BENEFIT SUMMARY

Administered by - Cigna Health and Life Insurance Co.
For - BorgWarner Inc.
Indemnity Plan
OOA Medicare Retiree Plan
Effective - 01/01/2023
Benefit Option: OOA1M

Plan Highlights	Benefit Amount
Lifetime Maximum	Unlimited
Plan Year Accumulation	Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a calendar year basis unless otherwise stated.
Plan Coinsurance	Plan pays 80%
Maximum Reimbursable Charge	90th Percentile
Plan Deductible	Individual: $200 Family: $400
• Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance. **Note:** Services where plan deductible applies are noted with a caret (^).	
Plan Out-of-Pocket Maximum	Individual: $3,000 Family: $6,000
• All benefit deductibles contribute towards your out-of-pocket maximum. • Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder. • After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.	

Benefit	Benefit Amount
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.	
Physician Services - Office Visits	
Primary Care Physician (PCP) Services/Office Visit	Plan pays 80%
Specialty Care Physician Services/Office Visit	Plan pays 80%
Surgery Performed in Physician's Office	Covered same as Physician Services - Office Visit
Allergy Treatment/Injections	Covered same as Physician Services - Office Visit
Allergy Serum Dispensed by the physician in the office	Plan pays 100%
Virtual Care	
Dedicated Virtual Providers - MDLIVE	

Benefit	Benefit Amount
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.	
MDLIVE Urgent Virtual Care Services	Plan pays 80%
MDLIVE Primary Care Services	Plan pays 80%
MDLIVE Specialty Care Services	Plan pays 80%
• Primary Care cost share applies to routine care. Virtual wellness screenings are payable under Preventive Care. • For MDLIVE Behavioral Services, please refer to the Mental Health and Substance Use Disorder section (below). • Lab services supporting a virtual visit must be obtained through dedicated labs. • Includes charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies.	
Virtual Physician Services - Office Visits	
Primary Care Physician (PCP) Services/Office Visit	Plan pays 80%
Specialty Care Physician Services/Office Visit	Plan pays 80%
• Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services). • Includes charges for the delivery of medical and health-related services and consultations as medically appropriate through audio, video, and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting.	
Convenience Care Clinic	
Convenience Care Clinic	Plan pays 80%
Preventive Care	
Preventive Care Birth through age 2 Ages 3 and older	 Plan pays 100% Plan pays 100% up to the combined $300 Preventive Care Maximum per Calendar Year, then plan pays 80% ^
• Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit when billed as part of office visit. • Birth through age 2 - Includes all wellness exams and other preventive screenings, lab and x-ray and associated professional charges. • Ages 3 and older - Includes Routine Pap, PSA, Mammogram, Immunizations, associated professional charges (when billed separately), lab and x-ray charges (when billed by the physician's office or an independent diagnostic facility or outpatient hospital). • Ages 3 and older - Preventive colonoscopy, sigmoidoscopy, etc. performed and billed by an outpatient hospital do not apply to the Preventive Care Maximum. • Annual Limit: Unlimited	
Immunizations Birth through age 2 Ages 3 and older • test	 Plan pays 100% Plan pays 100% up to the combined $300 Preventive Care Maximum per Calendar Year, then plan pays 80% ^

Benefit	Benefit Amount
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.	
Mammogram, PAP, and PSA Tests	Plan pays 100% up to the combined $300 Preventive Care Maximum per Calendar Year, then plan pays 80% ^
• Coverage includes the associated Preventive Outpatient Professional Services. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.	
Inpatient	
Inpatient Hospital Facility Services	Plan pays 80% ^
Note: Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs	
Inpatient Hospital Physician's Visit/Consultation	Plan pays 80% ^
Inpatient Professional Services	Plan pays 80% ^
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	
Outpatient	
Outpatient Facility Services	Plan pays 80% ^
Outpatient Professional Services	Plan pays 80% ^
• For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	
Emergency Services	
Emergency Room • Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit.	Plan pays 80% ^
Urgent Care Facility • Includes Professional, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the urgent care visit.	Plan pays 80% ^
Ambulance	Plan pays 80% ^
Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.	
Inpatient Services at Other Health Care Facilities	
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities • Annual Limit: Unlimited days	Plan pays 80% ^
Laboratory Services	
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit
Independent Lab	Plan pays 80% ^
Outpatient Facility	Plan pays 80% ^
Radiology Services	
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit
Outpatient Facility	Plan pays 80% ^

Benefit	Benefit Amount
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.	
Advanced Radiological Imaging (ARI)	Includes MRI, MRA, CAT Scan, PET Scan, etc.
Outpatient Facility	Plan pays 80% ^
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit
Outpatient Therapy Services	
Outpatient Therapy Services	Covered same as Physician Services - Office Visit
Annual Limits: • All Therapies Combined - Includes Cardiac Rehabilitation, Cognitive Therapy, Occupational Therapy, Physical Therapy, Pulmonary Rehabilitation, and Speech Therapy - Unlimited days **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum.	
Chiropractic Services	Covered same as Physician Services - Office Visit
Annual Limit: • Chiropractic Care - $500	
Hospice	
Inpatient Facilities	Plan pays 80% ^
Outpatient Services	Plan pays 80% ^
Note: Includes Bereavement counseling provided as part of a hospice program.	
Bereavement Counseling (for services not provided as part of a hospice program)	
Services Provided by a Mental Health Professional	Covered under Mental Health benefit
Medical Specialty Drugs	
Maternity	
Initial Visit to Confirm Pregnancy	Covered same as Physician Services - Office Visit
All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (Global Maternity Fee)	Plan pays 80% ^
Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)	Covered same as Physician Services - Office Visit
Delivery - Facility (Inpatient Hospital, Birthing Center)	Covered same as plan's Inpatient Hospital benefit
Abortion	
Abortion Services	Coverage varies based on Place of Service
Note: Non-elective procedures only	

Benefit	Benefit Amount
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.	
Family Planning	
Women's Services	Coverage varies based on Place of Service
Includes surgical sterilization services, such as tubal ligation (excludes reversals). Excludes coverage for contraceptive services.	
Men's Services	Coverage varies based on Place of Service
Includes surgical sterilization services, such as vasectomy (excludes reversals)	
Infertility	
Infertility Treatment	Coverage varies based on Place of Service
Infertility covered services: lab and radiology test, counseling, surgical treatment; excludes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.	
Outpatient Dialysis Services	
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit
Home Dialysis **Note:** Dialysis visits will not accumulate to Home Health Care maximum	Covered same as plan's Home Health Care benefit
Outpatient Facility Services	Covered same as plan's Outpatient Facility Services benefit
Outpatient Professional Services	Covered same as plan's Outpatient Professional Services benefit
Other Health Care Facilities/Services	
Home Health Care • Annual Limit: 120 days • 16 hour maximum per day **Note:** Includes outpatient private duty nursing when approved as medically necessary	Plan pays 80% ^
Organ Transplants • Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility Only: $10,000 maximum per Transplant per Lifetime • Organ Transplant Lifetime Maximum: $1,000,000	Plan pays 100% at Lifesource facility, otherwise plan pays 80% ^
Durable Medical Equipment • Annual Limit: Unlimited	Plan pays 80% ^
External Prosthetic Appliances (EPA) • Annual Limit: Unlimited	Plan pays 80% ^
Temporomandibular Joint Disorder (TMJ) • Non-surgical TMJ: Not Covered under medical plan • Includes injections made directly into the Temporomandibular Joint. **Note:** Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment.	Coverage varies based on Place of Service
Oral Surgery - Impacted Wisdom Teeth • Deductible waived for physician's office visit	Plan pays 80% ^

Benefit	Benefit Amount
Note: Services where plan deductible applies are noted with a caret (^). Benefit copays/deductibles always apply before plan deductible.	
Routine Foot Care	Not Covered
Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary.	
Mental Health and Substance Use Disorder	
Inpatient Mental Health	Plan pays 80% ^
Outpatient Mental Health – Physician's Office	Plan pays 80% ^
Outpatient Mental Health - MDLIVE Behavioral Services	Plan pays 80% ^
Outpatient Mental Health – All Other Services	Plan pays 80% ^
Inpatient Substance Use Disorder	Plan pays 80% ^
Outpatient Substance Use Disorder – Physician's Office	Plan pays 80% ^
Outpatient Substance Use Disorder - MDLIVE Behavioral Services	Plan pays 80% ^
Outpatient Substance Use Disorder – All Other Services	Plan pays 80% ^
Annual Limits: • Inpatient Mental Health and Substance Use Disorder: Unlimited days • Outpatient Mental Health and Substance Use Disorder (office/facility): Unlimited visits Notes: • Inpatient includes Acute Inpatient and Residential Treatment. • Outpatient - Physician's Office and MDLIVE Behavioral Services - may include Individual, family and group therapy, psychotherapy, medication management, etc. • Outpatient - All Other Services - may include Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy), etc. • Group Therapy applies to mental health only. • Services are paid at 100% after you reach your out-of-pocket maximum.	
Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs **Inpatient Management** • Inpatient utilization review and case management	
Pharmacy	
Benefits not provided by Cigna.	
Additional Information	
Maximum Reimbursable Charge Payments made to health care professionals are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a percentile (90th) of charges made by health care professionals of such service or supply in the geographic area where it is received. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then state, regional or national charge data may be used. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. These charges are compiled in a database selected by Cigna. The health care professional may bill the customer the difference between the health care professional's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles, co-payments and coinsurance. Services are subject to a Calendar Year deductible and maximum reimbursable charge limitations.	

Additional Information

Medicare Coordination
In accordance with the Social Security Act of 1965, this plan will pay as the Secondary plan to Medicare Part A and B as follows:
(a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent, or an Employee's Domestic Partner who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);
(b) an Employee, a former Employee, an Employee's Dependent, or former Employee's Dependent, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

When a person is eligible for Medicare A and B as described above, this plan will pay as the Secondary Plan to Medicare Part A and B **regardless if the person is actually enrolled in Medicare Part A and/or Part B and regardless if the person seeks care at a Medicare Provider or not for Medicare covered services.**

Multiple Surgical Reduction
Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

Pre-Existing Condition Limitation (PCL) does not apply.

Definitions

Coinsurance - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.
Copay - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.
Deductible - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.
Out-of-Pocket Maximum - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.
Place of Service - Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.
Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.
Professional Services - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists

Exclusions

What's Not Covered (not all-inclusive):
Your plan provides for most medically necessary services. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider or Pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Covered Expense (as shown on The Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right

Exclusions

to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a non-Participating Provider who has agreed to charge you or charged you at an In-Network benefits level or some other benefits level not otherwise applicable to the services received.

- Charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:
    - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
    - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
    - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or
    - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies or devices are experimental, investigational and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental Injury to teeth are covered provided a continuous course of dental treatment is started within six months of an accident.
- For medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.

Exclusions

- Non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or intellectual disabilities.
- 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.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- Aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All non-injectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening 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.
- Dental implants for any condition.
- 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.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet, unless provided as specifically described under Covered Expenses.
- Massage therapy.

Exclusions

- Abortions, unless a Physician certifies in writing that the pregnancy would endanger the life of the mother, or the expenses are incurred to treat medical complications due to abortion.

These are only the highlights
This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate, service agreement or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.

DISCRIMINATION IS AGAINST THE LAW

Medical coverage

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

Cigna:

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

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

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

Cigna

Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 800.537.7697 (TDD)

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. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

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. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

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。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

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. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

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. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

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. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

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。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

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

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).

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