SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.
For - State of Colorado a Self-Funded Plan
Open Access Plus Plan
HSA Qualified High Deductible Health Plan - 3343452
Effective - 07/01/2020

Selection of a Primary Care Provider - your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

Direct Access to Obstetricians and Gynecologists - You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

Plan Highlights	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Plan Coinsurance • Coinsurance values can vary for specific benefits	Your plan pays 75%	Your plan pays 50%
Maximum Reimbursable Charge	Not Applicable	110%
Contract Year Deductible	Individual: $1,750 Family: $3,500	Individual: $4,500 Family: $6,000

- Only the amount you pay for in-network covered expenses counts towards your in-network deductible. Only the amount you pay for out-of-network covered expenses counts towards your out-of-network deductible.
- Plan deductible always applies before any coinsurance.
- All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.
- This plan includes a combined Medical/Pharmacy plan deductible.

Note: Services where plan deductible applies are noted with a caret (^).

Plan Highlights	In-Network	Out-of-Network
Contract Year Out-of-Pocket Maximum	Individual: $5,000 Individual – In a Family: $8,000 Family: $10,000	Individual: $9,000 Individual – In a Family: $14,400 Family: $18,000

- Only the amount you pay for in-network covered expenses counts towards your in-network out-of-pocket maximum. Only the amount you pay for out-of-network covered expenses counts towards your out-of-network out-of-pocket maximum.
- Plan deductible contributes towards your out-of-pocket maximum.
- All benefit deductibles contribute towards your out-of-pocket maximum.
- Mental Health and Substance Use Disorder covered expenses contribute towards your out-of-pocket maximum.
- 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.
- This plan includes a combined Medical/Pharmacy out-of-pocket maximum.

Benefit	In-Network	Out-of-Network
Physician Services - Office Visits		
Paladina Primary Care Clinics	$40.00 per visit After the plan deductible is met, your plan pays 100%	Not Covered

- Includes, Physician Office, Surgery performed in the office, Telehealth, and Urgent care
- Paladina Health Providers can be found on www.mypaladinahealth.com
- Paladina Health offers highly coordinated Primary Care services for chronic condition care, in addition to acute, routine and preventive services with no copay. Office locations can be found on mycigna.com, mypaladinahealth.com, or by calling Paladina Health member services at: 1.866.808.6005 for more information

Benefit	In-Network	Out-of-Network
Physician Office Visit – Primary Care Physician (PCP)	After the plan deductible is met, your plan pays 75%	After the plan deductible is met, your plan pays 50%
Physician Office Visit – Specialist	After the plan deductible is met, your plan pays 75%	After the plan deductible is met, your plan pays 50%

NOTE: Obstetrician and Gynecologist (OB/GYN) visits are subject to either the PCP or Specialist cost share depending on how the provider contracts with Cigna (i.e. as PCP or as Specialist).

Benefit	In-Network	Out-of-Network
Surgery Performed in Physician's Office - PCP	After the plan deductible is met, your plan pays 75%	After the plan deductible is met, your plan pays 50%
Surgery Performed in Physician's Office – Specialist	After the plan deductible is met, your plan pays 75%	After the plan deductible is met, your plan pays 50%
Allergy Treatment/Injections Performed in Physician's Office PCP	After the plan deductible is met, your plan pays 75%	After the plan deductible is met, your plan pays 50%
Allergy Treatment/Injections Performed in Specialist Office	After the plan deductible is met, your plan pays 75%	After the plan deductible is met, your plan pays 50%

Benefit	In-Network	Out-of-Network
Allergy Serum - PCP	After the plan deductible is met, your plan pays 75%	After the plan deductible is met, your plan pays 50%
Allergy Serum - Specialist	After the plan deductible is met, your plan pays 75%	After the plan deductible is met, your plan pays 50%
• Dispensed by the physician in the office		
Cigna Telehealth Connection Services	After the plan deductible is met, your plan pays 75%	Not Covered
• Includes charges for the delivery of medical and health-related consultations via secure telecommunications technologies, telephones and internet only when delivered by contracted medical telehealth providers (see details on myCigna.com)		
Preventive Care		
Preventive Care	Plan pays 100%	Plan pays 100%
• 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.		
Immunizations	Plan pays 100%	Plan pays 100%
Mammogram, PAP, and PSA Tests	Plan pays 100%	Plan pays 100%
• 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.		
Diagnostic Colonoscopy, Sigmoidscopy and Endoscopy	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 50%
• Benefit does not include Outpatient Professional Services. Refer to Outpatient Professional Services for coverage information.		
Inpatient		
Inpatient Hospital Facility Services	After the plan deductible is met, your plan pays 75%	After the plan deductible is met, your plan pays 50%
Semi-Private Room: In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate **Private Room:** In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate **Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):** In-Network: Limited to the negotiated rate / Out-of-Network: Limited to ICU/CCU daily room rate		
Inpatient Hospital Physician's Visit/Consultation	After the plan deductible is met, your plan pays 75%	After the plan deductible is met, your plan pays 50%
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	After the plan deductible is met, your plan pays 75%	After the plan deductible is met, your plan pays 50%
Outpatient		
Outpatient Facility Services	After the plan deductible is met, your plan pays 75%	After the plan deductible is met, your plan pays 50%
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	After the plan deductible is met, your plan pays 75%	After the plan deductible is met, your plan pays 50%

Benefit	In-Network	Out-of-Network
Outpatient Therapy Services	After the plan deductible is met, your plan pays 75%	After the plan deductible is met, your plan pays 50%
Contract Year Maximums: • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy and Occupational Therapy – combined 60 day maximum. • Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies. • Physical, Speech and Occupational Therapy for children age 3-6 with a congenital disability will be covered subject to the combined 60 days maximum. **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum.		
Chiropractic Care	After the plan deductible is met, your plan pays 75%	After the plan deductible is met, your plan pays 50%
Contract Year Maximum: • Chiropractic Care - 20 days		
Cardiac Rehabilitation	After the plan deductible is met, your plan pays 75%	After the plan deductible is met, your plan pays 50%
Contract Year Maximum: • Cardiac Rehabilitation – 36 days **Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum.		
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private duty nursing subject to medical necessity)	After the plan deductible is met, your plan pays 75%	After the plan deductible is met, your plan pays 50%
• 100 days maximum per Contract Year (The limit is not applicable to mental health and substance use disorder conditions.) • 16 hour maximum per day		
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities • 60 days maximum per Contract Year	After the plan deductible is met, your plan pays 75%	After the plan deductible is met, your plan pays 50%
Durable Medical Equipment • Unlimited maximum per Contract Year	After the plan deductible is met, your plan pays 75%	After the plan deductible is met, your plan pays 50%
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician • Includes related supplies	Your plan pays 100%	After the plan deductible is met, your plan pays 50%
Enteral Formulas • Prior Authorization required to determine medical necessity. • Covered if a sole source of nutrition or a significant percentage of the daily caloric intake. or to treat inborn errors of metabolism.	After the plan deductible is met, your plan pays 100%	After the plan deductible is met, your plan pays 50%

Benefit	In-Network	Out-of-Network
External Prosthetic Appliances (EPA)	After the plan deductible is met, your plan pays 80%	After the plan deductible is met, your plan pays 80%
• Unlimited maximum per Contract Year		
Nutritional Evaluation	After the plan deductible is met, your plan pays 75%	After the plan deductible is met, your plan pays 50%
• Unlimited maximum per Contract Year		
Routine Foot Disorders	Not Covered	Not Covered
Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary.		
Acupuncture Performed in Physician's Office - PCP	After the plan deductible is met, your plan pays 75%	After the plan deductible is met, your plan pays 50%
Acupuncture Performed in Physician's Office - Specialist	After the plan deductible is met, your plan pays 75%	After the plan deductible is met, your plan pays 50%
• 20 days maximum per Contract Year		
Hearing Aid	After the plan deductible is met, your plan pays 75%	After the plan deductible is met, your plan pays 50%
• Maximum of 2 devices per 36 months for ages 19 and older. • Includes testing and fitting of hearing aid devices at Physician Office Visit cost share. • Limit does not apply to children under age 19.		
Medical Specialty Drugs		
Inpatient • This benefit applies to the cost of the Infusion Therapy drugs administered in an Inpatient Facility. This benefit does not cover the related Facility or Professional charges.	After the plan deductible is met, your plan pays 75%	After the plan deductible is met, your plan pays 50%
Outpatient Facility Services • This benefit applies to the cost of the Infusion Therapy drugs administered in an Outpatient Facility. This benefit does not cover the related Facility or Professional charges.	After the plan deductible is met, your plan pays 75%	After the plan deductible is met, your plan pays 50%
Physician's Office • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the Physician’s Office. This benefit does not cover the related Office Visit or Professional charges.	After the plan deductible is met, your plan pays 75%	After the plan deductible is met, your plan pays 50%
Home • This benefit applies to the cost of targeted Infusion Therapy drugs administered in the patient’s home. This benefit does not cover the related Professional charges.	After the plan deductible is met, your plan pays 75%	After the plan deductible is met, your plan pays 50%

Place of Service - your plan pays based on where you receive services

Note: Services where plan deductible applies are noted with a caret (^).

Benefit	Physician's Office		Independent Lab		Emergency Room/ Urgent Care Facility		Outpatient Facility	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Laboratory	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 75% ^	Plan pays 50% ^	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Emergency Room/Urgent Care Services	Plan pays 75% ^	Plan pays 50% ^
Radiology	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Not Applicable	Not Applicable	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Emergency Room/Urgent Care Services	Plan pays 75% ^	Plan pays 50% ^
Advanced Radiology Imaging	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Not Applicable	Not Applicable	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Emergency Room/Urgent Care Services	Covered same as plan's Outpatient Facility Services	Covered same as plan's Outpatient Facility Services

Advanced Radiology Imaging (ARI) includes MRI, MRA, CAT Scan, PET Scan, etc.
Note: All lab and x-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit

Benefit	Emergency Room / Urgent Care Facility		Outpatient Professional Services		*Ambulance	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Emergency Care	Plan pays 75% ^		Plan pays 75% ^		Plan pays 75% ^	
Urgent Care	Plan pays 75% ^	Plan pays 50% ^	Plan pays 75% ^	Plan pays 50% ^	Not Applicable*	

*Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.

Benefit	Inpatient Hospital and Other Health Care Facilities		Outpatient Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospice	Plan pays 75% ^	Plan pays 50% ^	Plan pays 75% ^	Plan pays 50% ^
Bereavement Counseling	Plan pays 75% ^	Plan pays 50% ^	Plan pays 75% ^	Plan pays 50% ^

Note: Services provided as part of Hospice Care Program

Benefit	Initial Visit to Confirm Pregnancy		Global Maternity Fee (All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges)		Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)		Delivery - Facility (Inpatient Hospital, Birthing Center)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Maternity	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 75% ^	Plan pays 50% ^	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit

Benefit	Physician's Office		Inpatient Facility		Outpatient Facility		Inpatient Professional Services		Outpatient Professional Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Abortion (Non-elective procedures)	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 75% ^	Plan pays 50% ^	Plan pays 75% ^	Plan pays 50% ^	Covered same as plan's Inpatient Professional Services	Covered same as plan's Inpatient Professional Services	Covered same as plan's Outpatient Professional Services	Covered same as plan's Outpatient Professional Services
• Covered when physician certifies in writing that the abortion is medically necessary to prevent the death of either a pregnant woman or her unborn child under circumstances where every reasonable effort is made to preservice the life of each.										
Family Planning - Men's Services	Covered same as plan's Physician's Office Services	Covered same as plan's Physician's Office Services	Plan pays 75% ^	Plan pays 50% ^	Plan pays 75% ^	Plan pays 50% ^	Covered same as plan's Inpatient Professional Services	Covered same as plan's Inpatient Professional Services	Covered same as plan's Outpatient Professional Services	Covered same as plan's Outpatient Professional Services
Includes surgical services, such as vasectomy (excludes reversals)										
Family Planning - Women's Services	Plan pays 100%	Covered same as plan's Physician's Office Services	Plan pays 100%	Plan pays 50% ^	Plan pays 100%	Plan pays 50% ^	Plan pays 100%	Covered same as plan's Inpatient Professional Services	Plan pays 100%	Covered same as plan's Outpatient Professional Services
Includes surgical services, such as tubal ligation (excludes reversals) Contraceptive devices as ordered or prescribed by a physician.										

Benefit	Physician's Office		Inpatient Facility		Outpatient Facility		Inpatient Professional Services		Outpatient Professional Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Infertility	Covered same as plan's Physician's Office Services	Not Covered	Plan pays 75% ^	Not Covered	Plan pays 75% ^	Not Covered	Covered same as plan's Inpatient Professional Services	Not Covered	Covered same as plan's Outpatient Professional Services	Not Covered
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination and excludes in-vitro fertilization, GIFT, ZIFT, etc.										
Bariatric Surgery	Covered same as plan's Physician's Office Services	Not Covered	Plan pays 75% ^	Not Covered	Plan pays 75% ^	Not Covered	Covered same as plan's Inpatient Professional Services	Not Covered	Covered same as plan's Outpatient Professional Services	Not Covered
Surgeon Charges Lifetime Maximum: Unlimited										

Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered.
The following are excluded:

- medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity.
- weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision

Benefit	Inpatient Hospital Facility			Inpatient Professional Services		
	Cigna LifeSOURCE Transplant Network ® Facility In-Network	Non-LifeSOURCE Facility In-Network	Out-of-Network	Cigna LifeSOURCE Transplant Network ® Facility In-Network	Non-LifeSOURCE Facility In-Network	Out-of-Network
Organ Transplants	Plan pays 100%	Plan pays 75% ^	Not Covered	Plan pays 100%	Covered same as plan's Inpatient Professional Services	Not Covered

- Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility: Unlimited

Benefit	Inpatient		Outpatient - Physician's Office		Outpatient – All Other Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health	Plan pays 75% ^	Plan pays 50% ^	Plan pays 75% ^	Plan pays 50% ^	Plan pays 75% ^	Plan pays 50% ^
Substance Use Disorder	Plan pays 75% ^	Plan pays 50% ^	Plan pays 75% ^	Plan pays 50% ^	Plan pays 75% ^	Plan pays 50% ^

Note: Services where plan deductible applies are noted with a caret (^).

Benefit	Inpatient		Outpatient - Physician's Office		Outpatient – All Other Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network

Notes:
- Unlimited maximum per Contract Year
- Services are paid at 100% after you reach your out-of-pocket maximum.
- Inpatient includes Acute Inpatient and Residential Treatment.
- Outpatient - Physician's Office - includes Individual, family and group therapy, psychotherapy, medication management and Behavioral Telehealth Consultation etc.
- Outpatient - All Other Services - includes Partial Hospitalization, Intensive Outpatient Services and Applied Behavior Analysis (ABA Therapy), etc.

Mental Health and Substance Use Disorder Services

Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs

Inpatient and Outpatient Management
- Inpatient utilization review and case management
- Outpatient utilization review and case management
- Partial Hospitalization
- Intensive outpatient programs

Pharmacy	In-Network
Cost Share and Supply	
Benefits provided by OptumRx • Retail – up to 30-day supply • Home Delivery – up to 90-day supply • Contact OptumRx for more information	**Retail (per 30-day supply):** Generic: After the plan deductible is met you pay $10 Preferred Brand: After the plan deductible is met you pay $40 Non-Preferred Brand: After the plan deductible is met you pay $60 Specialty: After the plan deductible is met you pay 25% up to a maximum of $120 **Home Delivery (per 90-day supply):** Generic: After the plan deductible is met you pay $20 Preferred Brand: After the plan deductible is met you pay $80 Non-Preferred Brand: After the plan deductible is met you pay $120 Specialty: After the plan deductible is met, you pay 25% up to a maximum of $240

Additional Information

Case Management

Coordinated by Cigna HealthCare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

Additional Information

Cigna Diabetes Prevention Program in collaboration with Omada
Cigna Diabetes Prevention Program in collaboration with Omada is a program to help you avoid the onset of diabetes, as well as health risks that might lead to heart disease or a stroke. The program is covered by your health plan at the preventive level, just like for your wellness visit. Program participants have access to a professional virtual health coach, an online support group, interactive lessons, and a smart-technology scale. The program will help you make small changes in your eating, activity, sleep, and stress to achieve healthy weight loss through a series of 16 weekly lessons and tools to help you maintain weight loss over time. You will also be offered the opportunity to join a gym for a low monthly fee and no enrollment fee.

Comprehensive Oncology Program • Care Management outreach • Case Management	Included
Healthy Pregnancies/Healthy Babies • Care Management outreach • Maternity Case Management • Neo-natal Case Management	$150 (1st trimester) / $75 (2nd trimester) - Option 3

Lifestyle Management Programs
- Weight Management
- Tobacco Cessation
- Stress Management

Additional Information

Maximum Reimbursable Charge

The allowable covered expense for non-network services is based on the lesser of the health care professional's normal charge for a similar service or a percentage of a fee schedule (110%) developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule will not be used and the maximum reimbursable charge for covered services is based on the lesser of the health care professional's normal charge for a similar service or a percentile (80th) 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 data in the database for similar services may be used. Out-of-network services are subject to a Contract Year deductible and maximum reimbursable charge limitations.

Out-of-Network Emergency Services Charges

1. Emergency Services are covered at the In-Network cost-sharing level if services are received from a non-participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or if no amount is agreed to, the greater of the following: (i) the median amount negotiated with In-Network providers for the Emergency Service, excluding any In-Network copay or coinsurance; (ii) the Maximum Reimbursable Charge; or (iii) the amount payable under the Medicare program, not to exceed the provider's billed charges.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is also responsible for all charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.
“The Plan has directed Cigna to implement certain aspects of Colorado’s Surprise Billing Law (HB 19-1174) (“Surprise Billing Law”), and Cigna has identified certain methodologies set forth in the Surprise Billing Law that Cigna may useto determine a reasonable reimbursement amount for: (1) Emergency Services rendered in an emergency department of an Out-of-Network Hospital; and (2) any services rendered by an Out-of-Network Provider in an In-Network Hospital. When implemented , Cigna will attempt to negotiate a reasonable reimbursement rate for the services provided by an out-of-network provider by paying the claim at a rate that Cigna determines to be fair and reasonable for the services provided rather than the amount initially billed by the provider. Where applicable, the final reimbursement amount may be higher than the initial payment amount determined by Cigna. You will only be responsible for the applicable cost share amounts. If an out-of-network provider bills amounts in excess of the applicable copay, coinsurance, and/or deductible amounts, please contact Cigna Customer Service at the number on your ID card.”

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.

Additional Information

Services under the Surgical and Treatment Support Program:
After the plan deductible is met, then your plan pays 100% for the bundled charge, subject to program participation requirements.
$600 travel maximum per procedure.

One Guide Concierge Customer Service Model

Available by phone or through myCigna mobile application. One Guide helps you navigate the health care system and make the most of your health benefits and programs.

Based in the US, available 24/7/365 days a year in approximately 140 languages

Language Line

Our health information line provides Language Line services to our non-English speaking customers. This telephone-based language service, capable of interpreting approximately 140 languages, allowing health advocates to communicate through interpreters with customers for whom English is not their primary language. When a non-English speaking customer calls, the health advocate reaches the appropriate language interpreter. The original phone call then becomes a conference call among the customer, interpreter, and health advocate. An interpreter directly translates the questions and answers during the phone call, reducing or eliminating the need for a returned phone call. We also provide services to our hearing impaired customers through the AT&T Relay Service.

Premium Personal Health Team
The Premium Personal Health Team is a designated and integrated service delivery approach using a one health advocate model. Core functions include:

- Case Management - Short term and complex
- Inpatient Advocacy
- Pre Admission Outreach
- Post Discharge Outreach
- 24 hour Health Information Line Outreach
- Lifestyle Management Programs
- Your Health First - 200
- Treatment Decision Support

State of Colorado designated Health Advocate Team

Coaches are available in St. Louis from 6am MST to 8pm MST

Team Number - 800.244.6224

Program Name - State of Colorado Health Team

Program Title - State of Colorado Health Advocate

Pre-Certification - Continued Stay Review – Complete Care Management Inpatient - required for all inpatient admissions
In-Network: Coordinated by your physician, customer not responsible for failure to precertify.
Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- 50% penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.
- Benefits are denied for any admission reviewed by Cigna Healthcare and not certified.
- Benefits are denied for any additional days not certified by Cigna Healthcare.

Pre-Certification - Complete Care Management Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing
In-Network: Coordinated by your physician, customer not respoonsible for failure to precertify.
Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- 50% penalty applied to outpatient procedures/diagnostic testing charges for failure to contact Cigna Healthcare and to precertify admission.
- Benefits are denied for any outpatient procedures/diagnostic testing reviewed by Cigna Healthcare and not certified.

Additional Information	
Network Adequacy Authorization The Network Adequacy Provision establishes criteria for authorization of services by a non-participating health care professional at the in-network level of benefits when a qualified, participating health care professional is not available to provide medically necessary services within a reasonable distance from the customer's home or within reasonable appointment availability timeframes. If at least one (1) participating health care professional is not available within the established mileage specifications from the customer's home, or in certain states, from the customer's home or work location, the customer may receive authorization to visit a non-participating health care professional at the in-network benefit level. Requests for network adequacy are subject to medical necessity review of all supporting information in order to make a determination of coverage. Please call 800.244.6224for more information.	
Pre-Existing Condition Limitation (PCL) does not apply.	
Treatment Decision Support Treatment decision support for common health conditions. Cigna health advocates provide unbiased information and education on treatment options for common health conditions, including: back pain, coronary artery disease, osteoarthritis of the hip and knee, benign uterine conditions, breast cancer and prostate cancer.	Included
Your Health First - 200 Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support: • Condition Management • Medication adherence • Risk factor management • Lifestyle issues • Health & Wellness issues • Pre/post-admission • Treatment decision support • Gaps in care	Holistic health support for the following chronic health conditions: • Heart Disease • Coronary Artery Disease • Angina • Congestive Heart Failure • Acute Myocardial Infarction • Peripheral Arterial Disease • Asthma • Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis) • Diabetes Type 1 • Diabetes Type 2 • Metabolic Syndrome/Weight Complications • Osteoarthritis • Low Back Pain • Anxiety • Bipolar Disorder • Depression

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
Transition of Care - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

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 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;

Exclusions

  - 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: acupressure; craniosacral/cranial therapy; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Surgical or non-surgical treatment of TMJ disorders.
- 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.
- Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, 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 medications, drugs, 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.
- 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 and driver safety courses.
- 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, elastic stockings, garter belts, corsets, dentures and wigs.
- 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.

Exclusions

- 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.
- 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 or is a sole source of nutrition or a significant percentage of the daily caloric intake.
- 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 the benefit section.
- Massage therapy.
- Abortions, unless a Physician certifies in writing that the abortion is medically necessary to prevent the death of either a pregnant woman or her unborn child under circumstances where every reasonable effort is made to preservice the life of each.

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.

EHB State: CO

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.

Cigna®

 ATTENTION: If you speak languages other than English, 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). ATENCIÓN: Si usted habla un idioma que no sea inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Si es un cliente actual de Cigna, 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).

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).