2018 CIGNA PLAN COMPARISON BROCHURE

Things to consider when shopping for a Cigna plan.

Together, all the way.®

Cigna®

Cigna Health and Life Insurance Company

906556 a 10/17

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.[1]
- 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.[2]
- 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: **Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas and Jefferson**. 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**.

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
Network name	Connect Network
Plan type	Exclusive Provider Organization (EPO)
To remain in-network:	
Primary care physician (PCP)	Visit an in-network PCP. PCP selection is required.[3]
Specialist physician	Visit specialists in the Connect Network. Referral is required by a PCP.[4]
Out-of-network coverage	Out-of-network services are ***not*** covered under this plan.
In the case of an emergency	Emergency care is covered for situations that qualify as an emergency, as defined by the plan.[5]
When traveling (away from home care)	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.[2]
Find providers in-network.	**Cigna.com/ifp-providers**

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.

MEDICAL	BRONZE		
	Cigna Connect HSA Bronze 5500	Cigna Connect Flex Bronze 6400	Cigna Connect Flex Bronze 6700
	In-network	In-network	In-network
Annual deductible[6] individual/family	$5,500/$11,000	$6,400/$12,800	$6,700/$13,400
Coinsurance[7]	You pay 30% after deductible	You pay 40% after deductible	You pay 50% after deductible
Annual out-of-pocket max[8] individual/family	$6,650/$13,300	$7,350/$14,700	$7,350/$14,700
Physician services (primary care/specialist)	You pay 30% after deductible	You pay $40, deductible waived/You pay 40% after deductible	You pay $50 for visits 1 & 2, deductible waived. You pay 50% after deductible for additional visits/You pay 50% after deductible
Preventive care	You pay 0%, deductible waived	You pay 0%, deductible waived	You pay 0%, deductible waived
Inpatient facility and physician services	You pay 30% after deductible	You pay 40% after deductible	You pay 50% after deductible
Lab, X-ray, and ultrasound	You pay 30% after deductible	You pay 40% after deductible	You pay 50% after deductible
Hospital ER	You pay 30% after deductible	You pay $500 after deductible	You pay 50% after deductible
Urgent care	You pay 30% after deductible	You pay $75, deductible waived	You pay $75, deductible waived
Telehealth	You pay 30% after deductible	You pay $10, deductible waived	You pay $10, deductible waived
RX DRUGS – Tier 1, 2, 3 and 4: Up to a 30-day supply at participating pharmacy or up to a 90-day supply at 90-day retail pharmacy. **Tier 5:** Up to a 30-day supply at participating pharmacy or 90-day retail pharmacy.			
Tier 1 retail pref. generic	You pay 30% after deductible	You pay $10, deductible waived for each 30 day supply	You pay 50% after deductible
Tier 2 retail non-pref. generic	You pay 30% after deductible	You pay $35, deductible waived for each 30 day supply	You pay 50% after deductible
Tier 3 retail pref. brands	You pay 30% after deductible	You pay $150, deductible waived for each 30 day supply	You pay 50% after deductible
Tier 4 retail non-pref. brands	You pay 30% after deductible	You pay $550, deductible waived for each 30 day supply	You pay 50% after deductible
Tier 5 retail specialty	You pay 30% after deductible	You pay $600, deductible waived	You pay 50% after deductible

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

MEDICAL	SILVER		
	Cigna Connect Flex Silver 4000	Cigna Connect Flex Silver 3500	Cigna Connect Flex Silver 2500
	In-network	In-network	In-network
Annual deductible[6] individual/family	$4,000/$8,000	$3,500/$7,000	$2,500/$5,000
Coinsurance[7]	You pay 10% after deductible	You pay 20% after deductible	You pay 40% after deductible
Annual out-of-pocket max[8] individual/family	$7,350/$14,700	$7,350/$14,700	$7,350/$14,700
Physician services (primary care/specialist)	You pay $30 for visits 1–3, deductible waived. You pay 10% after deductible for additional visits/You pay 10% after deductible	You pay $25 for visits 1–3, deductible waived. You pay 20% after deductible for additional visits/You pay 20% after deductible	You pay $20, deductible waived/ You pay 40% after deductible
Preventive care	You pay 0%, deductible waived	You pay 0%, deductible waived	You pay 0%, deductible waived
Inpatient facility and physician services	You pay 10% after deductible	You pay 20% after deductible	You pay 40% after deductible
Lab, X-ray, and ultrasound	You pay 10% after deductible	You pay 20% after deductible	You pay 40% after deductible
Hospital ER	You pay $500 after deductible	You pay 20% after deductible	You pay 40% after deductible
Urgent care	You pay $50, deductible waived	You pay $50, deductible waived	You pay $50, deductible waived
Telehealth	You pay $10, deductible waived	You pay $10, deductible waived	You pay $10, deductible waived
RX DRUGS – Tier 1, 2, 3 and 4: Up to a 30-day supply at participating pharmacy or up to a 90-day supply at 90-day retail pharmacy. **Tier 5:** Up to a 30-day supply at participating pharmacy or 90-day retail pharmacy.			
Tier 1 retail pref. generic	You pay $8, deductible waived for each 30 day supply	You pay $8, deductible waived for each 30 day supply	You pay $8, deductible waived for each 30 day supply
Tier 2 retail non-pref. generic	You pay $25, deductible waived for each 30 day supply	You pay $25, deductible waived for each 30 day supply	You pay $30, deductible waived for each 30 day supply
Tier 3 retail pref. brands	You pay $60, deductible waived for each 30 day supply	You pay $60, 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	You pay $350, deductible waived for each 30 day supply
Tier 5 retail specialty	You pay 40% after deductible	You pay 40% after deductible	You pay $600, deductible waived

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**.

Cigna's 24-hour Health Information Line℠

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.[2] 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 **ConnectForHealthColorado.com** or **Cigna.com**.

Colorado Connect Plans

2018 PLAN EXCLUSIONS AND LIMITATIONS

The Exclusions and Limitations for this medical plan are subject to change based on regulatory approvals. For an updated version:

Type in your browser or click on the following link:
Cigna.com/CO-2018-Cigna-Connect-Exclusions or call **877.Cigna.15**.
*Current customers, call **800.Cigna.30**.*

Excluded Services

Cigna may not deny, exclude, or otherwise limit coverage for Medically Necessary services, as determined by an Insured Person's medical provider, if the item or service would be provided based on current standards of care and as a covered benefit to another Insured Person without regard to their sexual orientation.

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.
- Any amounts in excess of maximum amounts of Covered Expenses stated in this Policy.
- Services not specifically listed as Covered Services in this Policy.
- Services for treatment of complications of non-covered procedures or services.
- Services or supplies that are not Medically Necessary.
- Services or supplies that Cigna considers to be for Experimental Procedures or Investigative Procedures.
- 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, even if the Insured Person does not claim those benefits.
- Conditions caused by: (a) an act of war (declared or un-declared); (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; (c) an Insured Person participating in the military service of any country; (d) an Insured Person participating in an insurrection, rebellion, or riot; (e) services received as a direct result of an Insured Person's commission of, or attempt to commit a felony (whether or not charged) or as a direct result of the Insured Person being engaged in an illegal occupation.
- Any services provided by a local, state or federal government agency, except (a) 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 or medical assistance benefits under the Colorado Medical Assistance Act, Title 25.5, Articles 4, 5, and 6, C.R.S.). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.
- 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 medically necessary and listed as covered in this plan.
- Professional services or supplies received or purchased from Yourself.

- Custodial Care.
- Private duty nursing except when provided as part of the Home Health Care Services or Hospice Services benefit in this Policy or as specifically stated in the section of this Policy titled "Benefits/Coverage (What is Covered)".
- 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; 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 "Short Term 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 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 an outpatient basis.
- Services which are self-directed to a free-standing or Hospital based diagnostic facility.
- Services ordered by a Physician or other provider 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.

- Treatment of Mental, Emotional or Functional Nervous Disorders or psychological testing, except as specifically provided in this Policy. However, medical conditions that are caused by behavior of the Insured Person and that may be associated with these mental conditions are not subject to these limitations.
- 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 treatment for medically necessary orthodontia for a person born with a cleft lip or cleft palate.
- 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, excludes medically necessary treatment of cleft lip, cleft palate.
- Hearing aids, except as specifically stated in this Policy, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), limited to the least expensive professionally adequate device. A hearing aid is any device that amplifies sound.
- Routine hearing tests except as specifically provided in this Policy under "Benefits/Coverage (What is Covered)".
- 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.
- 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).
- Any Drugs, medications, or other substances dispensed or administered in any outpatient setting except as specifically stated in this Policy. This includes, but is not limited to, items dispensed by a Physician.
- Cosmetic surgery or other services for beautification, to improve or alter appearance or self-esteem or to treat psychological or psychosocial complaints regarding one's appearance This exclusion does not apply to Reconstructive Surgery to restore a bodily function or to correct a deformity caused by Injury, medically necessary surgery or congenital defect of a Newborn child, or to treat congenital hemangioma (port wine stains) on the face and neck of an insured person 18 years and younger, or for Medically Necessary Reconstructive Surgery performed to restore symmetry incident to a mastectomy or lumpectomy.
- 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.
- Nonmedical counseling or ancillary services, including but not limited to: education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities and developmental delays, except as specifically stated in this Policy. This exclusion does not apply to health education services for chronic diseases and self-care on topics such as stress management and nutrition.
- Services and procedures for redundant skin surgery including abdominoplasty/panniculectomy, removal of skin tags, acupressure, acupuncture, craniosacral/cranial therapy, applied kinesiology, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, macromastia or gynecomastia; varicose veins; rhinoplasty and blepharoplasty, regardless of clinical indications.
- Surgery or treatments to change characteristics of the body to those of the opposite sex.
- Any treatment, prescription drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire.
- The following services related to the evaluation or treatment of fertility and/or Infertility, sterilization reversals; donor semen and donor eggs; ovum transplants; 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.
- Any Infusion or Injectable Specialty Prescription Drugs that require Physician supervision, except as otherwise stated in this Policy, if not provided by an approved Participating Provider specifically designated to supply that specialty prescription. Infusion and Injectable Specialty drugs include, but are not limited to, hemophilia factor and supplies, enzyme replacements and intravenous immunoglobulin.
- 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 (except for treatment as a result of diabetes).
- 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 except as otherwise stated in this Policy under "Bariatric Surgery".

- 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.
- 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, including wigs etc.).
- Massage therapy
- Educational services except for Diabetes Self-Management Training Program, and as specifically provided or arranged by Cigna.
- Nutritional counseling or food supplements, except as stated in this Policy.
- Durable medical equipment not specifically listed as Covered Services in the Covered Services section of this Policy. Excluded durable 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.
- Physical, and/or Occupational Therapy/Medicine except when provided during an inpatient Hospital confinement or as specifically stated in the Benefit Schedule and ' under Physical and/or Occupational Therapy/Medicine' in the section of this Policy titled " Benefits/Coverage (What is Covered)".
- 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 "Benefits/Coverage (What is Covered)".
- Growth Hormone Treatment except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured Person's condition; Growth hormone treatment for idiopathic short stature or improved athletic performance is not covered under any circumstances.
- Routine foot care including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, Injury or symptoms involving the feet, except as otherwise stated in this Policy.
- Charges for which We are unable to determine Our liability because the Insured Person failed, within 60 days, or as soon as reasonably possible to: (a) authorize Us to receive all the medical records and information We requested; or (b) provide Us with information We requested regarding the circumstances of the claim or other insurance coverage.
- Charges for the services of a standby Physician.
- Charges for animal to human organ transplants.
- Charges for elective abortions.
- Claims received by Cigna after 15 months from the date service was rendered, except in the event of a legal incapacity.

2018 PLAN IMPORTANT DISCLOSURES

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 60 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: CO: COINDEPO042017

The policy/service agreement may be canceled by Cigna due to failure to pay premium, fraud, ineligibility, when the insured no longer lives in the service area, or when we cease to offer policies/service agreements of this type or cease to offer any plans in the individual market in the state, in accordance with applicable law. You may cancel the policy/service agreement, on the first of the month following our receipt of your written notice. We reserve the right to modify the policy/service agreement, including plan provisions, benefits and coverages, consistent with state or federal law. Policies/service agreements renew on a calendar year basis.

ACCESS PLAN: If you would like more information on: (1) who participates in our provider network; (2) how we ensure that the network meets the health care needs of our members; (3) how our provider referral process works; (4) how care is continued if providers leave our network; (5) what steps we take to ensure medical quality and customer satisfaction; (6) where you can go for information on other policy services and features. You may request a copy of our Access Plan. The Access Plan is designed to disclose all the policy information required under Colorado law, and is available for review upon request.

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**.

CONNECT for HEALTH COLORADO

Cigna®