



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 1-866-494-2111 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> : \$1,000/individual or \$2,000/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, emergency room visits, <a href="#">urgent care</a> facility visits.             | 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 \$300/family for in-network <a href="#">prescription drugs</a><br>There are no other specific <a href="#">deductibles</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> : \$3,250/individual or \$6,500/family<br>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>               | <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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Will you pay less if you use a <a href="#">network provider</a>?</b>               | Yes. See <a href="http://www.cigna.com">www.cigna.com</a> or call 1-866-494-2111 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. |

| Important Questions                                                          | Answers | Why This Matters:                                                                          |
|------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------|
| 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.

| Common Medical Event                                                                                                                          | Services You May Need                                    | What You Will Pay                                                                                                                    |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                               |                                                          | In-Network Provider<br>(You will pay the least)                                                                                      | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                           |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                        | Primary care visit to treat an injury or illness         | \$25 <a href="#">copay</a> /office visit**<br>No charge/MDLIVE visit**<br><br>** <a href="#">Deductible</a> does not apply           | Not covered                                        | None                                                                                                                                                                                                                      |
|                                                                                                                                               | <a href="#">Specialist</a> visit                         | \$50 <a href="#">copay</a> /office visit**<br>No charge/MDLIVE visit**<br><br>** <a href="#">Deductible</a> does not apply           | Not covered                                        | None                                                                                                                                                                                                                      |
|                                                                                                                                               | <a href="#">Preventive care/ screening</a> /immunization | No charge<br><a href="#">Deductible</a> does not apply                                                                               | Not covered                                        | 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.                                 |
| If you have a test                                                                                                                            | <a href="#">Diagnostic test</a> (x-ray, blood work)      | 20% <a href="#">coinsurance</a>                                                                                                      | Not covered                                        | None                                                                                                                                                                                                                      |
|                                                                                                                                               | Imaging (CT/PET scans, MRIs)                             | 20% <a href="#">coinsurance</a> at an outpatient facility<br>20% <a href="#">coinsurance</a> in the office                           | Not covered                                        | None                                                                                                                                                                                                                      |
| If you need drugs to treat your illness or condition<br><br>More information about <a href="#">prescription drug coverage</a> is available at | Generic drugs (Tier 1)                                   | \$20 <a href="#">copay</a> /prescription (retail 30 days), \$40 <a href="#">copay</a> /prescription (retail & home delivery 90 days) | Not covered                                        | Coverage is limited up to a 90-day supply (retail and home delivery); up to a 30-day supply (retail and home delivery) for <a href="#">Specialty drugs</a> . Certain limitations may apply, including, for example: prior |
|                                                                                                                                               | Preferred brand drugs (Tier 2)                           | \$40 <a href="#">copay</a> /prescription (retail 30 days), \$80 <a href="#">copay</a> /prescription (retail & home delivery 90 days) | Not covered                                        |                                                                                                                                                                                                                           |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                                                                                                     |                                                                                                                       | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                         |
|---------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | In-Network Provider<br>(You will pay the least)                                                                                       | Out-of-Network Provider<br>(You will pay the most)                                                                    |                                                                                                                                                                                                                                                                |
| <a href="http://www.cigna.com">www.cigna.com</a>                          | Non-preferred brand drugs (Tier 3)               | \$70 <a href="#">copay</a> /prescription (retail 30 days), \$140 <a href="#">copay</a> /prescription (retail & home delivery 90 days) | Not covered                                                                                                           | authorization, step therapy, quantity limits.<br>For drugs in the Cigna Patient Assurance Program you may pay less than the noted retail or home delivery cost share amounts.<br>In-network Federally required preventive drugs will be provided at no charge. |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | 20% <a href="#">coinsurance</a>                                                                                                       | Not covered                                                                                                           | None                                                                                                                                                                                                                                                           |
|                                                                           | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>                                                                                                       | Not covered                                                                                                           | None                                                                                                                                                                                                                                                           |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | \$250 <a href="#">copay</a> /visit, plus 20% <a href="#">coinsurance</a><br><a href="#">Deductible</a> does not apply                 | \$250 <a href="#">copay</a> /visit, plus 20% <a href="#">coinsurance</a><br><a href="#">Deductible</a> does not apply | Per visit <a href="#">copay</a> is waived if admitted. Out-of-network services are paid at the in-network cost share.                                                                                                                                          |
|                                                                           | <a href="#">Emergency medical transportation</a> | 20% <a href="#">coinsurance</a>                                                                                                       | 20% <a href="#">coinsurance</a>                                                                                       | Out-of-network air ambulance services are paid at the in-network cost share and <a href="#">deductible</a> . Services for MH/SA diagnoses will be payable according to <a href="#">Emergency room care</a> benefits.                                           |
|                                                                           | <a href="#">Urgent care</a>                      | \$50 <a href="#">copay</a> /visit<br><a href="#">Deductible</a> does not apply                                                        | Not covered<br><a href="#">Deductible</a> does not apply                                                              | None                                                                                                                                                                                                                                                           |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 20% <a href="#">coinsurance</a>                                                                                                       | Not covered                                                                                                           | None                                                                                                                                                                                                                                                           |
|                                                                           | Physician/surgeon fees                           | 20% <a href="#">coinsurance</a>                                                                                                       | Not covered                                                                                                           | None                                                                                                                                                                                                                                                           |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$25 <a href="#">copay</a> /office visit**<br>No charge/all other services<br>** <a href="#">Deductible</a> does not apply            | Not covered                                                                                                           | Includes medical services for MH/SA diagnoses.                                                                                                                                                                                                                 |
|                                                                           | Inpatient services                               | 20% <a href="#">coinsurance</a>                                                                                                       | Not covered                                                                                                           | Includes medical services for MH/SA diagnoses.                                                                                                                                                                                                                 |
| If you are pregnant                                                       | Office visits                                    | 20% <a href="#">coinsurance</a>                                                                                                       | Not covered                                                                                                           | Primary Care or <a href="#">Specialist</a> benefit levels apply for initial visit to confirm                                                                                                                                                                   |

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                                                                                                                                                                                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                              |
|----------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | In-Network Provider<br>(You will pay the least)                                                                                                                                                              | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                     |
|                                                                | Childbirth/delivery professional services | 20% <a href="#">coinsurance</a>                                                                                                                                                                              | Not covered                                        | <p>pregnancy. <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a>.</p> <p>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).</p> |
|                                                                | Childbirth/delivery facility services     | 20% <a href="#">coinsurance</a>                                                                                                                                                                              | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                     |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | 20% <a href="#">coinsurance</a>                                                                                                                                                                              | Not covered                                        | Coverage is limited to 60 visits annual max. (The limit is not applicable to mental health and substance use disorder conditions.)                                                                                                                                                                                                                  |
|                                                                | <a href="#">Rehabilitation services</a>   | \$50 <a href="#">copay</a> /visit for Physical, Speech, Hearing & Occupational therapy**<br><br>20% <a href="#">coinsurance</a> /visit for Chiropractic care<br>** <a href="#">Deductible</a> does not apply | Not covered                                        | <p>Coverage is limited to an annual max of 60 visits for Physical therapy, Speech, Hearing &amp; Occupational therapy.</p> <p>Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.</p>                                                                                                            |
|                                                                | <a href="#">Habilitation services</a>     | \$50 <a href="#">copay</a> /visit for Physical, Speech, Hearing & Occupational therapy**<br>** <a href="#">Deductible</a> does not apply                                                                     | Not covered                                        | <p>Services are covered when <a href="#">Medically Necessary</a> to treat a mental health condition (e.g. autism) or a congenital abnormality.</p> <p>Limits are not applicable to mental health conditions for Physical, Speech and Occupational therapies.</p>                                                                                    |
|                                                                | <a href="#">Skilled nursing care</a>      | 20% <a href="#">coinsurance</a>                                                                                                                                                                              | Not covered                                        | Coverage is limited to 60 days annual max.                                                                                                                                                                                                                                                                                                          |
|                                                                | <a href="#">Durable medical equipment</a> | 20% <a href="#">coinsurance</a>                                                                                                                                                                              | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                |

| Common Medical Event                   | Services You May Need            | What You Will Pay                                                                                           |                                                    | Limitations, Exceptions, & Other Important Information |
|----------------------------------------|----------------------------------|-------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------|
|                                        |                                  | In-Network Provider<br>(You will pay the least)                                                             | Out-of-Network Provider<br>(You will pay the most) |                                                        |
|                                        | <a href="#">Hospice services</a> | 20% <a href="#">coinsurance</a> /inpatient services<br>20% <a href="#">coinsurance</a> /outpatient services | Not covered                                        | None                                                   |
| 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](#).)**

- |                                                                                                                                                               |                                                                                                                                                                                                         |                                                                                                                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Dental care (Children)</li> <li>• Hearing aids</li> </ul> | <ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside of the U.S.</li> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult)</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Children)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|

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

- |                                                                                                          |                                                                       |                                                                           |
|----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|---------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Acupuncture (12 visits)</li> <li>• Bariatric surgery</li> </ul> | <ul style="list-style-type: none"> <li>• Chiropractic care</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment</li> </ul> |
|----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|---------------------------------------------------------------------------|

### 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 1-866-494-2111, 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 1-866-494-2111. 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: Community Service Society of New York, Community Health Advocates at (888) 614-5400.

**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 1-866-494-2111.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-494-2111.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-494-2111.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-494-2111.

*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](#) \$1,000
- [Specialist copayment](#) \$50
- 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,000        |
| <a href="#">Copayments</a>        | \$30           |
| <a href="#">Coinsurance</a>       | \$2,200        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Peg would pay is</b> | <b>\$3,250</b> |

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist copayment](#) \$50
- 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$220          |
| <a href="#">Copayments</a>        | \$1,100        |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$40           |
| <b>The total Joe would pay is</b> | <b>\$1,360</b> |

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist copayment](#) \$50
- 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a> *     | \$1,005        |
| <a href="#">Copayments</a>        | \$500          |
| <a href="#">Coinsurance</a>       | \$200          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,705</b> |

\*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

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

PAGE INTENTIONALLY BLANK

# Discrimination is against the law

Cigna Healthcare® complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

Cigna Healthcare does not exclude people or treat them less favorably differently because of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

## **Cigna Healthcare:**

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids 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 assistance services to people whose primary language is not English in a timely manner, such as:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services or language assistance services, contact the Civil Rights Coordinator.



Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Evernorth Behavioral Health, Inc., Evernorth Care Solutions, Inc. and HMO or service company subsidiaries of Cigna Health Corporation, including Cigna HealthCare of Arizona, Inc. Cigna HealthCare of California, Inc. Cigna HealthCare of Colorado, Inc. Cigna HealthCare of Connecticut, Inc. Cigna HealthCare of Florida, Inc. Cigna HealthCare of Georgia, Inc. Cigna HealthCare of Illinois, Inc., Cigna HealthCare of Indiana, Inc., Cigna HealthCare of St. Louis, Inc., Cigna HealthCare of North Carolina, Inc., Cigna HealthCare of New Jersey, Inc., Cigna HealthCare of South Carolina, Inc., Cigna HealthCare of Tennessee, Inc., and Cigna HealthCare of Texas, Inc. ATTENTION: If you speak languages other than English, language assistance service, 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). ATENCIÓN: Si usted habla un idioma que no sea inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Si es un cliente actual de Cigna

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, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes, you can file a grievance with the Civil Rights Coordinator

P.O. Box 188016, Chattanooga, TN 37422,  
877.822.6561 (TTY: Dial 711)

ACAGrievance@CignaHealthcare.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator 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,  
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>

## Proficiency of Language Assistance Services

**English – ATTENTION:** If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1- 800-244-6224 (TTY: Dial 711) or speak to your provider.

**Spanish – ATENCIÓN:** Si habla español, los servicios de asistencia lingüística gratuitos están disponibles para usted. También están disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-244-6224 (TTY: Marque 711) o hable con su proveedor.

**Chinese – 注意:** 如果您讲中文，我们提供免费的语言援助服务。适当的辅助设备和服务也可以免费提供，以提供无障碍格式的信息。请拨打 1-800-244-6224（TTY：拨打 711）或与您的服务提供者联系。

**Vietnamese – XIN LƯU Ý:** Nếu bạn nói tiếng Viet, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho bạn. Các thiết bị và dịch vụ hỗ trợ phù hợp để cung cấp thông tin ở định dạng có thể tiếp cận cũng có sẵn miễn phí. Gọi số 1-800-244-6224 (TTY: Gọi 711) hoặc nói chuyện với nhà cung cấp của bạn).

**Korean – 주의:** 한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 기기 및 서비스도 무료로 제공됩니다. 1-800-244-6224 (TTY: 711 로 전화) 로 전화하시거나 제공자에게 문의하십시오.

**Tagalog – PAUNAWA:** Kung ikaw ay nagsasalita ng Tagalog, ang mga libreng serbisyo ng tulong sa wika ay magagamit para sa iyo. Ang mga angkop na pantulong na kagamitan at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay magagamit din ng libre. Tumawag sa 1-800-244-6224 (TTY: Tumawag sa 711) o makipag-usap sa iyong tagapagbigay.

**Russian – ВНИМАНИЕ:** Если вы говорите на русском, доступны бесплатные услуги языковой помощи. Также бесплатно предоставляются соответствующие вспомогательные средства и услуги для предоставления информации в доступных форматах. Позвоните по телефону 1-800-244-6224 (TTY: Наберите 711) или обратитесь к вашему провайдеру.

**Arabic - تنبيه:** إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا مساعدات قابلة للوصول إليها، وذلك مجانًا. اتصل بالرقم. أو تحدث إلى مقدم الخدمة الخاص بك (اطلب 711) 1-800-244-6224 (TTY: 711)

**French Creole – ATANSYON:** Si ou pale Kreyòl Ayisyen, sèvis asistans lang gratis yo disponib pou ou. Ekipman ak sèvis adisyonèl ki apwopriye pou bay enfòmasyon nan fòm ki aksesib yo disponib tou gratis. Rele 1-800-244- 6224 (TTY: Rele 711) oswa pale ak founisè ou a.

**French – ATTENTION :** Si vous parlez français, des services d'assistance linguistique gratuits sont disponibles pour vous. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-244-6224 (TTY : composez le 711) ou parlez à votre fournisseur.

**Portuguese – ATENÇÃO:** Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-244-6224 (TTY: disque 711) ou fale com seu prestador de serviços.

**Polish – UWAGA:** Jeśli mówisz po polsku, dostępne są bezpłatne usługi pomocy językowej. Odpowiednie pomoce i usługi wspierające w celu dostarczenia informacji w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-244-6224 (TTY: wybierz 711) lub skontaktuj się ze swoim dostawcą usług.

**Japanese – 注意:** 日本語を話す場合は、無料の言語支援サービスが利用できます。アクセス可能な形式で情報を提供するための適切な補助機器やサービスも無料で利用できます。1-800-244-6224（TTY: 711 にダイヤル）に電話するか、提供者に話してください。

**Italian – ATTENZIONE:** Se parli italiano, sono disponibili per te servizi gratuiti di assistenza linguistica. Sono disponibili gratuitamente anche ausili e servizi appropriati per fornire informazioni in formati accessibili. Chiama il numero 1-800-244-6224 (TTY: componi il 711) o parla con il tuo fornitore.

**German – Achtung:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzen zur Verfügung. Geeignete Hilfsmittel und Dienste, um Informationen in barrierefreien Formaten bereitzustellen, sind ebenfalls kostenlos verfügbar. Rufen Sie 1-800-244-6224 an (TTY: Wählen Sie 711) oder sprechen Sie mit Ihrem Anbieter.

**Persian (Farsi) - همچنین،** وسایل و خدمات کمکی مناسب برای در دسترس است. خدمات رایگان کمک زبان برای شما صحبت می‌کنند، توجه:

اگر به فارسی تماس بگیرید یا با (شماره 711 را بگیرید: TTY) ارائه اطلاعات در قالبهای قابل دسترس به صورت رایگان در دسترس هستند. با شماره 1-800-244-6224 ارائه‌دهنده خود صحبت کنید