PENDING REGULATORY APPROVAL

Cigna+Oscar LocalPlus Platinum $0$20 Schedule of Benefits

All services and supplies may be provided by either an In-Network or Out-of-Network Provider. However, some services require preauthorization to be covered. Out-of-Network reimbursement is based on the Allowed Amount. Your certificate has detailed information about how the Allowed Amount is calculated. If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this Plan, call the number on the back of your I.D. card to obtain authorization of Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level. If you receive covered services at an In-Network facility at which or as a result of which you receive services provided by an Out-of-Network provider, you will pay no more than the same cost sharing you would pay for the same covered services received from an In-Network provider. Covered Services received from an Out-of-Network Provider under these circumstances are provided at In-Network Cost Sharing. This schedule is intended to help you compare covered benefits and is a summary only. The Certificate should be consulted for a detailed description of covered benefits and limitations.

Prior Authorization

Coverage for certain benefits requires Prior Authorization. To verify Prior Authorization requirements, You can call Customer Service at 1-855-672-2789 or refer to the Prior Authorization List at hioscar.com/prior-authorization. All elective Inpatient Hospital admissions require Prior Authorization, unless it would delay Emergency Care. In an emergency, Preauthorization should take place within two (2) business days after admission, or as soon thereafter as reasonably possible. Prior Authorization is required for certain prescription drugs and related supplies. For complete, detailed information about prescription drug authorization procedures, exceptions and Step Therapy, please refer to the PHARMACY BENEFITS section of this Plan, or call Customer Service at 1-855-672-2789.

Deductible

This is the Allowed Amount that a Member must pay before this Certificate pays any benefits for such charges. The Deductible applies before any copayments or Coinsurance are applied (i.e. “after deductible”). The Deductible may not apply to all Covered Services (i.e. “not subject to deductible”). Deductible does not include Coinsurance and Copayments for Non-Covered Charges. For policies that cover two or more members, each covered member is responsible for satisfying only the individual deductible. Prescription drug manufacturer coupons or rebates applied to Copayment or Coinsurance amounts will not be credited toward the Deductible. Deductibles do not cross-accumulate between In-Network and Out-of-Network.

Maximum Out of Pocket

This is the annual maximum dollar amount that a Member must pay as Copayment, Deductible, and Coinsurance for all covered services and supplies in a Benefit Period. All amounts paid as a Copayment, Deductible, and Coinsurance shall count toward the Maximum Out of Pocket. The cost sharing for the following accrues to the Maximum Out of Pocket: out-of-network emergency hospital care and emergency medical transportation; urgently needed services received from an out-of-network provider while the member is located outside the network's service area; and preauthorized care received from an out-of-network provider. The following amounts will not be credited toward the Maximum Out-of-Pocket: prescription drug manufacturer coupons or rebates applied to Copayment or Coinsurance, and infertility benefits (if covered by this plan). Once the Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible, or Coinsurance for In-Network covered services and supplies for the remainder of the Benefit Period. For policies that cover two or more members, each covered member is responsible for satisfying only the individual Maximum Out of Pocket.

Copayment

This is a specified dollar amount a Member must pay for specified Allowed Amounts. This dollar amount will never exceed the actual cost of the service.

Coinsurance

This is the percentage of an Allowed Amount that must be paid by a Member.

Benefit Period

Benefit Period begins on the Effective Date and runs through a 12-month period following the Effective Date, for which a health benefit plan provides coverage for health benefits. The Benefit Period runs concurrently with the Plan Year. Benefit Period does not apply to the Skilled Nursing Facility benefit (see Skilled Nursing Facility benefit for applicable description).

In-Network Deductible	
Individual	$0.00
Family	$0.00

In-Network Out-of-Pocket Maximum	
Individual	$4,500.00
Family	$9,000.00

Out-of-Network Deductible	
Individual	$1,000.00
Family	$2,000.00

Out-of-Network Out-of-Pocket Maximum	
Individual	$9,000.00
Family	$18,000.00

Medical Professional Services

Service Type	Participating Provider Member Responsibility for Cost Sharing	Non-Participating Provider Member Responsibility for Cost Sharing	Limits
Primary Care Office Visits	$20.00 copayment	50% coinsurance after deductible	Includes telemedicine services. Applicable cost share for physician office visits for mental health and substance use disorders is located under the Mental Health Services and Substance Use Disorder Services sections below. Well-child and well-woman office visits are covered free of charge (including, but not limited to, annual wellness visit, annual gynecological examination, counseling visit to discuss lung cancer or colorectal screening).
Specialist Office Visits	$30.00 copayment	50% coinsurance after deductible	Includes telemedicine services. Applicable cost share for physician office visits for mental health and substance use disorders is located under the Mental Health Services and Substance Use Disorder Services sections below. Well-child and well-woman office visits are covered free of charge (including, but not limited to, annual wellness visit, annual gynecological examination, counseling visit to discuss lung cancer or colorectal screening).

Service Type	Participating Provider Member Responsibility for Cost Sharing	Non-Participating Provider Member Responsibility for Cost Sharing	Limits
All other Practitioner Visits	$20.00 copayment	50% coinsurance after deductible	Includes telemedicine services. Applicable cost share for physician office visits for mental health and substance use disorders is located under the Mental Health Services and Substance Use Disorder Services sections below. Well-child and well-woman office visits are covered free of charge (including, but not limited to, annual wellness visit, annual gynecological examination, counseling visit to discuss lung cancer or colorectal screening).
Virtual Urgent Care Visits	Covered in full	Not Covered	Virtual services provided by Oscar-designated virtual providers are covered in full; deductible does not apply. Well-child and well-woman virtual visits are covered free of charge (including, but not limited to, annual wellness visit and counseling visit to discuss lung cancer or colorectal screening).
Virtual PCP Visits	Covered in full	50% coinsurance after deductible	Services must be provided by Oscar designated virtual providers.
All Preventive Well Care Services	Covered in full	50% coinsurance after deductible	If you receive non-preventive services during a preventive visit, the applicable cost share will apply to those non-preventive services. Well-child and well-woman office visits are covered free of charge (including, but not limited to, annual wellness visit, annual gynecological examination, counseling visit to discuss lung cancer or colorectal screening).
Acupuncture Visits	$20.00 copayment	50% coinsurance after deductible	None
Allergy Testing and Treatment/Injections	$30.00 copayment	50% coinsurance after deductible	PCP/Other Practitioner or Specialist cost share will apply as appropriate for treatment/injections. The cost share includes the cost of the serum.

Service Type	Participating Provider Member Responsibility for Cost Sharing	Non-Participating Provider Member Responsibility for Cost Sharing	Limits
Laboratory Procedures			
Physician's Office/Independent Laboratory Testing	$20.00 copayment	50% coinsurance after deductible	None
All other Outpatient Laboratory Testing	$20.00 copayment	50% coinsurance after deductible	None
X-rays and Diagnostic Imaging	$30.00 copayment	50% coinsurance after deductible	None
Advanced Imaging (MRIs, and CT/PET scans)			
Office and Freestanding Facility	$100.00 copayment	50% coinsurance after deductible	None
Outpatient Hospital	$100.00 copayment	50% coinsurance after deductible	None
Outpatient Rehabilitation Physical Medicine Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$20.00 copayment	50% coinsurance after deductible	None
Outpatient Habilitation Physical Medicine Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$20.00 copayment	50% coinsurance after deductible	None
Chiropractic Manipulation Therapy	Not Covered	Not Covered	None
Cardiac & Pulmonary Rehabilitation	$20.00 copayment	50% coinsurance after deductible	Maximum of 36 visits per Benefit Period for Cardiac Rehabilitation. Pulmonary Rehabilitation is unlimited.

Emergency/Urgent and Ambulance Services

Service Type	Participating Provider Member Responsibility for Cost Sharing	Non-Participating Provider Member Responsibility for Cost Sharing	Limits
Emergency Room Facility Fee	$150.00 copayment	$150.00 copayment	Cost-share waived if admitted. See Medical Inpatient Services or Mental Health Services for details on emergency admissions. Emergency Room care by an Out-of-Network provider is covered if the services are for an emergency condition.
Emergency Room Physician Fees	Covered in full	Covered in full	Cost-share waived if admitted. See Medical Inpatient Services or Mental Health Services for details on emergency admissions. Emergency Room care by an Out-of-Network provider is covered if the services are for an emergency condition.
Urgent Care Center	$20.00 copayment	50% coinsurance after deductible	None
Emergency and Non-Emergency Transportation/Ambulance	$150.00 copayment	$150.00 copayment	Emergency transportation services by an Out-of-Network provider, including air ambulance, are covered if the services are for an emergency condition. Non-emergency ambulance transportation by a licensed ambulance service is covered when the vehicle transports the member to or from covered services, and the use of other means of transportation may endanger the insured’s life. The cost share also applies to covered non-emergency transportation.

Medical Outpatient Services

Service Type	Participating Provider Member Responsibility for Cost Sharing	Non-Participating Provider Member Responsibility for Cost Sharing	Limits
Outpatient Hospital Facility - Surgery	$100.00 copayment	50% coinsurance after deductible	None
Outpatient Hospital Facility Fee (Non-Surgical services)	10% coinsurance	50% coinsurance after deductible	Covered services include but are not limited to dialysis, radiation therapy and inhalation therapy.
Outpatient Physician/Surgeon Fees	$25.00 copayment	50% coinsurance after deductible	None
Outpatient Anesthesia	$25.00 copayment	50% coinsurance after deductible	None

Medical Inpatient Services

Service Type	Participating Provider Member Responsibility for Cost Sharing	Non-Participating Provider Member Responsibility for Cost Sharing	Limits
Inpatient Hospital Facility Fee	$250.00 copayment/day up to 5 days	50% coinsurance after deductible	Preauthorization is not required for emergency admissions.
Inpatient Physician/Surgeon Fees	Covered in full	50% coinsurance after deductible	None
Skilled Nursing Facility Fee	$150.00 copayment/day up to 5 days	50% coinsurance after deductible	Coverage limited to 100 days per Benefit Period. A benefit period begins on the date you are admitted to a hospital or Skilled Nursing Facility at a skilled level of care. A benefit period ends on the date you have not been inpatient in a hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required.
Inpatient Anesthesia	Covered in full	50% coinsurance after deductible	None

Transplant Services

Service Type	Participating Provider Member Responsibility for Cost Sharing	Non-Participating Provider Member Responsibility for Cost Sharing	Limits
Inpatient Hospital Facility - LifeSource Facility (including physician/surgeon fees)	$250.00 copayment/day up to 5 days	Not Applicable	Includes a $10,000 Travel maximum/per transplant for LifeSource facilities.
Inpatient Hospital Facility - Non-LifeSource Facility	$250.00 copayment/day up to 5 days	Not Covered	Travel expenses are not covered.
Non-LifeSource Inpatient Physician/Surgeon Fees	Covered in full	Not Covered	Travel expenses are not covered.

Maternity and Newborn Care

Service Type	Participating Provider Member Responsibility for Cost Sharing	Non-Participating Provider Member Responsibility for Cost Sharing	Limits
Prenatal and Postnatal Care recommended by the USPSTF and HRSA	Covered in full	50% coinsurance after deductible	Preventive services are recommended by the U.S. Preventive Services Task Force (USPSTF) and the Health Resources and Services Administration (HRSA), agencies of the U.S. Department of Health and Human Services. Includes the routine sequence of prenatal care office visits as recommended by the American College of Obstetricians and Gynecologists (ACOG).
Non-Preventive Laboratory Services for Prenatal and Postnatal Care	$20.00 copayment	50% coinsurance after deductible	None
Inpatient Hospital and Birthing Center	$250.00 copayment/day up to 5 days	50% coinsurance after deductible	None
Physician and Midwife Services for Delivery	Covered in full	50% coinsurance after deductible	None
Breast Pumps	Covered in full	50% coinsurance after deductible	Includes lactation support services, including counseling, education, and breastfeeding equipment and supplies for the duration of breastfeeding.
California Prenatal Screening Program	Covered in full	50% coinsurance after deductible	None
Termination of Pregnancy Services	Covered In Full	Covered In Full	Includes all related services

Additional Services, Equipment, and Devices

Service Type	Participating Provider Member Responsibility for Cost Sharing	Non-Participating Provider Member Responsibility for Cost Sharing	Limits
Durable Medical Equipment and Orthotics	10% coinsurance	50% coinsurance after deductible	Includes coverage for medically necessary orthotics and special footwear.
Prosthetics	10% coinsurance	50% coinsurance after deductible	None
Diabetic Equipment (insulin pump, continuous glucose monitor)	10% coinsurance	50% coinsurance after deductible	None
Diabetic Supplies (test strips, lancets, and syringes)	$20.00 copayment	Not Covered	Includes diabetic supplies (including but not limited to blood glucose testing strips, lancets and disposable needles and syringes) obtained through In-Network durable medical equipment providers or In-Network pharmacies.
Health Education Services	Covered in full	50% coinsurance after deductible	Health education counseling, programs, and materials to improve your health and manage chronic conditions includes diabetic self management education, medical nutrition therapy, tobacco cessation, and stress management.
Hearing Exams	$30.00 copayment	50% coinsurance after deductible	Services for diagnostic audiometry to determine the need for hearing correction. Preventive hearing exams for children are covered in full.
Hospice Services	Covered in full	50% coinsurance after deductible	None
Home Health Care Services	$20.00 copayment per visit	50% coinsurance after deductible	Coverage limited to 100 visits per plan year. The limit is not applicable to mental health and substance use disorder conditions. Home health visits for rehabilitative and habilitative purposes are each subject to a separate 100-visit limit.
Chemotherapy	10% coinsurance	50% coinsurance after deductible	None
Infusion Therapy	10% coinsurance	50% coinsurance after deductible	None

Mental Health Services

Service Type	Participating Provider Member Responsibility for Cost Sharing	Non-Participating Provider Member Responsibility for Cost Sharing	Limits
Important Note on Mental Health Disorder Coverage: Covered medical services, which are received to diagnose or treat a Mental Health condition will be payable according to this section titled "Mental Health Services".			
Inpatient Mental Health Care (a continuous confinement in a Hospital or residential treatment center)	$250.00 copayment/day up to 5 days	50% coinsurance after deductible	Preauthorization is not required for emergency admissions. Services include: Psychiatric hospitalization; Residential Treatment Services, including psychiatric observation for an acute psychiatric crisis and gender dysphoria.
Outpatient Mental Health - Office Visits	$20.00 copayment	50% coinsurance after deductible	Services include: Physician office visits for treatment of mental health diagnoses, including gender dysphoria behavioral health counseling office visits; Mental health therapists counselors' office visits.
Outpatient Mental Health - Non-Office	$20.00 copayment	50% coinsurance after deductible	Services include: Intensive outpatient programs; Partial hospitalization/day treatment; Psychological and neuropsychological testing; Electroconvulsive therapy; Behavioral health treatment for autism; PT/ST/OT for autism; gender dysphoria procedures; transcranial magnetic stimulation and other mental health diagnoses.

Substance Use Disorder Services

Service Type	Participating Provider Member Responsibility for Cost Sharing	Non-Participating Provider Member Responsibility for Cost Sharing	Limits
Important Note on Substance Use Disorder Coverage: Covered medical services, which are received to diagnose or treat a Substance Use Disorder condition will be payable according to this section titled "Substance Use Disorder Services".			
Inpatient Substance Use Disorder (a continuous confinement in a Hospital or residential treatment center)	$250.00 copayment/day up to 5 days	50% coinsurance after deductible	Preauthorization is not required for emergency admissions. Services include: Inpatient detoxification, including hospitalization for medical management of withdrawal symptoms, including room and board, physician services, drugs, dependency recovery services, education, and counseling; Residential Treatment Center Services.
Outpatient Substance Use Disorder - Office Visits	$20.00 copayment	50% coinsurance after deductible	Services include: Physician office visits for treatment of substance use disorder diagnoses; Addiction counselors' office visits.
Outpatient Substance Use Disorder - Non-Office	$20.00 copayment	50% coinsurance after deductible	Services include: Intensive outpatient programs; Partial hospitalization/day treatment; Outpatient drug detoxification (facility-based); narcotic treatment programs.

Prescription Drugs

Service Type	Participating Provider Member Responsibility for Cost Sharing	Non-Participating Provider Member Responsibility for Cost Sharing	Limits
Retail Pharmacy (30-day supply)	You may request a partial fill for oral, solid dosage Schedule II controlled substances and cost share will be prorated.		Your cost share for a covered prescription drug will be the lower of the pharmacy's retail price or the applicable cost sharing amount for the drug. The amount you pay will be applied to your plan deductible and Out-of-Pocket Maximum limit. Preauthorization/step therapy may be required. Cost sharing for oral anti-cancer drugs limited to $250 per 30-day supply.
Tier 1 - Generic Drugs	$5.00 copayment	Not Covered	Consists of preferred generic drugs which have the same active ingredients, safety, dosage, quality and strength, as their brand name counterparts.
Tier 2 - Preferred Brand Name Drugs	$20.00 copayment	Not Covered	Consists of preferred brand name drugs (with no generic equivalent).
Tier 3 - Non-preferred Brand Name Drugs	$30.00 copayment	Not Covered	Consists of Non-preferred brand-name drugs and other drugs that usually have a generic version and/or one or more preferred brand alternatives on a lower tier, as well as non-formulary drugs approved for pre-authorization through a Medically Necessary review.

Service Type	Participating Provider Member Responsibility for Cost Sharing	Non-Participating Provider Member Responsibility for Cost Sharing	Limits
Tier 4 - Specialty Drugs	10% coinsurance	Not Covered	You will pay no more than $250 for a 30-day supply script. Consists of specialty drugs that are biologics, drugs that the FDA or the manufacturer requires to be distributed through a specialty pharmacy, drugs that require the insured to have special training or clinical monitoring for self administration, or drugs that cost more than six hundred dollars ($600) for a one month supply, as well as non-formulary specialty drugs approved for preauthorization through a Medically Necessary Review.
Prescription and Over The Counter (OTC) Preventive Care Items and Contraceptives	Covered in full	Not Covered	A prescription must be presented at a network pharmacy for OTC preventive care items and contraceptives to be covered without charge.
Mail Order Pharmacy (90-day supply, except for Tier 4)			Your cost share for a covered prescription drug will be the lower of the pharmacy's retail price or the applicable cost sharing amount for the drug. The amount you pay will be applied to your plan deductible and Out-of-Pocket Maximum limit. Preauthorization/step therapy may be required. Cost sharing for oral anti-cancer drugs limited to $250 per 30-day supply.
Tier 1 - Generic Drugs	$15.00 copayment	Not Covered	Consists of preferred generic drugs which have the same active ingredients, safety, dosage, quality and strength, as their brand name counterparts.
Tier 2 - Preferred Brand Name Drugs	$60.00 copayment	Not Covered	Consists of preferred brand name drugs (with no generic equivalent).

Service Type	Participating Provider Member Responsibility for Cost Sharing	Non-Participating Provider Member Responsibility for Cost Sharing	Limits
Tier 3 - Non-preferred Brand Name Drugs	$90.00 copayment	Not Covered	Consists of non-preferred brand-name drugs and other drugs that usually have a generic version and/or one or more preferred brand alternatives on a lower tier, as well as non-formulary drugs approved for pre-authorization through a Medically Necessary review.
Tier 4 - Specialty Drugs	10% coinsurance	Not Covered	You will pay no more than $250 for a 30-day supply script. Consists of specialty drugs that are biologics, drugs that the FDA or the manufacturer requires to be distributed through a specialty pharmacy, drugs that require the insured to have special training or clinical monitoring for self administration, or drugs that cost more than six hundred dollars ($600) for a one month supply, as well as non-formulary specialty drugs approved for preauthorization through a Medically Necessary Review.

Pediatric Dental and Vision Services

Service Type	Participating Provider Member Responsibility for Cost Sharing	Non-Participating Provider Member Responsibility for Cost Sharing	Limits
Pediatric Dental Care (up to age 19)			Preauthorization required for orthodontics and major services.
Diagnostic and Preventive Care	Covered in full	50% coinsurance after deductible	One (1) visit per 6 months
Basic Services	See Supplemental Pediatric Dental Care Schedule of Benefits.	50% coinsurance after deductible	See Supplemental Pediatric Dental Care Schedule of Benefits.
Major Services	See Supplemental Pediatric Dental Care Schedule of Benefits.	50% coinsurance after deductible	See Supplemental Pediatric Dental Care Schedule of Benefits.
Orthodontics	$1,000.00 copayment	50% coinsurance after deductible	Copayment applies to the entire course of treatment.

Service Type	Participating Provider Member Responsibility for Cost Sharing	Non-Participating Provider Member Responsibility for Cost Sharing	Limits
Pediatric Vision Care (up to age 19)			
Vision Exams	Covered in full	50% coinsurance after deductible	One (1) exam per plan year
Lenses and Frames	Covered in full	50% coinsurance after deductible	One (1) prescribed lenses and frames per plan year
Contact Lenses	Covered in full	50% coinsurance after deductible	Only in lieu of glasses
Low Vision Exam and Supplies	Covered in full	50% coinsurance after deductible	One comprehensive low vision evaluation every 5 years. Low vision follow-up care (4 visits in any 5 year period). Low vision aids, including high-power spectacles, magnifiers, telescopes (no fewer than 1 aid per plan year).

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not covered under the Certificate, You will be responsible for the full cost of the services.

*Emergency Medical Conditions and Urgent Care Coverage are covered by Us. Members are responsible for their respective cost share only (copay, coinsurance, and deductible).

You may contact the California Department of Insurance to obtain information on companies, coverage, rights or complaints at:

1-800-927-HELP (4357) Calling within California. TDD: 1-800-482-4TDD.

You may write the California Department of Insurance at:

300 South Spring Street, South Tower
Los Angeles, CA 90013
www.insurance.ca.gov

Notice of Non-Discrimination:

Discrimination is Against the Law

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

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 at all times 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 phone 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, you can file a grievance by sending an email to ACAGrievance@cigna.com or by writing to the following address:

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

Persons who believe they have been subject to unlawful discrimination should contact the Department's Consumer Complaint Center at 1-800-927-4357, or submit a complaint through the Department's website at www.insurance.ca.gov.

To contact the Department of Insurance, for complaints regarding the above, a complaint may be submitted on CDI's website, or You may write or call:

California Department of Insurance Consumer Services
Division 300 South Spring Street, South Tower
Los Angeles, CA 90013
www.insurance.ca.gov
1-800-927-HELP (4357). TDD: 1-800-482-4TDD

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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/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 customers, call the number on the back of your ID card.

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación.

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên.

Korean –주의:한국어를사용하시는경우, 언어지원서비스를무료로이용하실수있습니다.현재Cigna 가입자님들께서는ID 카드뒷면에있는전화번호로연락해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card.

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана.

ربية لها – **Arabic** يرجى الانتباه: تتوفر خدمات الترجمة المجانية لك. لعملاء Cigna الحاليين، يرجى الاتصال بالرقم الموجود خلف بطاقتك الشخصية.

Armenian(Eastern) – ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Ձեզ հասանելի են անվճար լեզվական օգնության ծառայություններ: Cigna-ի ընթացիկ հաճախորդների համար, զանգահարեք Ձեր ճանաչողական քարտի դարձակողմում գտնվող համարով:

Punjabi (India), – ਧਿਆਨ ਦੇ: ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ, ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ, ਉਪਲਬਧ ਹਨ. ਮੌਜੂਦਾ Cigna

ਗਾਹਕਾਂ ਲਈ, ਆਪਣੇ ID ਕਾਰਡ ਦੇ ਪਿਛਲੇ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ

Khmer – ចំណាប់អារម្មណ៍៖ សេវាជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ គឺមានសម្រាប់អ្នក

សម្រាប់អតិថិជន Cigna បច្ចុប្បន្ន សូមហៅទៅលេខនៅខាងក្រោយប័ណ្ណ ID របស់អ្នក

Hmong– LUS CEEV: Muaj kev pab txhais lus pub dawb rau koj. Rau cov neeg qhuas tam sim no rau ntawm Cigna, hu rau tus nab npawb xov tooj nyob sab tom qab ntawm koj daim npav ID.

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。

Hindi – ध्यान दें: आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। Cigna के मौजूदा ग्राहक अपने आईडी कार्ड के पीछे

लिखे नंबर पर कॉल कर सकते हैं।

Thai – โปรดทราบ: มีบริการความช่วยเหลือด้านภาษาให้แก่คุณฟรี สำหรับลูกค้าปัจจุบันของ Cigna โปรดโทรศัพท์ถึงหมายเลขที่อยู่บนหลังบัตรประจำตัวของคุณ

(Farsi) Persian – توجه: خدمات ترجمه رایگان در دسترس شماست. مشتریان فعلی Cigna، لطفاً با شماره پشت کارت شناسایی خود تماس بگیرید.

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