



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is **only a summary**. For more information about your coverage, or to get a copy of the complete terms of coverage, go online at [www.cigna.com/sp](http://www.cigna.com/sp). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-800-Cigna24 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	For <a href="#">in-network providers</a> : \$2,000/individual or \$4,000/family For <a href="#">out-of-network providers</a> : \$2,000/individual or \$4,000/family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. In-network <a href="#">preventive care</a> & immunizations, office visits, <a href="#">diagnostic test</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. \$100/individual or \$100/family for in-network Preferred (Tier2) and Non-Preferred Brand (Tier 3) <a href="#">prescription drugs</a>	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <a href="#">in-network providers</a> : \$5,500/individual or \$11,000/family For <a href="#">out-of-network providers</a> : \$10,000/individual or \$20,000/family Combined medical/behavioral and pharmacy <a href="#">out-of-pocket limit</a>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	Penalties for failure to obtain <a href="#">pre-authorization</a> for services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

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



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

What You Will Pay				
Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> /office visit; No charge/MDLIVE visit <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	No charge for office visits with an in-network physician that is a member of the RWJBarnabas Health Medical Group
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /office visit; No charge/MDLIVE visit <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening</a> / immunization	No charge <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="#">express-scripts.com</a>	Generic drugs (Tier 1)	\$10 <a href="#">copay</a> /prescription (retail 30 days), \$20 <a href="#">copay</a> /prescription (retail & home delivery 90 days) <a href="#">Deductible</a> does not apply	Not covered	<b>Specialty medications</b> must be filled through Express Scripts and the SaveOn Program.  <b>SaveOn</b> Members filling Specialty Rx for the first time will be asked to enroll in the SaveOn program. Members that enroll and have eligible specialty medications will receive their medications for a \$0 copay. Your Medications must be on the SaveOn Drug List in order to be covered at No charge.
	Preferred brand drugs (Tier 2)	\$40 <a href="#">copay</a> /prescription (retail 30 days), \$100 <a href="#">copay</a> /prescription (retail & home delivery 90 days)	Not covered	
	Non-preferred brand drugs (Tier 3)	\$55 <a href="#">copay</a> /prescription (retail 30 days), \$138 <a href="#">copay</a> /prescription (retail & home delivery 90 days)	Not covered	
	<a href="#">Specialty drugs</a> (Tier 4)	30% <a href="#">coinsurance</a> <a href="#">Deductible</a> does not apply	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Out-of-network services are paid at the in-network cost share and <a href="#">deductible</a> .
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Out-of-network air ambulance services are paid at the in-network cost share and <a href="#">deductible</a> .
	<a href="#">Urgent care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	\$750 penalty for no out-of-network precertification.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	\$750 penalty for no out-of-network precertification.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 <a href="#">copay</a> /office visit; 30% <a href="#">coinsurance</a> /all other services <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a> /office visit 50% <a href="#">coinsurance</a> /all other services	Includes medical services for MH/SA diagnoses.
	Inpatient services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	\$750 penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses.
If you are pregnant	Office visits	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Primary Care or <a href="#">Specialist</a> benefit levels apply for initial visit to confirm pregnancy.
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	\$750 penalty for no out-of-network precertification. Coverage is limited to 100 days annual max. 16 hour maximum per day (The limit is not applicable to mental health and substance use disorder conditions.)
	<a href="#">Rehabilitation services</a>	\$20 <a href="#">copay</a> / visit; \$40 <a href="#">copay</a> / <a href="#">Specialist</a> visit for chiropractic care; \$20 <a href="#">copay</a> /PCP visit for cardiac rehab services; \$40 <a href="#">copay</a> / <a href="#">Specialist</a> visit for cardiac rehab services  <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a> / visit	Coverage is limited to annual max of: 20 days for Pulmonary rehab and Cognitive therapy services; 30 days maximum each therapy type for Physical, Speech & Occupational therapies; 36 days for Cardiac rehab services; 25 days for Chiropractic care services.  Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Habilitation services</a>	\$20 <a href="#">copay</a> / visit <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a> / visit	Services are covered when <a href="#">Medically Necessary</a> to treat a mental health condition (e.g. autism) or a congenital abnormality.  Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	\$750 penalty for no out-of-network precertification. Coverage is limited to 100 days annual max.
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	\$750 penalty for no out-of-network precertification.
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a> /inpatient services 30% <a href="#">coinsurance</a> /outpatient services	50% <a href="#">coinsurance</a> /inpatient services 50% <a href="#">coinsurance</a> /outpatient services	\$750 penalty for no out-of-network precertification.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

## Excluded Services & Other Covered Services:

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

- |                          |  |                          |
|--------------------------|--|--------------------------|
| • Cosmetic surgery       | • Long-term care                                     | Routine eye care (Adult) |
| • Dental care (Adult)    | • Non-emergency care when traveling outside the U.S. | • Routine foot care      |
| • Dental care (Children) | • Eye care (Children)                                | • Weight loss programs   |

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

- |                     |  |  |
|---------------------|--|--|
| • Acupuncture       | • Chiropractic care (25 days)            | • Infertility treatment (Lifetime max \$5,000) |
| • Bariatric Surgery | • Hearing aids (2 devices per 24 months) | • Private-duty nursing (30 days)               |

## Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Cigna at 1-800-Cigna24, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

## Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#) or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Cigna Customer service at 1-800-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](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your [appeal](#). Contact: New Jersey Department of Banking and Insurance at (800) 446-7467.

## 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, kwiiijigo holne' 1-800-244-6224.

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

## About these Coverage Examples:



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

### Peg is Having a Baby

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist coinsurance</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

This EXAMPLE event includes services like:

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

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

*Cost Sharing*

<a href="#">Deductibles</a>	\$2,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2,000

*What isn't covered*

Limits or exclusions	\$20
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**The total Peg would pay is \$4,020**

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist coinsurance</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

This EXAMPLE event includes services like:

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

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

*Cost Sharing*

<a href="#">Deductibles</a>	\$220
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$0

*What isn't covered*

Limits or exclusions	\$40
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**The total Joe would pay is \$760**

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,000
■ <a href="#">Specialist coinsurance</a>	0%
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

This EXAMPLE event includes services like:

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

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

*Cost Sharing*

<a href="#">Deductibles</a>	\$2,005
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$10

*What isn't covered*

Limits or exclusions	\$0
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**The total Mia would pay is \$2,015**

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



# Discrimination is against the law.

## Medical coverage

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

### Cigna Healthcare:

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

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



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

### Cigna Healthcare

Nondiscrimination Complaint Coordinator  
P.O. Box 188016  
Chattanooga, TN 37422

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

### U.S. Department of Health and Human Services

200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, DC 20201  
**1.800.368.1019, 800.537.7697 (TDD)**

Complaint forms are available at  
<https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

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## Proficiency of Language Assistance Services

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

**Spanish** - ATENCION: Hay servicios de asistencia de idiomas, sin cargo, a su disposici6n. Si es un cliente actual de Cigna Healthcare, llame al numero que figura en el reverso de su tarjeta de identificaci6n. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

**Chinese** - It Cigna Healthcare EfJJJi P , ID -t1rEf1 . 1.800.244.6224 C IrIH,i : fti 711) .

**Vietnamese** - XIN LU'U Y: Quy vi dU'Q'C c p djch v1,1 trQ' giup v ng6n ngQ> mien phi. Danh cha khach hang hi(m tc;1i cua Cigna Healthcare, vui long goi s6 (l mc;it sau the Hoi vien. Cac tmcng hQ'p khac xin goi s6 1.800.244.6224 (TTY: Quay s6 711).

**Korean** - J Oj J..-o J..: = . <2! Oj 7'1 J..i 1:11 A 1f-E OI-S-o " ? LIq\_ XH Cigna Healthcare 7'fl 7' 'a 7JllJ..i := ID 7' 121011 : = 2te!:2.E '2: !oH-? J..12.. 7IE q 0011:= 1.800.244.6224 (TTY: qo1 711)te: ! ° 20H-? J..12..

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

**Russian** - BHv1MAHv1E: BaM MoryT npeAOCTaBt,1Tb 6ecnnaTHble ycnynr nepeBOAa. Ecm1 Bbl y)f(e y4acTByeTe B nnaHe Cigna Healthcare, no3BOH11Te no HOMepy, yKa3aHHOMY Ha o6paTHO CTOpOHe Bawe 111A8HT111q:>111Kal...1110HHO KapTO4KI11 y4aCTH11Ka nnaHa. Ecn111 Bbl He f!BmleTeCb y4aCTH11KOM OAHOpO 1113 HaW11IX nnaHOB, no3BOH11Te no HOMepy 1.800.244.6224 (TTY: 711).

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(711 '-,I I :TTY) 1.800.244.6224 '-:I I .Jl

**French Creole** - ATANSYON: Gen sevis ed nan lang ki disponib gratis pou ou. Pou kliyan Cigna Healthcare yo, rele nimewo ki deye kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

**French** - ATTENTION: Des services d'aide linguistique vous sont proposes gratuitement. Si vous etes un client actuel de Cigna Healthcare, veuillez appeler le numero indique au verso de votre carte d'identite. Sinon, veuillez appeler le numero 1.800.244.6224 (ATS : composez le numero 711).

**Portuguese** - ATENCAO: Tern ao seu dispor servi<;:os de assistencia lingufstica, totalmente gratuitos. Para clientes Cigna Healthcare atuais, ligue para o numero que se encontra no verso do seu cartao de identifica<;:ao. Caso contrario, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

**Polish** - UWAGA: w celu skorzystania z dost pnej, bezpfatnej pomocy j zykowej, obecni klienci firmy Cigna Healthcare mogg dzwonic pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

**Japanese** - 51\$ :l:W : 87\$:iR7;£-it n -g-, {O} iRs::titt-!:'A7;£-c'f1Jffll,'tctdt\*9。 IJH'IO)Cigna HealthcareO)S J ;t: ID:b- t- : ' jijO) it: ffl: \*c\ s it,LZc'Ji ( tc. ,'. f-O){(QO)7J i, 1.800.244.6224 (TTY: 711) \*c\ s it,LZc'Ji ( tc. ,'. ,'

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

**German** - ACHTUNG: Die Leistungen der Sprachunterstotzung stehen Ihnen kostenlos zur Verfung. Wenn Sie gegenwartiger Cigna Healthcare-Kunde sind, rufen Sie bitte die Nummer auf der Ruckseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wahlen Sie 711).

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