paid to participants and beneficiaries.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. An accountant's report, plan financial information and information on payments to service providers, assets held for investment, and transactions in excess of 5% of plan assets are included in that report. To obtain a copy of the full annual report, or any part thereof, write Ms. Laverne Thompson, Executive Director, Management-ILA Managed Health Care Trust Fund (MILA-MHCTF), 55 Broadway-27th Floor, New York, NY 10006, or call the MILA office at (212) 766-5700. The charge to cover copying costs for the full annual report is $10.00, or $0.25 per page for any part thereof.

You also have the right to receive from the Executive Director, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the Executive Director, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge. You also have the right to examine the annual report at the main office of the plan at 55 Broadway – 27th Floor, New York, NY 10006, and at the U.S. Department of Labor in Washington, D.C. or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to Public Disclosure Room, N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Summary of Material Modifications

PREVENTIVE HEALTHCARE VISITS

Effective January 1, 2022, MILA will be removing the one-visit per year limit on preventive healthcare visits. Accordingly, the following provision replaces the test under "Routine Preventive Care (IN-NETWORK ONLY) " on page 30 of the MILA's Summary Plan Description:

> The Plan covers preventive care only when provided by an In-Network doctor (unless you are eligible for the Premier plan Out-of-Area benefits or the MILA Medicare Wraparound plan). Covered routine preventive care refers to regular checkups that are generally recommended on a fixed schedule and performed by a primary care physician (PCP). A PCP can be a family or general practitioner, internist, pediatrician, or gynecologist. Visits to your PCP for routine preventive care require no advance approval and include the following services when provided by the PCP during the visit: Annual physical exams; Annual gynecological exams or initial maternity visits; Annual Pap smears; Mammograms; Newborn/well-baby care to age three—routine exams and immunizations; Children age three or older—annual exam and immunizations; and Hearing exams—once every two years.

CLAIMS FOR MEDICAL AND BEHAVIORAL - HEALTH BENEFITS

Effective January 1, 2022, MILA will be changing from a 2-year deadline for submitting claims from healthcare providers to a one-year deadline. For example, if you see your doctor on March 22, 2022, your doctor must file the claim for that visit no later than March 22, 2023. Accordingly, the following provisions replace the text under "Claims for Benefits" on page 88 of MILA's Summary Plan Description:

> A claim for benefits is a request for Plan benefits made in accordance with the Plan's claims procedures. In order to file a claim for benefits offered under this Plan, you must complete a claim form from the applicable Claims Administrator—Cigna, CVS Caremark, Aetna, or First American Administrators (FAA), a wholly-owned subsidiary of EyeMed Vision Care. However, if you receive In-Network benefits from a participating provider (as described in the applicable sections in the SPD), you will not have to submit a claim. Claims for medical and behavioral-health benefits submitted by a healthcare provider must have been filed prior to the end of the first calendar year, following the date the claim was incurred in order to be eligible for payment under the Plan. Claims for medical and behavioral-health benefits submitted by a participant must have been filed prior to the end of the second calendar year following the date the claim was incurred in order to be eligible for payment under the Plan. Claims for pharmaceutical, dental and vision benefits must have been filed prior to the end of the second calendar year following the date the claim was incurred in order to be eligible for payment under the Plan.

DEFINITION OF "EMERGENCY"

Effective January 1, 2022, the definition of "Emergency" on page 33 of MILA's Summary Plan Description shall be:

> An "Emergency" that will justify emergency Hospital treatment means a medical condition, including a mental-health condition or substance-use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of the person, including an unborn child, in serious jeopardy.

WHEN/WHERE TO FILE CLAIMS

And the following provisions replace the text under "When/Where to File Claims" on page 91 of MILA's Summary Plan Description:

> Claims for benefits should be filed as soon as reasonably possible in order that timely payment may be made. Claims for medical and behavioral-health benefits submitted by a healthcare provider must have been filed prior to the end of the first calendar year following the date the claim was incurred in order to be eligible for payment under the Plan. Claims for medical and behavioral-health benefits submitted by a participant must have been filed prior to the end of the second calendar year following the date the claim was incurred in order to be eligible for payment under the Plan. Claims for pharmaceutical, dental and vision benefits must have been filed prior to the end of the second calendar year following the date the claim was incurred in order to be eligible for consideration for payment under the Plan. Failure to file claims within the time required shall not invalidate or reduce any claim if it can be demonstrated that it was not reasonably possible to file the claim within such time.

PRIOR-AUTHORIZATION PROGRAMS IMPLEMENTED DURING 2021

Page 28 of MILA's Summary Plan Description is amended to provide that prior authorization is required for all inpatient admissions and the following outpatient services:

- Integrated medical oncology, including medically-infused medications, oral-cancer medications and support drugs;
- Musculoskeletal services for the treatment of pain and discomfort in muscles, bones and joints;
- Nuclear diagnostic cardiology;
- Durable medical equipment;
- Home infusion therapy;
- Cigna Sleep Program;
- Potentially cosmetic services;
- Potentially experimental and investigational treatment;
- Transplants; and
- Unlisted procedures.

The procedures currently listed on page 28 continue to require advance approval.

YOUR SUBSTANCE USE DISORDER TREATMENT PILOT PROGRAM

We know that some individuals struggle with substance abuse. We want to help those families and individuals get out from under the struggles of addiction. In partnership with Cigna, MILA is participating in a new pilot program to help individuals and families struggling with substance abuse (please see brochure below).

MILA

SUBSTANCE USE DISORDER TREATMENT PROGRAM

MILA has developed a 12-month program to encourage individuals struggling with addiction to get quality treatment and achieve a successful recovery. This program is available to all MILA members, spouses and dependents, as long as they are enrolled and eligible for the MILA medical plan administered by Cigna. This program includes:

- No out-of-pocket costs
- 30 days of inpatient care, including medical detoxification as needed
- Initial screening by phone to assess a patient's need for services
- Medical and psychotherapy services are available onsite, provided by licensed or credentialed professionals as needed (includes group and individual counseling)
- Participation in recovery support activities, recreation and 12-step meetings while in treatment
- Family members are invited to participate in in-person recovery activities at their own cost. For those unable to travel to the treatment location, use of phone conference or online family sessions can be arranged
- All meals, bedding and supplies necessary during the 30-day stay, not including personal hygiene products and clothing.
- Discharge planning, including coordination of additional treatment services in home community
- 11 months of continued care and monitoring
- Pilot program benefits are limited to two admissions to the program per lifetime

Substance use disorder treatment program

Program benefits*	Plan pays	You pay
Inpatient stay – 30 days	100%	0%
Extended treatment – If needed	100%	0%
Successful completion – 12-month follow-up care	100%	0%
Travel to treatment • First admission – you and support person • Second admission – patient only	100%	0%

* See program brochure or call Cigna for additional information. Individual treatment may vary depending on need.

Recovery is possible.

Under your MILA benefits, there are NEW Substance Use Disorder treatment benefits available to you and your dependents as of July 1, 2019.

How can I get started?

Step 1: Call the MILA dedicated customer service phone number on the back of your Cigna ID card – or **800.794.7882**

Step 2: Ask about the MILA Substance Use Treatment Pilot Program

Addiction can bring chaos and conflict. Recovery offers peace and an opportunity for individuals to return to a productive life, and rebuild relationships with family and friends.

Together, all the way.®

Cigna.

AFFORDABLE CARE ACT (ACA) - IMPORTANT INFORMATION

Notice of Grandfathered Plan

The MILA Trustees believe the Premier plan, the Basic plan, and the Core plan are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your benefit plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to MILA's Executive Director at 212-766-5700. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at **1-866-444-3272** or access information online at **www.dol.gov/ebsa/healthreform**. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

The MILA Medicare Wrap-Around plan is considered a "retiree-only" plan and is not subject to the requirements of the Affordable Care Act that define grandfathered plans. Rather, it is exempt from the provisions of the Affordable Care Act because it covers only retired persons and their Medicare-eligible dependents, and its benefits are provided to supplement those available from Medicare Parts A & B. In addition, it provides prescription drug benefits that qualify as "creditable coverage" under the regulations governing the requirement to enroll in Medicare Part D. This means that MILA's coverage is equal to or better than the coverage provided in Medicare Part D, and persons covered in the MILA Medicare Wrap- Around plan are not required to enroll in a Medicare Part D plan.

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The Board of Trustees reserves the right, in its sole and absolute discretion, to amend, modify or terminate the Fund, or any benefits provided under the Fund, in whole or in part, at any time and for any reason, in accordance with the amendment procedures established under the plan and the trust agreement establishing the plan. The formal plan documents and trust agreement are available at the Fund Office and may be inspected by you during normal business hours. No individual other than the Board of Trustees (or its duly authorized designee) has any authority to interpret the plan documents, make any promises to you about benefits under the plan, or change any plan provision. Only the Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the terms of the plan and decide all matters arising under the plan.

USMX and ILA, as the plan sponsors of MILA, can jointly agree at any time and for any reason to terminate the "Fund".

Form 1095-B

Form 1095-B is a tax form that reports the type of health insurance coverage you have, any dependents covered by your insurance policy, and the coverage period for the prior year. This form is used to verify that you and your dependents have at least minimum qualifying health insurance coverage on your tax return.

Since 2015, MILA has mailed to all MILA members in accordance with the Affordable Care Act Form 1095-B, documenting their eligibility for coverage from MILA. The Internal Revenue Service has issued a notice advising insurers and plans, like MILA, that they are no longer required to mail Form 1095-B to their participants. However, MILA members who live in New Jersey will receive Form 1095-B from MILA by mail because New Jersey requires MILA to send New Jersey members Form 1095-B. **If you would like to receive a copy of your Form 1095-B, please e-mail MILA at info@milamhctf.com or send a written request to the MILA Plan office:**

LaVerne Thompson, Executive Director
MILA Managed Health Care Trust Fund
55 Broadway, 27th Floor
New York, NY 10006

- **URGENT CARE vs. EMERGENCY ROOM (E.R.) CARE**

Next time you need medical attention, consider your options!

Illness and injuries come along when you least expect them. When it is time to make a decision fast, it is good to know your options.

When you have a non-emergency situation, consider using the nearest Urgent Care Center before going to the E.R. Urgent Care Centers offer state-of-the-art facilities, shorter wait times, and quality medical care.

Are you "sick" of waiting in the E.R.? Getting the right care quickly is important.

When should you go to the Emergency Room? When medical attention is needed for life-threatening conditions such as:

- chest pain or pressure
- uncontrolled bleeding
- sudden or severe pain
- coughing or vomiting blood
- difficulty breathing or shortness of breath
- sudden dizziness, weakness, or changes in vision
- severe or persistent vomiting or diarrhea
- changes in mental status, such as confusion

When should you go to the Urgent Care Center? Urgent Care Centers provide prompt treatment for non-life-threatening conditions and help you avoid the long waiting times one often encounters when seeking treatment for non-life-threatening conditions in the E.R.

When medical attention is needed, and you are unable to see your doctor, you can visit your local Urgent Care Center for non-life-threatening conditions such as:

- colds, flu, fevers
- earaches and sore throats
- sprains and strains
- minor burns
- small cuts
- rashes
- nausea
- migraines
- conjunctivitis (pink eye)
- bladder/urinary symptoms

For information on the Urgent Care Centers near you, you can check the online Provider Director on myCigna.com or Cigna.com, or by calling a customer service representative at the number listed on the back or your MILA/Cigna I.D. card.

NOTE: We want to encourage you to make the best decisions when it comes to your health care, whether that is saving you time or money. In no way do we wish to discourage you from visiting the ER if the need arises.

➢ TELEHEALTH MEDICINE

MDLIVE is the primary virtual care vendor for MILA/Cigna Telehealth Medicine services. MILA's Primary Care Physician (PCP) copay will apply to these Telehealth visits. As a result, we provide our members with convenient access to an efficient and cost-effective alternative to in-person care for minor, non-emergency health care issues-when, where, and how it works best for them. MILA participants can see a board-certified doctor with private, online, and live appointments via a secure video or phone conversation.

Members can decide how they want to connect and the time and day that works best for them. Medical Telehealth services will be available 24/7/365. A Telehealth service provides a more immediate and low-cost alternative to traditional "in-person" care, such as E.R.s, Urgent Care Centers or Convenience Care Clinics. It has the same or lower cost than PCP visits.

Telehealth doctors can treat many common health issues, including cold and flu, joint aches and pains, fever, bronchitis, and more. Members with children can also turn to Telehealth services for non-emergency pediatric care. (See pages 12-13 of this booklet for more information or call the number on the back of your Cigna ID card).

Life is demanding. It's hard to find time to take care of yourself and your family members as it is, never mind when one of you isn't feeling well. That's why your health plan through Cigna includes access to minor medical and behavioral/mental health virtual care.

Whether it's late at night and your doctor or therapist isn't available or you just don't have the time or energy to leave the house, you can:

- Access care from anywhere via video or phone.
- Get minor medical virtual care 24/7/365 – even on weekends and holidays.
- Schedule a behavioral/mental health virtual care appointment online in minutes.
- Connect with quality board-certified doctors and pediatricians as well as licensed counselors and psychiatrists.
- Have a prescription sent directly to your local pharmacy, if appropriate.

Convenient? Yes. Costly? No.

Medical virtual care for minor conditions costs less than ER or urgent care center visits, and maybe even less than an in-office primary care provider visit.

Together, all the way.®

MILA

Cigna.

937207 b 08/20

Offered by Cigna Health and Life Insurance Company or its affiliates.

Minor medical virtual care

Board-certified doctors and pediatricians can diagnose, treat and prescribe most medications for minor medical conditions, such as:

- Acne
- Allergies
- Asthma
- Bronchitis
- Cold and flu
- Constipation
- Diarrhea
- Earaches
- Fever
- Headaches
- Infections
- Insect bites
- Joint aches
- Nausea
- Pink eye
- Rashes
- Respiratory infections
- Shingles
- Sinus infections
- Skin infections
- Sore throats
- Urinary tract infections

MDLIVE providers can also conduct virtual wellness screenings.

Behavioral/Mental health virtual care

Licensed counselors and psychiatrists can diagnose, treat and prescribe most medications for nonemergency behavioral/mental health conditions, such as:

- Addictions
- Bipolar disorders
- Child/Adolescent issues
- Depression
- Eating disorders
- Grief/Loss
- Life changes
- Men's issues
- Panic disorders
- Parenting issues
- Postpartum depression
- Relationship and marriage issues
- Stress
- Trauma/PTSD
- Women's issues

Connect with virtual care your way.

- Contact your in-network provider or counselor
- Talk to an MDLIVE medical provider on demand on **myCigna.com**
- Schedule an appointment with an MDLIVE provider or licensed therapist on **myCigna.com**
- Call MDLIVE 24/7 at 888.726.3171

To connect with an MDLIVE virtual provider, visit myCigna.com, locate the "Talk to a doctor or nurse 24/7" callout and click "Connect Now."

To locate a Cigna Behavioral Health provider, visit myCigna.com, go to "Find Care & Costs" and enter "Virtual counselor" under "Doctor by Type," or call the number on the back of your Cigna ID card 24/7.

Medical and behavioral/mental health virtual care is available from MDLIVE.

*Availability may vary by location and plan type and is subject to change. See vendor sites for details.

Cigna provides access to virtual care through national telehealth providers as part of your plan. Providers are solely responsible for any treatment provided to their patients. Video chat may not be available in all areas or with all providers. This service is separate from your health plan's network and may not be available in all areas or under all plan types. A primary care provider referral is not required for this service.

In general, to be covered by your plan, services must be medically necessary and used for the diagnosis or treatment of a covered condition. Not all prescription drugs are covered. Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. See your plan materials for costs and details of coverage, including other telehealth/telemedicine benefits that may be available under your specific health plan.

➢ EMPLOYEE ASSISTANCE PROGRAM (EAP)

The Member Assistance Program (MAP) for members and their dependents is provided through Cigna Health Care. It is entirely voluntary and confidential and offers the following benefits**:**

PROFESSIONAL COUNSELING FROM LICENSED BEHAVIORAL HEALTH PROVIDERS:

- Up to three free face-to-face behavioral health visits with a member of CIGNA Behavioral Health's network providers
- Household Member Benefit (Anyone living with the member is eligible for MAP)
- Clinical Assistance
- Crisis Intervention
- 24-hour, live telephonic access 365 days per year
- 24-hour crisis intervention support with licensed behavioral health clinicians
- 24-hour telephonic counseling with CIGNA's Master's- and PhD-level licensed behavioral health clinicians

RESOURCES TO SUPPORT YOUR NEEDS THAT ARE NOT MEDICALLY RELATED SUCH AS:

- **Legal Assistance**: Free 30-minute telephonic or face-to-face consultation with an attorney.
- **Financial**: Free 30-minute telephonic consultation with a qualified specialist on issues such as debt counseling or planning for retirement.
- **Child Care:** Resources and referrals for child-care providers, before- and after-school programs, camps, adoption organizations, and information about parenting and prenatal care.
- **Senior Care:** Resources and referrals for home health agencies, assisted-living facilities, social and recreational programs, and long-distance caregiving.
- **Identity Theft:** 60-minute free consultation with a fraud resolution specialist.
- **Pet Care:** Resources and referrals for veterinarians, pet-sitting resources, obedience training, pet store.

➢ HEALTH AND WELLNESS VOLUNTARY PROGRAMS

For our participants in the Premier, Basic, and Core Plans

Your Health First is MILA/Cigna's **chronic condition management** program that takes a unique approach to help people who have ongoing conditions such as:

- Heart disease
- Asthma
- Chronic obstructive pulmonary disease (emphysema and chronic bronchitis)
- Diabetes type 1, diabetes type 2
- Metabolic syndrome/weight complications
- Osteoarthritis
- Low back pain
- Anxiety
- Bipolar disorder
- Depression
- Weight Complications

The **Cigna HealthCare 24-Hour Health Information Line** is available day and night for participants who need information on a wide variety of health-related topics. Callers can speak directly and confidentially with a trained nurse. Please call the number on the back of your Cigna I.D. card to start working with a health advocate. A health advocate is available to talk with you. To get access to online programs, visit myCigna.com and register today. Online features include:

- Interactive tools
- Educational materials
- Self-search provider locators
- E-mail for consultant-assisted search
- Live messaging for consultant-assisted search
- Web seminars

SPECIAL OFFER FROM TARGET OPTICAL

Under Your Vision Benefits A special offer from Target Optical: For $0 out-of-pocket expense, you can get any available frame, any brand — no matter the original retail price point. You're free to choose any frame in the store at no additional cost to you. For example, if you purchase frames that retail for $180, your out-of-pocket cost is still $0 — even if you have a $130 frame allowance.

This offer is valid for frames only and must be used **with your EyeMed frame benefit of $130 or more** (see page 16 for more information and your **Freedom Pass Offer Code# 755288).** Lenses are covered based on the benefits outlined in your MILA Summary Plan Description (SPD) and may include an additional copay.

Please visit the provider locator at EyeMed.com, call Member Services on your EyeMed I.D. card, or see the next page for more information.

FREEDOM PASS

Feeling free is so you

YOUR STYLE. YOUR PERSONALITY. YOUR CHOICE OF FRAMES

You have a style all your own. Now you can get the frames to match – with a special offer from Target Optical®. For $0 out-of-pocket expense get any available frame, any brand – no matter the original retail price point. You're free to choose any frame in the store at no additional cost to you.

For example, if you purchase a pair of frames that retails for $180, your out-of-pocket cost is still $0 – even if you have a $130 frame allowance. That's up to a $50 value! Plus, you get extra savings on lenses through your EyeMed vision benefits to complete your look.

Any frame, any price for $0 out-of-pocket

at Target Optical®

PLUS ENJOY SAVINGS ON LENSES

HOW TO REDEEM

Take this flyer to any Target Optical®.
They'll handle the rest. OFFER CODE: 755288

OPTICAL

SHOP THESE TOP BRANDS AND MORE

Ray-Ban · A|X · OAKLEY · COACH · RALPH LAUREN · VOGUE

WANT MORE? YOU GOT IT

Visit eyemed.com to get special offers from other in-network providers

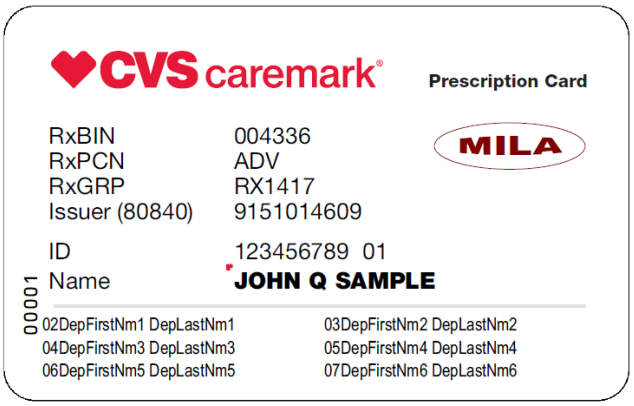
A special offer from Target Optical. $130 or higher frame allowance required. Valid for each year of the initial contract term and in-store only at Target Optical. Complete pair purchase required – member is still responsible for lenses, which are covered based on benefits outlined in the vision benefits and may include an additional copay. Discounts are not insured benefits. Proof of offer is required at time of purchase. Store associates enter code: 755288.

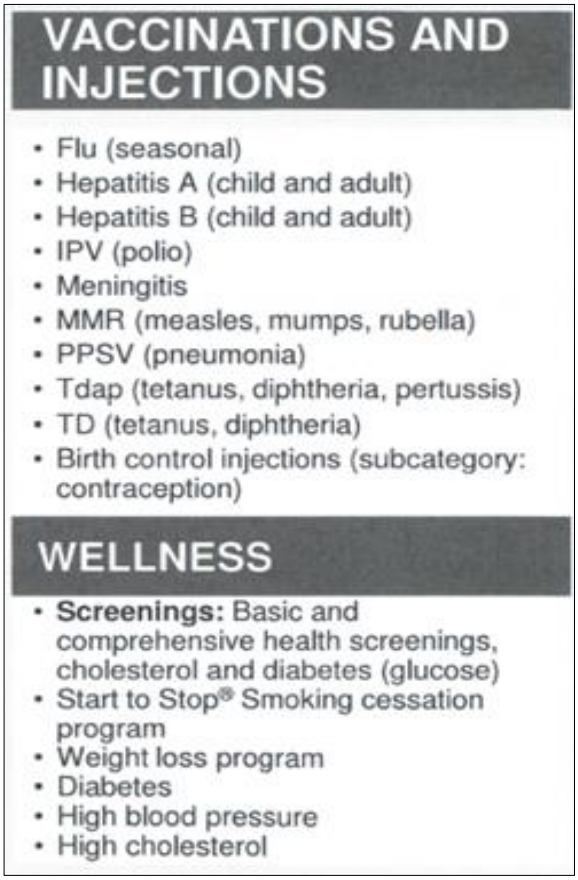
PDF-2002-M-74

➢ VACCINE FOR $0.00 COPAY

The MILA Plan offers a Nationwide Vaccine Network through our Pharmacy Benefits Manager, CVS Caremark. As a result, members age 16 and older can access seasonal flu shots and other non-seasonal vaccinations through any **CVS/pharmacy** location, as well as most other pharmacies, and have it covered with no out-of-pocket expense.

Just show your **CVS Caremark Rx ID card** to the pharmacist and be prepared to present one form of identification (such as a driver's license).





COVID-19 VACCINATIONS

You can walk in or schedule your FREE COVID-19 VACCINE at any CVS pharmacy or other locations where vacinnations are offered. Walk in or schedule your COVID-19 vaccine today.

COVID-19 TESTING

COVID-19 tests are available to eligible individuals for $0 out-of-pocket cost.

"FYI: **The Centers for Disease Control ("CDC") recommends that anyone with any signs or symptoms of COVID-19 get tested, regardless of vaccination status or prior infection.**

➢ DRUG FORMULARY

The MILA drug plan has a list of prescription drugs (called a formulary) that MILA covers. The MILA plan covers both generic and brand-name prescription drugs. The formulary must include a range of drugs in the most commonly prescribed categories and classes. This makes sure that people with different medical conditions get the prescription drugs they need.

The formulary may not include your specific drug. However, in most cases, a similar drug should be available. If your prescriber (your doctor or other health care provider who is legally allowed to write prescriptions) believes none of the drugs on the MILA formulary will work for your condition, your doctor must provide MILA a detailed letter that explains the medical reason that a similar drug covered by the MILA plan will not work for you. MILA will send this letter to CVS/Caremark for its review. After CVS/Caremark completes its review, a determination will be made as to whether MILA will cover your requested drug based on your doctor's letter.

If a drug is removed from the MILA drug formulary, in most cases, you will be notified in advance. You may have to change to another drug (similar to the one you are taking) on the MILA formulary or pay more to keep taking the drug you have been taking.

Note: MILA is not required to tell you in advance when it removes a drug from its formulary if the Food and Drug Administration (FDA) takes the drug off the market for safety reasons, but CVS/Caremark will let you know afterward. Generally, using drugs on your plan's formulary will save you money. Using generics instead of brand-name drugs can also save you money.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (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 are covered by applying the same cost-sharing as is relevant to other medical/surgical benefits.

These provisions are generally described in the Plan's Summary Plan Description (SPD). If you have any questions about mastectomies or reconstructive surgery coverage, please contact Cigna (at the phone number listed on your I.D. card) or the MILA Plan Office.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE REMINDER

Under federal law, group health plans, like MILA, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, MILA may pay for a shorter stay if the attending Physician (e.g., Physician or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, under federal law, MILA may not require that a physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification for a length of staying longer than 48 hours for a vaginal birth or 96 hours for a C-section, contact Cigna at the number on your I.D. card. If you have questions about this Notice, contact the MILA Plan Office.

MANDATORY NOTIFICATION OF DIVORCE

The MILA Trustees have instructed the MILA staff to remind the MILA participants who are married that if the participant gets divorced, the participant **MUST immediately notify both MILA and the participant's local welfare fund of the divorce.** In addition, the participant must immediately provide both MILA and the local welfare fund with a copy of the official document that memorializes the divorce.

The Trustees also want to remind the participants that if any participant fails to notify MILA and the local welfare fund about the divorce immediately after the divorce occurs, the participant will be responsible for any claims paid by MILA for the ex-spouse and any other dependent(s), such as step-children, who are no longer eligible for MILA benefits as a result of the divorce.

In addition, any MILA participant who fails to notify MILA and the local welfare fund about their divorce immediately after the divorce occurs **can have their MILA benefits suspended if MILA pays any claims for ineligible persons and the participant fails to reimburse MILA for the ineligible claims which MILA paid.**

The Trustees want to remind all participants that when MILA pays for ineligible claims, that reduces the available funds to protect the MILA participants and their families.

INFORMATION FOR RETIREES

Medicare Enrollment/Eligibility in the MILA National Health Plan for Pensioners

If you are a Pensioner, the spouse of a Pensioner, or another dependent of a Pensioner and you do not have other coverage by virtue of active employment and you are eligible to enroll in Medicare, you must enroll in and keep Medicare Parts A and B in order to have complete benefits under MILA.

Benefits that are paid for by this Plan for Medicare-eligible individuals are reduced by the amounts payable under Medicare Parts A (Hospital) and B (Medical). This reduction will apply even if a Medicare-eligible individual is NOT enrolled in Medicare Parts A and B; therefore, if you are Medicare-eligible, you must enroll in Medicare Parts A and B in order to receive the maximum amount of benefits under this Plan.

Complete information regarding Medicare benefits and how to enroll may be obtained from your local Social Security office.

MILA provides prescription-drug coverage which is creditable coverage; that is, it is comparable to or better than Medicare Part D coverage. **Do not sign up for any other Medicare Part D coverage or you will lose your MILA prescription benefits!**

To find out more about Prescription Drug Benefits and Medicare, you should review the Plan's Medicare Part D Notice of Creditable Coverage, which is available from the MILA Plan Office.

Medicare Part B Annual Deductible

Your annual deductible under MILA will match the Medicare Part B Annual Deductible that is set by the Centers for Medicare & Medicaid Services each year. Please refer to the "Medicare and You" handbook which is mailed to all Medicare households each fall for the annual deductible or visit Medicare.gov or call 1-800-MEDICARE to get specific cost information.

For more information on how your Medicare Plan works, see your "Medicare and You" handbook or contact Medicare at 1-800-Medicare (1-800-633-4227) or visit the Medicare's website at https://www.medicare.gov

IMPORTANT WARNING

For active MILA members who are already enrolled in MEDICARE. (Age 65, Disabled, or End Stage Renal Disease (ESRD)) WHEN THEY START RECEIVING A PENSION

When an active MILA member who is eligible for MILA retiree benefits retires and starts receiving a pension from the local pension plan:

- If the member is already enrolled in Medicare when the member leaves active service, the member must have both Medicare Part A and Medicare Part B coverage when the member's pension starts, and the member's MILA coverage is transferred to the MILA Medicare Wrap-around Plan.
- If the member's spouse is already enrolled in Medicare when the member starts receiving a pension, the member's spouse must have both Medicare Part A and Medicare Part B in order to be eligible for the MILA Medicare Wraparound Plan.

For active MILA members who are eligible for Medicare (Age 65, Disabled, or ESRD) WHEN THEY START RECEIVING A PENSION.

If the member/spouse is eligible for Medicare when the member starts receiving a pension and either the member or spouse does not have **Medicare Part A and Medicare Part B** coverage:

- The member/spouse must sign up for **Medicare Part A and Medicare Part B**
- If the member/spouse has **Medicare Part A but does not have Medicare Part B,** when MILA pays the member's or spouse's medical bills under the MILA Medicare Wraparound Plan, the payment will be based on the assumption that the member/spouse has **Medicare Part B coverage.**
- If the member/spouse does not have **Medicare Part B** coverage, the member/spouse will be billed for the amount that would have been paid by the **Medicare Part B** coverage. These bills for the amount that would have been paid by the **Medicare Part B** coverage are the member's or spouse's responsibility. MILA **WILL NOT** pay these bills.

According to medicare.gov, the official U.S. Government site for Medicare:

In most cases, if you don't sign up for **Medicare Part B** when you're first eligible, you'll have to pay a late enrollment penalty. You'll have to pay this penalty for as long as you have **Medicare Part B** and you could have a gap in your health coverage.

Between January 1 and March 31 of each year: You can sign up for **Medicare Part A and/or Medicare Part B** during the General Enrollment Period between January 1 and March 31 each of year, if both of these conditions apply:

- You didn't sign up for **Medicare Part A and Medicare Part B** when you were first eligible.
- You aren't eligible for a Special Enrollment Period (see below).

You must pay premiums for **Medicare Part A and Medicare Part B**. Your coverage will start July 1. You may have to pay a higher premium for late enrollment in **Medicare Part A** and/or a higher premium for late enrollment in **Medicare Part B.**

DISCRIMINATION IS AGAINST THE LAW

The MILA Managed Health Care Trust Fund (MILA) complies with applicable Federal civil-rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MILA does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The MILA Managed Health Care Trust Fund:

- 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 LaVerne Thompson (contact information listed below).

If you believe that MILA 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 with:

LaVerne Thompson, Executive Director
MILA Managed Health Care Trust Fund
55 Broadway, 27TH Floor
New York, New York 10006
Tel: 212-766-5700
Fax: 212 766-0844/45
E-mail: info@milamhctf.com

You can file a grievance in person or by mail, fax, or e-mail. If you need help filing a grievance, LaVerne Thompson is available to help you.

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, S.W.
Washington, D.C. 20201
Telephone: 1-877-696-6775

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

IMPORTANT NOTICES

Medical Treatment for On-The-Job Injuries

This Notice is being sent to you in order to bring to your attention the proper procedure for obtaining medical treatment for on-the-job injuries under your MILA coverage. As an active longshore employee working at a port that is covered by the Management-ILA Managed Health Care Trust Fund a/k/a MILA, you may be granted medical coverage.

If you are injured on the job, your employer is required by law to pay for medical treatment you need to treat your injury. However, if your employer does not pay or controverts the treatment, MILA may advance the payment for your treatment under limited circumstances provided that there is compliance with all procedures as determined solely by MILA. This creates a problem for both MILA and you.

The Problem for MILA

The problem for MILA is that MILA is paying claims for which it is not responsible. This wastes MILA's assets instead of preserving MILA's money to pay claims for you, your family members, and the other eligible MILA members for which MILA is responsible.

The Problem for You

If MILA pays for your treatment instead of your employer, under MILA's subrogation or reimbursement policy you are required to repay any monies which MILA paid on your behalf. Subrogation is MILA's right to recover any money MILA spent paying claims related to your injury if you successfully pursue a claim against your employer under the Longshore and Harbor Workers Compensation Act (LHWCA) or a state worker's compensation law or any liable third party. MILA's right to be repaid comes before your right to receive any recovery under those laws.

For example:

Assume you are injured on the job and MILA pays $20,000 for medical care to treat your injury. Your recovery in the claim against your employer or another third party will be reduced by $20,000 to repay MILA for the medical care you received to treat your injury that MILA paid on your behalf. In some cases where you recover money, if the monies owed to MILA are not repaid, your MILA benefits can be suspended until you have repaid MILA.

To avoid this problem, you should:

1) ensure that MILA does not pay the medical claims incurred on account of your work-related injury;

2) provide proper Notice to your employer as to your injury and file the necessary worker's compensation claim documents;

3) inform your medical providers that your injury is work-related;

4) as soon as possible after being injured, provide MILA with all information as to what injuries are involved and who your medical providers are by calling MILA at (212) 766-5700, sending an e-mail to laverne@milamhctf.com, or sending a fax to (212) 766-0844; and

5) provide a copy of any and all state or federal worker's compensation claim documents which you should receive from the employer and/or carrier, including but not limited to the *Notice of Employee's Injury or Death* (LS-201), *Employer's First Report of Injury* (LS-202 or WC-1), *Notice of Controversion of Right to Compensation* (LS-207 or WC-3) by e-mail to laverne@milamhctf.com or fax (212-766-0844).

As the above list of the steps you must take makes clear, the key to avoiding subrogation is to make sure that MILA knows as soon as possible that you have suffered a work-related injury.

WHEN YOUR EMPLOYER CONTROVERTS YOUR CLAIM

Finally, let's talk about the situation where an employer claims that an injury is not work-related. In such a case, if the employer denies responsibility, MILA will advance the cost of your medical treatment. For this to happen, you must first notify MILA of the claim and of your employer's denial or controversion of the claim. As a condition of providing coverage, MILA will require you to execute a MILA Lien Form.

MILA may also require you to sign a Reimbursement Agreement, which will be provided at the appropriate time. The Lien Form and the Reimbursement Agreement protect MILA's right to recover the amount it pays on your behalf in the event you file a LHWCA claim, or other type of worker's compensation claim against your employer or a third party and you are successful. If your employer prevails on its claim that your injury is not work-related, you will not be required to repay benefits paid by MILA on your behalf.

In the event the employer controverts your claim, and the case is eventually settled, MILA will review the terms of the settlement to determine the amount it will require you to repay.

If you have any questions about this Notice or how subrogation works, please contact MILA.

ADDITIONAL INFORMATION

Where to Find Plan Documents

The easiest way to access plan documents is from the Plan's website at www.milamhctf.com. There you can find important Plan documents, including the Summary Plan Description (SPD), Summary of Material Modifications (SMM), Summary of Benefits and Coverage (SBC), forms, contact information, and other important information. You may also request a paper copy of Plan documents and other notifications by calling the MILA Plan Office.

Collective Bargaining Agreement

MILA is maintained under Article XIII of the collective bargaining agreement between the United States Maritime Alliance, Ltd. and the International Longshoremen's Association. A copy of that agreement may be obtained by MILA participants upon written request to the Plan Administrator and is available for examination by MILA participants.

Keep the MILA Plan Office Informed of Address Changes

To protect your family's rights and privacy, make sure to let the MILA Plan Office know about any change in address. Remember, in order to update or change your address, you must do so in writing by completing the MILA change-of-address form. You may request a change-of-address form from the MILA Plan Office. You should also keep a copy of any notices you send to MILA for your records.

MILA TRUSTEES

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ATTENTION: FREE LANGUAGE ASSISTANCE

This chart displays, in various languages, the phone number to call for free language assistance services for individuals with limited English proficiency.

Language	Message About Language Assistance
1. Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
2. Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 CIGNA 1-800-794-7882/ CVS Caremark 1-866-875-6452
3. French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
4. Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
5. German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
6. Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
7. Persian	هجوت :ا گر ب ه ز ب ا ن ف ا ر س ی گ ف ت گ و م ی ک ن ی د ، ت س ه ی ل ا ت ز ب ا ن ی ب ص و ر ت ر ا ی گ ا ن ب ر ا ی ش م ا ب ف ر ا ه م م ی ب ا ش د. ب ا CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452 ت م ا س ب گ ی ر ی د
8. Hindi	ध्यान द: यद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452 पर कॉल कर।
9. Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
10. Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452 번으로 전화해 주십시오.
11. Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
12. Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
13. Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452 まで、お電話にてご連絡ください。
14. French Creole (Haitian)	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
15. Portuguese	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
16. Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
17. Gujarati	ચુના: જો તમે જરાતી બોલતા હો, તો િન:લ્કુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
18. Urdu	خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
19. Cambodian	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទCIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452
20. Armenian	ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք CIGNA 1-800-794-7882/CVS Caremark 1-866-875-6452