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

### Important Questions | Answers | Why This Matters:

**What is the overall deductible?**

For in-network providers: $2,500/individual - employee only or $4,500/family maximum  
For out-of-network providers: $4,000/individual - employee only or $8,000/family maximum  
Combined medical/behavioral and pharmacy deductible Deductible per individual applies when the employee is the only individual covered under the plan.

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 policy, the overall family deductible must be met before the plan begins to pay.

**Are there services covered before you meet your deductible?**

Yes. In-network preventive care & immunizations, in-network generic preventive drugs.

This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.

**Are there other deductibles for specific services?**

No.

You don’t have to meet deductibles for specific services.

**What is the out-of-pocket limit for this plan?**

For in-network providers: $5,000/individual - employee only or $10,000/family maximum  
For out-of-network providers: $8,000/individual - employee only or $16,000/family maximum  
Combined medical/behavioral and pharmacy out-of-pocket limit

The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.

**What is not included in the out-of-pocket limit?**

Penalties for failure to obtain pre-authorization for services, certain drug coupon amounts, premiums, balance-billing charges, and health care this plan doesn’t cover.

Even though you pay these expenses, they don’t count toward the out-of-pocket limit.
### Important Questions

| Will you pay less if you use a network provider? | Yes. See [www.cigna.com](http://www.cigna.com) or call 1-800-Cigna24 for a list of network providers. |
| Do you need a referral to see a specialist? | No. |

### Why This Matters:

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.

You can see the specialist you choose without a referral.

---

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

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</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 visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>20% coinsurance/visit</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% coinsurance/visit</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening/ immunization</td>
<td>No charge Deductible does not apply</td>
<td>40% coinsurance</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>50% penalty for no out-of-network precertification.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td>----------------------------------------</td>
<td>---------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs (Tier 1)</td>
<td>$15 <strong>copay</strong>/prescription (retail 30 days), $30 <strong>copay</strong>/prescription (retail &amp; home delivery 90 days)</td>
<td>30% <strong>coinsurance</strong>/prescription (retail); Not covered (home delivery)</td>
<td>Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail and home delivery) for Specialty drugs. Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits. In-network Federally required preventive drugs will be provided at no charge.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs (Tier 2)</td>
<td>$40 <strong>copay</strong>/prescription (retail 30 days), $80 <strong>copay</strong>/prescription (retail &amp; home delivery 90 days)</td>
<td>30% <strong>coinsurance</strong>/prescription (retail); Not covered (home delivery)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs (Tier 3)</td>
<td>20% <strong>coinsurance</strong> but not less than $70 or more than $300/prescription (retail 30 days), 20% <strong>coinsurance</strong> but not less than $140 or more than $600/prescription (retail &amp; home delivery 90 days)</td>
<td>30% <strong>coinsurance</strong>/prescription (retail); Not covered (home delivery)</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
<td>50% penalty for no out-of-network precertification.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
<td>50% penalty for no out-of-network precertification.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td><strong>Emergency room care</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td>Out-of-network services are paid at the in-network cost share and deductible.</td>
</tr>
<tr>
<td></td>
<td><strong>Emergency medical transportation</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td>Out-of-network air ambulance services are paid at the in-network cost share and deductible.</td>
</tr>
<tr>
<td></td>
<td><strong>Urgent care</strong></td>
<td>20% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
<td>50% penalty for no out-of-network precertification.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% <strong>coinsurance</strong></td>
<td>40% <strong>coinsurance</strong></td>
<td>50% penalty for no out-of-network precertification.</td>
</tr>
</tbody>
</table>
If you need mental health, behavioral health, or substance abuse services

<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>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Outpatient services</td>
<td></td>
<td>40% coinsurance</td>
<td>40% coinsurance</td>
</tr>
</tbody>
</table>

50% penalty if no precert of out-of-network non-routine services (i.e., partial hospitalization, etc.). Includes medical services for MH/SA diagnoses.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
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</thead>
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<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>40% coinsurance</td>
<td>40% coinsurance</td>
</tr>
</tbody>
</table>

50% penalty for no out-of-network precertification. Includes medical services for MH/SA diagnoses.

If you are pregnant

<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>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>40% coinsurance</td>
<td>40% coinsurance</td>
</tr>
</tbody>
</table>

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).

If you need help recovering or have other special health needs

<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>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>40% coinsurance</td>
<td>40% coinsurance</td>
</tr>
</tbody>
</table>

50% 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.)

Home health care

20% coinsurance

40% coinsurance
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</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>Rehabilitation services</td>
<td>20% coinsurance/visit</td>
<td>40% coinsurance/visit</td>
<td>50% penalty for failure to precertify out-of-network speech therapy services. Coverage is limited to annual max of: 30 days for Pulmonary rehab and Cognitive therapy services; 30 days for Physical and Occupational therapies; 30 days for Speech therapy; 30 days for Chiropractic care services. Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.</td>
<td></td>
</tr>
<tr>
<td>Habilitation services</td>
<td>20% coinsurance/visit</td>
<td>40% coinsurance/visit</td>
<td>50% penalty for failure to precertify out-of-network speech therapy services. Services are covered when Medically Necessary 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.</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>50% penalty for no out-of-network precertification. Coverage is limited to 100 days annual max.</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>50% penalty for no out-of-network precertification.</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>20% coinsurance/inpatient services 20% coinsurance/outpatient services</td>
<td>40% coinsurance/inpatient services 40% coinsurance/outpatient services</td>
<td>50% penalty for failure to precertify out-of-network inpatient hospice services.</td>
<td></td>
</tr>
</tbody>
</table>
### Common Medical Event Services You May Need

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</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 your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</td>
</tr>
</tbody>
</table>

### Excluded Services & Other Covered Services:

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

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Children)

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

- Chiropractic care (30 days)
- Infertility treatment
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

### 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 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: Virginia State Corporation Commission at (877) 310-6560.
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'o hvol ninisingo, kwii jigo holne’ 1-800-244-6224.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
### About these Coverage Examples:

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

### Peg is Having a Baby

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

- The **plan's overall deductible** $2,500
- **Specialist coinsurance** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:

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

**Total Example Cost** $12,700

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>$2,500</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayments</td>
<td>$30</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,000</td>
<td></td>
</tr>
</tbody>
</table>

What isn't covered

- Limits or exclusions $20
- The total Peg would pay is $4,550

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

### Managing Joe's type 2 Diabetes

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

- The **plan's overall deductible** $2,500
- **Specialist coinsurance** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:

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

**Total Example Cost** $5,600

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>$2,500</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayments</td>
<td>$300</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$80</td>
<td></td>
</tr>
</tbody>
</table>

What isn't covered

- Limits or exclusions $40
- The total Joe would pay is $2,920

### Mia's Simple Fracture

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

- The **plan's overall deductible** $2,500
- **Specialist coinsurance** 20%
- **Hospital (facility) coinsurance** 20%
- **Other coinsurance** 20%

This EXAMPLE event includes services like:

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

**Total Example Cost** $2,800

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>$2,500</th>
</tr>
</thead>
<tbody>
<tr>
<td>Copayments</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$60</td>
<td></td>
</tr>
</tbody>
</table>

What isn't covered

- Limits or exclusions $0
- The total Mia would pay is $2,560

---

**Plan Name:** VALUE High Deductible HDHPQ  **Ben Ver:** 28 **Plan ID:** 17320884
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)

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Proficiency of Language Assistance Services

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

Spanish - ATENCION: 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 - 您可致电1-800-244-6224（TTY: 711）。

Vietnamese - XIN LUY Y: Ouy vj OLIQC cap djch v1, tlrq giup v ngon ngfr mi n phi Danh cho khach hang hien tai cua Cigna, vui long goi so A mt sau the Hoi vien. Cac trL Pah ngq hqp khi xe xin goi so 1.800.244.6224 (TTY: Quay so 711)

Korean - TTY: qo1 711 (711) 1-800 6224 244.

Tagalog - PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika naka libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. 0 kaya, tumawag sa 1.800.244.6224 (TTY: 1-dial ang 711).

Russian - BHVIMAHILLIE: BaM Moryr npep, ocraB1, 11 Tb 6e cnna TH ble ycnvyr11 nepeBOAa. Ecm, 1Bbl y Ke y4acrByere B nnaHe Cigna, no3BOHI Te no HOMepy, yKaxa3AHOHy Ha o6pa THOCropoHe BaweH11 AeHT1 (pl1Kx1.110 HHOHKap T04K11 y4aCTHI1Ka nnaHa. Eci1111 Bbl He flm1:1erecb y4aCTHI1 KOM OAHOrO 113 Havi1x nnaHOB, no3BOHI Te no HOMepy 1.800.244.6224 (TTY 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 ROcke Seite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) - Persian (Farsi)