



# 2018 CIGNA PLAN COMPARISON BROCHURE

Things to consider when shopping for a Cigna plan.

**Together, all the way.®**





**More than a health plan.**

When you choose Cigna, you get more than a health plan. You also get a trusted partner who can help you get the most out of your plan. Cigna wants to help you live well and stay well – at a lower price. Our plans offer:

- › Detailed coverage information and plan tools you can find online.
- › An online listing to help you find quality in-network doctors near you.
- › Customer service, available 24 hours a day, seven days a week, 365 days a year.
- › Preventive care coverage at no extra cost to you.<sup>1</sup>
- › Doctor consults by phone or secure video chat with Cigna Telehealth Connection. Out-of-pocket costs are the same or less than a primary care provider (PCP) visit.<sup>2</sup>
- › Health and wellness coaching to help you reach your personal goals. We partner with WebMD® to offer the latest content.



**Know the network.**

When choosing a plan, you should know how the plan’s network operates and the area that it covers. The Cigna Connect Network is an Exclusive Provider Organization (EPO) which gives you access to a highly engaged, in-network care team. With Cigna Connect plans, you have access to local, quality doctors.

Cigna Connect health plans are available to residents living in the following counties: **Northern Virginia:** Alexandria City, Arlington, Clarke, Fairfax City, Fairfax, Falls Church City, Loudoun, Manassas City, Manassas Park City, Prince William, Stafford and Warren. **Richmond:** Amelia, Charles City, Chesterfield, Dinwiddie, Hanover, Henrico, Prince George, Sussex, Colonial Heights City, Hopewell City, Petersburg City and Richmond City. Care provided outside of the service area is generally not covered.

If you or your family takes any prescriptions, be sure to check if they are covered under your plan. You can find a prescription drug list by visiting [cigna.com/ifp-drug-list](https://cigna.com/ifp-drug-list).

**KNOW BEFORE YOU GO** – Cigna Connect plans do not have out-of-network coverage, except in case of emergency as defined by the plan. Be sure you are staying in-network when you seek care to get the most value from your plan.

**IMPORTANT INFORMATION ABOUT CIGNA CONNECT PLANS**

<b>Network name</b>	Connect Network
<b>Plan type</b>	Exclusive Provider Organization (EPO)
<b>To remain in-network:</b>	
<b>Primary care physician (PCP)</b>	Visit an in-network PCP. PCP selection is required. <sup>3</sup>
<b>Specialist physician</b>	Visit specialists in the Connect Network. Referral is required by a PCP. <sup>4</sup>
<b>Out-of-network coverage</b>	Out-of-network services are <i>not</i> covered under this plan.
<b>In the case of an emergency</b>	Emergency care is covered for situations that qualify as an emergency, as defined by the plan. <sup>5</sup>
<b>When traveling (away from home care)</b>	Covered for emergency medical services as defined by the plan. Telehealth benefits are available for care on the phone or via secure video chat anywhere, anytime. <sup>2</sup>
<b>Find providers in-network.</b>	<a href="https://cigna.com/ifp-providers">Cigna.com/ifp-providers</a>

1. Includes eligible in-network preventive care services when you see an in-network doctor. Some services may not be covered, including most immunizations for travel. Read plan documents for a list of covered and non-covered preventive care services.

2. Telehealth providers participating in the Cigna Telehealth Connection program are independent contractors and separate from Plan network providers. Not all providers have video chat capabilities. Video chat is not available in all areas. PCP referral is not required. Read plan documents for a complete description of covered services, including other telehealth/telemedicine benefits.

3. For children, you may select a participating pediatrician as the PCP. See plan documents for more information on selecting a PCP.

4. Females can obtain services for obstetrical or gynecological care from a participating provider without a referral from their PCP. See plan documents for this and other exceptions to the referral process.

5. To get the most value from your plan, please use an in-network emergency room (ER) whenever possible.

	 <b>BRONZE</b>	
<b>MEDICAL</b>	<b>Cigna Connect 6400</b>	<b>Cigna Connect 6000</b>
	<b>In-network</b>	<b>In-network</b>
<b>Annual deductible<sup>6</sup> individual/family</b>	\$6,400/\$12,800	\$6,000/\$12,000
<b>Coinsurance<sup>7</sup></b>	You pay 50% after deductible	You pay 40% after deductible
<b>Annual out-of-pocket max<sup>8</sup> individual/family</b>	\$7,350/\$14,700	\$7,350/\$14,700
<b>Physician services (primary care/specialist)</b>	You pay 50% after deductible	Visits 1–3: You pay \$20, deductible waived Visits 4+: You pay 40% after the deductible
<b>Preventive care</b>	You pay 0%, deductible waived	You pay 0%, deductible waived
<b>Inpatient facility and physician services</b>	You pay 50% after deductible	You pay 40% after deductible
<b>Lab, X-ray, and ultrasound</b>	You pay 50% after deductible	You pay 40% after deductible
<b>Hospital ER</b>	You pay 50% after deductible	You pay 40% after deductible
<b>Urgent care</b>	You pay 50% after deductible	You pay \$50, deductible waived
<b>Telehealth</b>	You pay 50% after deductible	You pay \$20, deductible waived

**RX DRUGS – Tier 1, 2, 3 and 4: Up to a 90-day supply. Tier 5: Up to a 30-day supply.**

<b>Tier 1 retail pref. generic</b>	You pay 50% after deductible	You pay \$5, deductible waived for each 30 day supply
<b>Tier 2 retail non-pref. generic</b>	You pay 50% after deductible	You pay \$35, deductible waived for each 30 day supply
<b>Tier 3 retail pref. brands</b>	You pay 50% after deductible	You pay 40% after deductible
<b>Tier 4 retail non-pref. brands</b>	You pay 50% after deductible	You pay 50% after deductible
<b>Tier 5 retail specialty</b>	You pay 50% after deductible	You pay 40% after deductible

This summary contains highlights only. See plan coverage documents for full benefit information.

MEDICAL	 <b>SILVER</b>	
	Cigna Connect 4500	Cigna Connect 6500
	In-network	In-network
Annual deductible <sup>6</sup> individual/family	\$4,500/\$9,000	\$6,500/\$13,000
Coinsurance <sup>7</sup>	You pay 20% after deductible	You pay 30% after deductible
Annual out-of-pocket max <sup>8</sup> individual/family	\$7,350/\$14,700	\$7,350/\$14,700
Physician services (primary care/specialist)	You pay \$20, deductible waived	You pay \$15, deductible waived
Preventive care	You pay 0%, deductible waived	You pay 0%, deductible waived
Inpatient facility and physician services	You pay 20% after deductible	You pay 30% after deductible
Lab, X-ray, and ultrasound	You pay 20% after deductible	You pay 30% after deductible
Hospital ER	You pay 20% after deductible	You pay 30% after deductible
Urgent care	You pay \$50, deductible waived	You pay \$50, deductible waived
Telehealth	You pay \$20, deductible waived	You pay \$15, deductible waived

**RX DRUGS – Tier 1, 2, 3 and 4:** Up to a 90-day supply. **Tier 5:** Up to a 30-day supply.

Tier 1 retail pref. generic	You pay \$4, deductible waived for each 30 day supply	You pay \$4, deductible waived for each 30 day supply
Tier 2 retail non-pref. generic	You pay \$20, deductible waived for each 30 day supply	You pay \$20, deductible waived for each 30 day supply
Tier 3 retail pref. brands	You pay \$55, deductible waived for each 30 day supply	You pay \$60, deductible waived for each 30 day supply
Tier 4 retail non-pref. brands	You pay 50% after deductible	You pay 50% after deductible
Tier 5 retail specialty	You pay 30% after deductible	You pay 50% after deductible

This summary contains highlights only. See plan coverage documents for full benefit information.

6. Annual Deductible (Individual/family deductible is satisfied when each member has reached their annual individual deductible or when the total annual family deductible amount has been reached by any combination of family members, includes medical and pharmacy)

7. Coinsurance (Amount you pay for covered medical services)

8. Annual Out-of-Pocket Maximum (Individual/family copays, deductibles, coinsurance and pharmacy charges apply to the out-of-pocket maximum)

## Once you've chosen a plan, here's how you can use it.

Below you will find some additional information that you might find helpful if you are in need of medical care. There are many options available for you, and your starting point is your PCP.



### PCP

The doctor's office is the best place to go for routine or preventive care, and to obtain prescriptions for medication. Your PCP can help coordinate your care and refer you to a specialist if needed.

Where should you go if your PCP isn't available? There are various in-network services and facilities that provide quality care for different needs. You may save hundreds of dollars by choosing the in-network option that best meets your need. To find a participating provider, visit [cigna.com/ifp-providers](https://www.cigna.com/ifp-providers).



### Cigna's 24-hour Health Information Line<sup>SM</sup>

A nurse can help you decide if you should see your doctor, go to an urgent care center or use another option. They can also help you find a doctor in your plan's network. You can use this service by calling **800.244.6224**.



### Cigna Telehealth Connection

Connect with a board-certified doctor by phone or secure, online video chat – anytime, from anywhere.<sup>2</sup> This can be a great option when traveling or when you cannot see your PCP. Available 24/7/365.



### Convenience care clinic

When you need immediate treatment for common ailments and injuries, you have more choices than just going to your doctor, such as a convenience care clinic. Look for this type of clinic in grocery stores, pharmacies and other retail locations. They are staffed by nurse practitioners or physician assistants, and are usually open nights and weekends.



### Urgent care center

For conditions that are not life threatening. They're staffed by nurses and doctors, and are usually open nights and weekends.



### Emergency room

Emergency rooms are for the immediate treatment of critical injuries or illness. If a situation seems life threatening, call 911 or go to the nearest ER. Open 24/7.



We hope you have a better understanding of the many advantages of Cigna Connect health plans. For additional information, please visit [healthcare.gov](https://www.healthcare.gov) or [Cigna.com](https://www.cigna.com).

## Virginia Connect Plans

### 2018 PLAN EXCLUSIONS AND LIMITATIONS

#### Excluded Services

In addition to any other exclusions and limitations described in this Policy, there are no benefits provided for the following:

- ▶ Services obtained from an Out-of-Network (Non-Participating) Provider, except for Emergency Services (including Emergency Services provided by an Urgent Care facility), and specialty care, in the event that Medically Necessary specialist services are not available from an In-network Provider, as described under the “Special Circumstances” section of this Policy.
- ▶ Any amounts in excess of maximum amounts of Covered Expenses stated in this Policy.
- ▶ Services not specifically listed as Covered Services in this Policy in the sections titled “Comprehensive Services What The Policy Pays For”, “Prescription Drug Benefits”, “Pediatric Vision Benefits” and the “Schedule of Benefits”.
- ▶ Services for treatment of complications of non-covered procedures or services.
- ▶ Services or supplies that are not Medically Necessary, except for Preventive Care Services as provided in this Plan.
- ▶ Services or supplies that are considered to be for Experimental Procedures or Investigative Procedures, except as otherwise stated in this Policy under ‘Clinical Trials’.
- ▶ Services received before the Effective Date of coverage.
- ▶ Services received after coverage under this Policy ends.
- ▶ Services for which You have no legal obligation to pay or for which no charge would be made if You did not have health plan or insurance coverage.
- ▶ Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers’ compensation, employer’s liability law or occupational disease law, except coverage for any medical condition pursuant to such exclusion if (i) an award of the Workers’ Compensation Commission denies compensation benefits relating to such medical condition and no request for review of such award is made pursuant to and within the time prescribed by applicable law; or (ii) an award of the Workers’ Compensation Commission, after review by the full Commission, denies compensation benefits relating to such medical condition. Following the entry of a workers’ compensation award pursuant to clause (i) or (ii) having the effect of prohibiting the application of any such exclusion, Cigna shall immediately provide coverage for such medical condition to the extent otherwise covered under the contract, subscription contract or health services plan. If, upon appeal to the Court of Appeals or the Supreme Court, such medical condition is held to be compensable under the Virginia Workers’ Compensation Act (Title 65.2), Cigna may recover from the applicable employer or workers’ compensation insurance carrier the costs of coverage for medical conditions found to be compensable under the Act.
- ▶ Conditions caused by: (a) an act of war (declared or undeclared); (b) the inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; however, benefits may not be able to be provided or may be delayed in the event of a major disaster. (c) an Insured Person participating in the military service of any country; (d) an Insured Person participating in an insurrection, rebellion, or riot.
- ▶ Any services provided by a local, state or federal government agency (except Medicaid), except when payment under this Policy is expressly required by federal or state law.
- ▶ Any services required by state or federal law to be supplied by a public school system or school district.
- ▶ Any services for which payment may be obtained from any local, state or federal government agency (except Medicaid). Veterans Administration Hospitals and Military Treatment Facilities, except for services rendered on an emergency basis where a legal liability exists for charges made to the Insured Person for such services.
- ▶ If the Insured Person is eligible for Medicare Part≈A, B or D, Cigna will provide claim payment according to this Policy minus any amount paid by Medicare, not to exceed the amount Cigna would have paid if it were the sole insurance carrier.

- › Court-ordered treatment or hospitalization, unless such treatment is an involuntary hold or prescribed by a Physician and listed as covered in this plan.
- › Professional services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance.
- › Supplies received or purchased directly or on Your behalf from any of the following:
  - Yourself, or a company under Your partial or complete ownership;
  - A person who is Your spouse, Domestic Partner, child, stepchild, parent, brother or sister.
- › Custodial Care. This exclusion does not apply to Hospice Care services, or Occupational Therapy to restore activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, bathing, and job related activities.
- › Private duty nursing in the inpatient setting, except when provided as part of the Hospice Services benefit in this Policy.
- › Inpatient room and board charges in connection with a Hospital stay primarily for environmental change or physical therapy; Custodial Care or rest cures; services provided by a rest home, a home for the aged, a nursing home or any similar facility service.
- › Services received during an inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of mental health.
- › Complementary and alternative medicine services, including but not limited to: massage therapy; animal therapy, including but not limited to equine therapy or canine therapy; art therapy; meditation; visualization; acupuncture; acupressure; reflexology; rolfing; light therapy; aromatherapy; music or sound therapy; dance therapy; sleep therapy, except as stated in this Policy under "Sleep Testing and Treatment"; hypnosis; energy-balancing; breathing exercises; movement and/or exercise therapy including but not limited to yoga, pilates, tai-chi, walking, hiking, swimming, golf; and any other alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. Services specifically listed as covered under "Rehabilitative Therapy" and "Habilitative Therapy" are not subject to this exclusion.
- › Any services or supplies provided by or at a place for the aged, a nursing home, or any facility where a significant portion of the activities of which include rest, recreation, leisure, or any other services that are not Covered Services.
- › Assistance in activities of daily living, including but not limited to: bathing, eating, dressing, or other Custodial Care, self-care activities or homemaker services, and services primarily for rest, domiciliary or convalescent care.
- › Services performed by unlicensed practitioners or services which do not require licensure to perform, for example mediation, breathing exercises, guided visualization.
- › Inpatient room and board charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on Provider an outpatient basis.
- › Services which are self-directed to a free-standing or Hospital based diagnostic facility.
- › Services ordered by a Physician or other who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other Provider:
  - Has not been actively involved in Your medical care prior to ordering the service, or
  - Is not actively involved in Your medical care after the service is received.

This exclusion does not apply to mammography.
- › Dental services, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically provided in this Policy.
- › Orthodontic Services, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction, except for services as stated in this Policy under "Congenital Defects and Birth Anomalies for Newborns".
- › Dental Implants: Dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants.
- › Hearing aids including but not limited to semi-implantable hearing devices, audient bone conductors and Bone Anchored Hearing Aids (BAHAs), For the purposes of this exclusion, a hearing aid is any device that amplifies sound. Does not apply to cochlear implants.

- › Routine hearing tests except as provided under Preventive Care.
- › Genetic screening, except as stated in this Policy under “Pregnancy and Maternity Care” and “Women’s Preventive Care”, or pre-implantations genetic screening: general population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- › Optometric services, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Policy under Pediatric Vision.
- › An eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
- › Cosmetic surgery or other services for beautification, to improve or alter appearance or self-esteem. This exclusion shall not include Reconstructive Surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and Reconstructive Surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.
- › Aids or devices that assist with nonverbal communication, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- › Non-Medical counseling or ancillary services, including but not limited to: education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities and developmental delays.
- › Services and procedures for redundant skin surgery including abdominoplasty/panniculectomy, removal of skin tags, craniosacral/cranial therapy, applied kinesiology, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, macromastia or gynecomastia; rhinoplasty, and blepharoplasty regardless of clinical indications.
- › All services related to Applied Behavioral Therapy treatment, including but not limited to: the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.
- › Any treatment, prescription drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire.
- › All services related to the evaluation or treatment of fertility and/or Infertility, including, but not limited to, all tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including reversals of elective sterilization and In vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), except as specifically stated in this Policy.
- › Cryopreservation of sperm or eggs, or storage of sperm for artificial insemination (including donor fees).
- › All non-prescription Drugs, devices and/or supplies, except drugs designated as preventive by the Patient Protection and Affordable Care Act (PPACA), that are available over the counter or without a prescription; Injectable drugs (“self-injectable medications) that do not require Physician supervision; All noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, and Self-administered Injectable Drugs, except as stated in the Benefit Schedule and in the Prescription Drug Benefits section of this Policy.
- › Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician’s opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- › Blood administration for the purpose of general improvement in physical condition
- › Orthopedic shoes (except when joined to braces), shoe inserts, foot orthotic devices.
- › Services primarily for weight reduction or treatment of obesity including morbid obesity, or any care which involves weight reduction as a main method for treatment. This includes any morbid obesity



- surgery, even if the Insured Person has other health conditions that might be helped by a reduction of obesity or weight, or any program, product or medical treatment for weight reduction or any expenses of any kind to treat obesity, weight control or weight reduction.
- ▶ Routine physical exams or tests that do not directly treat an actual illness, injury or condition, including those required by employment or government authority, physical exams required for or by an employer or for school, or sports physicals, except as otherwise specifically stated in this Plan.
  - ▶ Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected. This exclusion shall not include Habilitative services or therapies that are provided by a licensed therapist to keep, learn or improve skills needed for daily living.
  - ▶ Items which are furnished primarily for personal comfort or convenience (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for hygiene or beautification, etc. Except for wigs as specifically provided in the treatment of cancer).
  - ▶ Massage therapy.
  - ▶ Educational services except for the treatment of autism or otherwise stated in this Policy under “Treatment of Diabetes”, “Mastectomy Notice” regarding lymphedema under “Reconstructive Surgery” and “Inpatient Treatment” under “Mental Health and Substance Use Disorders” or as specifically provided or arranged by Cigna.
  - ▶ Nutritional counseling except when provided as part of Home Health Care, treatment of an eating disorder, or “Treatment of Diabetes”, “Preventive Care Services” subsections; or food supplements except as described in the “Nutritional Formulas: Amino Acid-Based Elemental Formula or Organic Acid Metabolism, Metabolic Abnormality or Severe Protein or Soy Allergies” sections, of this Policy.
  - ▶ Exercise equipment, comfort items and other medical supplies and equipment not specifically listed as Covered Services in the Covered Services section of this Policy. Excluded medical equipment includes, but is not limited to: orthopedic shoes or shoe inserts; air purifiers, air conditioners, humidifiers; exercise equipment, treadmills; spas; elevators; supplies for comfort, hygiene or beautification; disposable sheaths and supplies; correction appliances or support appliances and supplies such as stockings, and consumable medical supplies other than ostomy supplies and urinary catheters, including, but not limited to, bandages and other disposable medical supplies, skin preparations and test strips except as otherwise stated in this Policy under the “Prescription Drug Benefit” section.
  - ▶ All Foreign Country Provider charges are excluded under this Policy except as specifically stated under “Treatment received from Foreign Country Providers” in the section of this Policy titled “Comprehensive Benefits What the Policy Pays For”.
  - ▶ Routine foot care unless Medically Necessary. This Exclusion applies to cutting or removing corns and calluses; trimming nails; cleaning and preventive foot care, including but not limited to:
    - a) Cleaning and soaking the feet.
    - b) Applying skin creams to care for skin tone.
    - c) Other services that are given when there is not an illness, injury or symptom involving the foot.

This Exclusion does not apply to the treatment of corns, calluses, and care of toenails for patients with diabetes or vascular disease.
  - ▶ Charges for which We are unable to determine Our liability.
  - ▶ Charges for the services of a standby Physician.
  - ▶ Charges for animal to human organ transplants.
  - ▶ Claims received by Cigna after 90 days from the date service was rendered, except (a) in the event of a legal incapacity this time frame is extended to 15 months or (b) if the claim is received by Cigna later than 90 days but as soon as reasonably possible.

## 2018 PLAN IMPORTANT DISCLOSURES

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Medical plan rates vary based on plan design, age, family size, geographic location (residential zip code) and tobacco use.

Rates for new medical policies/service agreements with an effective date on or after 01/01/2018 are guaranteed through 12/31/2018. Thereafter, medical rates are subject to change upon 75 days' prior notice.

Insurance policies/service agreements have exclusions, limitations, reduction of benefits and terms under which the policies/service agreements may be continued in force or discontinued. Medical applications are accepted during the annual open enrollment period, or within 60 calendar days of a qualifying life event. Benefits are provided only for those services that are medically necessary as defined in the policy/service agreement and for which the insured person has benefits.

Form Series for Cigna Health and Life Insurance Company:

Exclusive Provider VA: VAINDEPO042017, VAINDEPO042017-HIX

Cigna does not intentionally discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

For costs, and additional details about coverage, contact Cigna at 900 Cottage Grove Rd, Hartford, CT 06152 or call 1-866-GET-Cigna. (1-866-438-2446).

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at **866.494.2111**.

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al **866.494.2111**.



Health Insurance Marketplace



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