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 CSN in-network providers: $250/individual or $500/family  
For in-network providers: $250/individual or $500/family  
For out-of-network providers: $250/individual or $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, office visits, in-network prescription drugs, emergency room visits, urgent care facility visits. | 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, $100 for out-of-network outpatient hospital visit and $200 per admission for out-of-network hospital stay  
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 CSN in-network providers: $1,500/individual or $3,000/family  
For in-network providers: $1,500/individual or $3,000/family  
For out-of-network providers: $2,500/individual or $5,000/family  
For in-network prescription drugs: $1,300/individual or $1,950/family | 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.
<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.cigna.com">www.cigna.com</a> or call 1-800-Cigna24 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

⚠️ All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Client Specific Network</td>
<td>In-Network Provider (You will pay the least)</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$15 copay/visit <strong>Deductible</strong> does not apply</td>
<td>$15 copay/visit <strong>Deductible</strong> does not apply</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>CCN Specialist: $35 copay/visit** Non-CCN Specialist: $40 copay/visit** <strong>Deductible</strong> does not apply</td>
<td>CCN Specialist: $35 copay/visit** Non-CCN Specialist: $40 copay/visit** <strong>Deductible</strong> does not apply</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge/visit** No charge/screening** No charge/immunizations** <strong>Deductible</strong> does not apply</td>
<td>No charge/visit** No charge/screening** No charge/immunizations** <strong>Deductible</strong> does not apply</td>
</tr>
<tr>
<td></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$50 copay per type of scan/day <strong>Deductible</strong> does not apply</td>
<td>$50 copay per type of scan/day <strong>Deductible</strong> does not apply</td>
</tr>
</tbody>
</table>

If you visit a health care provider’s office or clinic:

- **Primary care visit to treat an injury or illness**
  - Client Specific Network: $15 copay/visit
  - Deductible does not apply
  - In-Network Provider: $15 copay/visit
  - Out-of-Network Provider: 20% coinsurance
  - Limitations, Exceptions, & Other Important Information: None

- **Specialist visit**
  - CCN Specialist: $35 copay/visit
  - Non-CCN Specialist: $40 copay/visit
  - Deductible does not apply
  - In-Network Provider: CCN Specialist: $35 copay/visit
  - Non-CCN Specialist: $40 copay/visit
  - Out-of-Network Provider: 20% coinsurance
  - Limitations, Exceptions, & Other Important Information: None

- **Preventive care/screening/immunization**
  - No charge/visit
  - No charge/screening
  - No charge/immunizations
  - Deductible does not apply
  - In-Network Provider: No charge/visit
  - No charge/screening
  - No charge/immunizations
  - Out-of-Network Provider: 20% coinsurance/visit 20% coinsurance/screening 20% coinsurance/immunizations
  - Limitations, Exceptions, & Other Important Information: None

- **Diagnostic test (x-ray, blood work)**
  - No charge
  - In-Network Provider: No charge
  - Out-of-Network Provider: 20% coinsurance
  - Limitations, Exceptions, & Other Important Information: None

- **Imaging (CT/PET scans, MRIs)**
  - $50 copay per type of scan/day
  - Deductible does not apply
  - In-Network Provider: $50 copay per type of scan/day
  - Out-of-Network Provider: 20% coinsurance
  - Limitations, Exceptions, & Other Important Information: The lesser of 50% of covered services or $500 penalty for no precertification.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Client Specific Network</th>
<th>What You Will Pay</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs (Tier 1)</td>
<td>Not covered</td>
<td>$5 preventive generic copay/prescription (retail 30 days), $10 non-preventive copay/prescription (retail 30 days), $10 preventive generic copay/prescription (retail &amp; home delivery 90 days), $20 copay/prescription (retail &amp; home delivery 90 days)</td>
<td>Not covered</td>
<td>Coverage is limited up to a 90-day supply (retail and home delivery). Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs (Tier 2)</td>
<td>Not covered</td>
<td>$25 copay/prescription (retail 30 days), $50 copay/prescription (retail &amp; home delivery 90 days)</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs (Tier 3)</td>
<td>Not covered</td>
<td>$40 copay/prescription (retail 30 days), $80 copay/prescription (retail &amp; home delivery 90 days)</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
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<td>-----------------------------------------------------</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$100 copay/visit, Deductible does not apply</td>
<td>$100 copay/visit, Deductible does not apply</td>
<td>$100 deductible/visit, plus 20% coinsurance</td>
<td>The lesser of 50% of covered services or $500 penalty for no precertification. Per visit copay/ deductible is waived for non-surgical procedures.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>The lesser of 50% of covered services or $500 penalty for no precertification. CCN Benefit level may apply for Surgeons only.</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>$100 copay/visit, Deductible does not apply</td>
<td>$100 copay/visit, Deductible does not apply</td>
<td>$100 copay/visit, Deductible does not apply</td>
<td>Per visit copay is waived if admitted</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge</td>
<td>No charge</td>
<td>No charge</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$25 copay/visit, Deductible does not apply</td>
<td>$25 copay/visit, Deductible does not apply</td>
<td>$25 copay/visit, Deductible does not apply</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$100 copay/admission, Deductible does not apply</td>
<td>$200 copay/admission, Deductible does not apply</td>
<td>$200 deductible/admission, plus 20% coinsurance</td>
<td>The lesser of 50% of covered services or $500 penalty for no precertification.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>The lesser of 50% of covered services or $500 penalty for no precertification. CCN Benefit level may apply for Surgeons only.</td>
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<td>Common Medical Event</td>
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<td>--------------------------------------------------</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$15 copay/office visit** No charge/all other services** <strong>Deductible</strong> does not apply</td>
<td>$15 copay/office visit** No charge/all other services** <strong>Deductible</strong> does not apply</td>
<td>20% coinsurance/office visit 20% coinsurance/all other services</td>
<td>The lesser of 50% of covered services or $500 penalty if no precert of non-routine services (i.e., partial hospitalization, IOP, etc.).</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$100 copay/admission Deductible does not apply</td>
<td>$200 copay/admission Deductible does not apply</td>
<td>$200 deductible/admission, plus 20% coinsurance</td>
<td>The lesser of 50% of covered services or $500 penalty for no precertification.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Cost sharing does not apply for preventive services. 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).</td>
</tr>
<tr>
<td></td>
<td>Childhood/delivery professional services</td>
<td>No charge</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childhood/delivery facility services</td>
<td>$100 copay/admission Deductible does not apply</td>
<td>$200 copay/admission Deductible does not apply</td>
<td>$200 deductible/admission, plus 20% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Client Specific Network</td>
<td>In-Network Provider (You will pay the least)</td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>No charge</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>The lesser of 50% of covered services or $500 penalty for no precertification. 16 hour maximum per day</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$15 copay/visit</td>
<td>$15 copay/visit</td>
<td>20% coinsurance/PCP visit</td>
<td>The lesser of 50% of covered services or $500 penalty for failure to precertify speech therapy services.</td>
<td></td>
</tr>
<tr>
<td>Habilitation services</td>
<td>$15 copay/visit</td>
<td>$15 copay/visit</td>
<td>20% coinsurance/PCP visit</td>
<td>Services are covered when Medically Necessary to treat a mental health condition (e.g. autism).</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>The lesser of 50% of covered services or $500 penalty for no precertification. Coverage is limited to 100 days annual max.</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>No charge</td>
<td>No charge</td>
<td>20% coinsurance</td>
<td>The lesser of 50% of covered services or $500 penalty for no precertification.</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>No charge/inpatient; No charge/outpatient services</td>
<td>No charge/inpatient; No charge/outpatient services</td>
<td>20% coinsurance/inpatient; 20% coinsurance/outpatient services</td>
<td>The lesser of 50% of covered services or $500 penalty for no precertification.</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>--------------------------------</td>
<td>--------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td>Children's eye exam</td>
<td>No charge Deductible does not apply</td>
<td>Under age 18: Coverage is limited to one exam per 12 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not covered</td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>None</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Excluded Services & Other Covered Services:**

**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.)

- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs
- Infertility treatment (in-network only)
- Routine eye care (Adult) (one exam per 24 months)

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

- Acupuncture
- Bariatric Surgery
- Chiropractic care (combined with Rehabilitation Services)
- Hearing aids (2 devices per 36 months)
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 more information 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.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-244-6224.
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, kwijigo 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)

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan's overall deductible</td>
<td>$250</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$40</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>0%</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>0%</td>
</tr>
</tbody>
</table>

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** $12,700

In this example, Peg would pay:

- **Cost Sharing**
  - Deductibles $250
  - Copayments $200
  - Coinsurance $0

  **What isn't covered**
  - Limits or exclusions $20

  **The total Peg would pay is** $470

---

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

<table>
<thead>
<tr>
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</thead>
<tbody>
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<td>Specialist copayment</td>
<td>$40</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>0%</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>0%</td>
</tr>
</tbody>
</table>

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** $5,600

In this example, Joe would pay:

- **Cost Sharing**
  - Deductibles $120
  - Copayments $800
  - Coinsurance $0

  **What isn't covered**
  - Limits or exclusions $20

  **The total Joe would pay is** $940

---

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

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>The plan's overall deductible</td>
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</tr>
<tr>
<td>Specialist copayment</td>
<td>$40</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>0%</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>0%</td>
</tr>
</tbody>
</table>

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** $2,800

In this example, Mia would pay:

- **Cost Sharing**
  - Deductibles $250
  - Copayments $300
  - Coinsurance $0

  **What isn't covered**
  - Limits or exclusions $0

  **The total Mia would pay is** $550

---

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

**Plan Name:** OAPA AFUM Incentive Copay Plan  **Ben Ver:** 19  **Plan ID:** 9785078
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)
Profile 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）。


**Korean** – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주시십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: Quay số 711).


**Russian** – ВНИМАНИЕ: вами 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: Wählen Sie 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).

**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).

**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).

**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).

**Persian (Farsi)** – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای این‌صورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).