



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-494-2111 or visit us at [www.cigna.com/ifp-documents](http://www.cigna.com/ifp-documents). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-866-494-2111 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                    | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$1,000 person/ \$2,000 family                                                                                                                                                                             | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                                            |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> and other services indicated in chart starting on page 2.                                                                                                             | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount, but a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                       |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                                                                                        | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$2,825 person/ \$5,650 family                                                                                                                                                                             | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                                             |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, penalties for failure to obtain <a href="#">preauthorization</a> for services and health care this <a href="#">plan</a> doesn't cover. | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.cigna.com/ifp-providers">www.cigna.com/ifp-providers</a> or call 1-866-494-2111 for a list of <a href="#">network providers</a> .                                             | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |

| Important Questions                                                          | Answers | Why This Matters:                                                                          |
|------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------|
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | No.     | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> . |

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event                                                                                                                                                                                                   | Services You May Need                                   | What You Will Pay                                                                                                                                                                                                                                     |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                        |                                                         | Network Provider<br>(You will pay the least)                                                                                                                                                                                                          | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                                                                 | Primary care visit to treat an injury or illness        | \$1 <a href="#">copayment</a> /visit, <a href="#">deductible</a> does not apply                                                                                                                                                                       | Not covered                                        | Refer to the policy for more information about Virtual Care Services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                        | <a href="#">Specialist</a> visit                        | \$40 <a href="#">copayment</a> /visit, <a href="#">deductible</a> does not apply                                                                                                                                                                      | Not covered                                        | None.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                        | <a href="#">Preventive care/screening</a> /immunization | No charge, <a href="#">deductible</a> does not apply                                                                                                                                                                                                  | Not covered                                        | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.                                                                                                                                                                                                                                                                                                                                                                                   |
| If you have a test                                                                                                                                                                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)     | 10% <a href="#">coinsurance</a>                                                                                                                                                                                                                       | Not covered                                        | None.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                        | Imaging (CT/PET scans, MRIs)                            | 10% <a href="#">coinsurance</a>                                                                                                                                                                                                                       | Not covered                                        | None.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.cigna.com/ifp-drug-list">www.cigna.com/ifp-drug-list</a> | Generic drugs                                           | Preventive drugs:<br>No charge (retail/home delivery); <a href="#">deductible</a> does not apply.<br>Generic:<br>\$15 <a href="#">copayment</a> (retail) / \$45 <a href="#">copayment</a> (home delivery); <a href="#">deductible</a> does not apply. | Not covered                                        | Generic, Preferred, and Non-Preferred Drugs: Limited to up to a 30-day supply (retail) or a 90-day supply (designated 90-day retail pharmacy/home delivery). You pay a <a href="#">copayment</a> for each 30-day supply (retail), if applicable.<br><a href="#">Specialty drugs</a> : Limited to up to a 30-day supply (retail) or a 30-day supply (designated 90-day retail pharmacy/home delivery). Cigna Healthcare's specialty pharmacy can assist you in obtaining your <a href="#">specialty drugs</a> . Call Accredo, at 1-877-826-7657 to talk to a representative. |
|                                                                                                                                                                                                                        | Preferred brand drugs                                   | \$75 <a href="#">copayment</a> (retail) / \$225 <a href="#">copayment</a> (home delivery); <a href="#">deductible</a> does not apply.                                                                                                                 | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

| Common Medical Event                                                      | Services You May Need                                     | What You Will Pay                                                                                                                                              |                                                                                  | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                     |
|---------------------------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                           | Network Provider<br>(You will pay the least)                                                                                                                   | Out-of-Network Provider<br>(You will pay the most)                               |                                                                                                                                                                                                                                                                                            |
|                                                                           | Non-preferred drugs                                       | \$125 <a href="#">copayment</a> (retail)/<br>\$375 <a href="#">copayment</a> (home delivery); <a href="#">deductible</a> does not apply.                       | Not covered                                                                      |                                                                                                                                                                                                                                                                                            |
|                                                                           | <a href="#">Specialty drugs</a> and other high cost drugs | \$250 <a href="#">copayment</a> (retail)/<br>\$225 <a href="#">copayment</a> (home delivery); <a href="#">deductible</a> does not apply.                       | Not covered                                                                      |                                                                                                                                                                                                                                                                                            |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)            | 10% <a href="#">coinsurance</a>                                                                                                                                | Not covered                                                                      | None.                                                                                                                                                                                                                                                                                      |
|                                                                           | Physician/surgeon fees                                    | 10% <a href="#">coinsurance</a>                                                                                                                                | Not covered                                                                      | None.                                                                                                                                                                                                                                                                                      |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>                       | 10% <a href="#">coinsurance</a>                                                                                                                                | 10% <a href="#">coinsurance</a>                                                  | You pay the same level as In-Network if it is an emergency as defined in your <a href="#">plan</a> , otherwise Not covered<br><br><a href="#">Emergency medical transportation</a> services for MH/SA diagnoses will be payable according to <a href="#">emergency room care</a> benefits. |
|                                                                           | <a href="#">Emergency medical transportation</a>          | 10% <a href="#">coinsurance</a>                                                                                                                                | 10% <a href="#">coinsurance</a>                                                  |                                                                                                                                                                                                                                                                                            |
|                                                                           | <a href="#">Urgent care</a>                               | \$40 <a href="#">copayment</a> /visit, <a href="#">deductible</a> does not apply                                                                               | \$40 <a href="#">copayment</a> /visit, <a href="#">deductible</a> does not apply |                                                                                                                                                                                                                                                                                            |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)                        | 10% <a href="#">coinsurance</a>                                                                                                                                | Not covered                                                                      | None.                                                                                                                                                                                                                                                                                      |
|                                                                           | Physician/surgeon fees                                    | 10% <a href="#">coinsurance</a>                                                                                                                                | Not covered                                                                      | None.                                                                                                                                                                                                                                                                                      |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                                       | Office visit: \$40 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply. All other outpatient services: 10% <a href="#">coinsurance</a> | Not covered                                                                      | Includes medical services for MH/SA diagnoses.                                                                                                                                                                                                                                             |
|                                                                           | Inpatient services                                        | 10% <a href="#">coinsurance</a>                                                                                                                                | Not covered                                                                      | Includes medical services for MH/SA diagnoses.                                                                                                                                                                                                                                             |

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                                                                                                                                                                       |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                           |
|----------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | Network Provider<br>(You will pay the least)                                                                                                                                            | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                  |
| If you are pregnant                                            | Office visits                             | 10% <a href="#">coinsurance</a>                                                                                                                                                         | Not covered                                        | <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
|                                                                | Childbirth/delivery professional services | 10% <a href="#">coinsurance</a>                                                                                                                                                         | Not covered                                        |                                                                                                                                                                                                                                                                  |
|                                                                | Childbirth/delivery facility services     | 10% <a href="#">coinsurance</a>                                                                                                                                                         | Not covered                                        |                                                                                                                                                                                                                                                                  |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | 10% <a href="#">coinsurance</a>                                                                                                                                                         | Not covered                                        | Coverage is limited to 28 hours per week.                                                                                                                                                                                                                        |
|                                                                | <a href="#">Rehabilitation services</a>   | \$1 <a href="#">copayment</a> /visit for physical, occupational and chiropractic therapy; <a href="#">deductible</a> does not apply; 10% <a href="#">coinsurance</a> for speech therapy | Not covered                                        | Coverage of physical, occupational and chiropractic therapy is unlimited annual max. Speech therapy is limited to 20 visit annual max.                                                                                                                           |
|                                                                | <a href="#">Habilitation services</a>     | 10% <a href="#">coinsurance</a>                                                                                                                                                         | Not covered                                        | Coverage is limited to 20 visits annual max per therapy.                                                                                                                                                                                                         |
|                                                                | <a href="#">Skilled nursing care</a>      | 10% <a href="#">coinsurance</a>                                                                                                                                                         | Not covered                                        | Coverage is limited to 100 days annual max.                                                                                                                                                                                                                      |
|                                                                | <a href="#">Durable medical equipment</a> | 10% <a href="#">coinsurance</a>                                                                                                                                                         | Not covered                                        | None.                                                                                                                                                                                                                                                            |
|                                                                | <a href="#">Hospice services</a>          | 10% <a href="#">coinsurance</a>                                                                                                                                                         | Not covered                                        | None.                                                                                                                                                                                                                                                            |
| If your child needs dental or eye care                         | Children's eye exam                       | No charge, <a href="#">deductible</a> does not apply                                                                                                                                    | Not covered                                        | Children up to age 19, through the end of their birth month. Coverage limited to one exam/year.                                                                                                                                                                  |
|                                                                | Children's glasses                        | No charge, <a href="#">deductible</a> does not apply                                                                                                                                    | Not covered                                        | Children up to age 19, through the end of their birth month. Coverage limited to one pair of glasses (lenses and frames from pediatric selection), per every two years.                                                                                          |
|                                                                | Children's dental check-up                | Not covered                                                                                                                                                                             | Not covered                                        |                                                                                                                                                                                                                                                                  |

## Excluded Services & Other Covered Services:

### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- |                       |                                                      |                            |
|-----------------------|------------------------------------------------------|----------------------------|
| • Cosmetic surgery    | • Long-term care                                     | • Routine eye care (Adult) |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. | • Routine foot care        |
|                       |                                                      | • Weight loss programs     |

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |                     |                                                                            |
|---------------------|----------------------------------------------------------------------------|
| • Abortion          | • Hearing aids (limited to 1 hearing aid per ear every 3 years, to age 18) |
| • Acupuncture       | • Infertility treatment                                                    |
| • Bariatric surgery | • Private duty nursing                                                     |
| • Chiropractic care |                                                                            |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Colorado Department of Insurance at 1-800-930-3745. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596. For more information on your rights to continue coverage, contact the insurer at 1-866-494-2111.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Colorado Department of Insurance at 1-800-930-3745.

### Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

### Does this plan meet the Minimum Value Standards? Not Applicable.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-494-2111.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-494-2111.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-866-494-2111.

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-494-2111.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of [in-network](#) pre-natal care and a hospital delivery)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$40    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 10%     |
| ■ Other <a href="#">coinsurance</a>                             | 10%     |

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>         |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$1,000 |
| <a href="#">Copayments</a>  | \$10    |
| <a href="#">Coinsurance</a> | \$1,200 |

| <i>What isn't covered</i> |      |
|---------------------------|------|
| Limits or exclusions      | \$60 |

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Peg would pay is</b> | <b>\$2,270</b> |
|-----------------------------------|----------------|

### Managing Joe's Type 2 Diabetes

(a year of routine [in-network](#) care of a well-controlled condition)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$40    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 10%     |
| ■ Other <a href="#">coinsurance</a>                             | 10%     |

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>         |       |
|-----------------------------|-------|
| <a href="#">Deductibles</a> | \$900 |
| <a href="#">Copayments</a>  | \$600 |
| <a href="#">Coinsurance</a> | \$0   |

| <i>What isn't covered</i> |      |
|---------------------------|------|
| Limits or exclusions      | \$20 |

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Joe would pay is</b> | <b>\$1,520</b> |
|-----------------------------------|----------------|

### Mia's Simple Fracture

([in-network](#) emergency room visit and follow up care)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$40    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 10%     |
| ■ Other <a href="#">coinsurance</a>                             | 10%     |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic tests](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>         |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$1,000 |
| <a href="#">Copayments</a>  | \$100   |
| <a href="#">Coinsurance</a> | \$70    |

| <i>What isn't covered</i> |     |
|---------------------------|-----|
| Limits or exclusions      | \$0 |

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Mia would pay is</b> | <b>\$1,170</b> |
|-----------------------------------|----------------|

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

## Colorado Supplement to the Summary of Benefits and Coverage Form

|                                                      |                                                                                                                                                 |
|------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>INSURANCE COMPANY NAME</b>                        | Cigna Health and Life Insurance Company                                                                                                         |
| <b>NAME OF PLAN</b>                                  | Cigna Connect Flex Silver 2750 Rx Copay (150-200% FPL)                                                                                          |
| <b>1. Type of Policy</b>                             | Individual Policy                                                                                                                               |
| <b>2. Type of plan</b>                               | Exclusive provider organization (EPO)                                                                                                           |
| <b>3. Areas of Colorado where plan is available.</b> | Plan is available only in the following areas: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso, Jefferson, Larimer, Teller, Weld |

### SUPPLEMENTAL INFORMATION REGARDING BENEFITS

**Important Note:** The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

|                                  | Description                                                                                                                                                                                                                                                                                                                                                                                       |
|----------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>4. Annual Deductible Type</b> | <p>EMBEDDED DEDUCTIBLE</p> <p>INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid. Claims will not be paid for any other individual until their individual deductible or the family deductible has been met.</p> <p>FAMILY – The maximum amount that the family will pay for the year. The family deductible can be met by any number of individuals.</p> |
| <b>5. Out-of-Pocket Maximum</b>  | <p>EMBEDDED OUT-OF-POCKET</p> <p>INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met.</p>                                                                                                                 |

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                     | FAMILY – The maximum amount that the family will pay for the year. The family out-of-pocket can be met by any number of individuals.                                                                                                                                                                                                                                                                                                        |
| <b>6. What is included in the In-Network Out-of-Pocket Maximum?</b> | Deductibles, Copayments and Coinsurance<br>As specified in § 10-16-161, C.R.S., effective for all health benefit plans issued or renewed on or after January 1, 2025, all carriers shall include any amount paid by the covered person and/or by another person on behalf of the covered person for a prescription drug when calculating the covered person's overall contribution to an out-of-pocket maximum or cost-sharing requirement. |
| <b>7. Is pediatric dental covered by this plan?</b>                 | No, the plan does not include pediatric dental                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>8. What cancer screenings are covered?</b>                       | Breast Cancer Screening with Mammography, Cervical Cancer Screening, Colorectal Cancer Screening, Prostate Cancer Screening                                                                                                                                                                                                                                                                                                                 |

#### USING THE PLAN

|                                                                                                                                         | IN-NETWORK | OUT-OF-NETWORK |
|-----------------------------------------------------------------------------------------------------------------------------------------|------------|----------------|
| <b>9. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?</b> | No         | N/A            |
| <b>10. Does the plan have a binding arbitration clause?</b>                                                                             | No         |                |

**Questions:** Call 1-800-244-6224 or visit us at [www.cigna.com](http://www.cigna.com).

**ATENCIÓN:** 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).

If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance  
Consumer Services, Life and Health Section  
1560 Broadway, Suite 850, Denver, CO 80202  
Call: 303-894-7490 (in-state, toll-free: 800-930-3745)  
Email: [dora\\_insurance@state.co.us](mailto:dora_insurance@state.co.us)

# Discrimination is against the law

Cigna Healthcare® complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

Cigna Healthcare does not exclude people or treat them less favorably differently because of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes.

## Cigna Healthcare:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids 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 assistance services to people whose primary language is not English in a timely manner, such as:
  - Qualified interpreters
  - Information written in other languages



Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company, Evernorth Behavioral Health, Inc., Evernorth Care Solutions, Inc., Cigna Dental Health, Inc., and HMO or service company subsidiaries of Cigna Health Corporation, including Cigna HealthCare of Arizona, Inc., Cigna HealthCare of Georgia, Inc., Cigna HealthCare of Illinois, Inc., Cigna HealthCare of North Carolina, Inc., and Cigna HealthCare of Texas, Inc. In Texas, the Dental plan is known as Cigna Dental Choice, and this plan uses the national Cigna DPPO Advantage network. ATTENTION: If you speak languages other than English, language assistance service, free of charge are available to you. For current Cigna Healthcare 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).

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If you need reasonable modifications, appropriate auxiliary aids and services or language assistance services, contact the Civil Rights Coordinator.

If you believe that Cigna Healthcare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, ancestry, religion, marital status, gender, sexual orientation, gender identity or sexual stereotypes, you can file a grievance with the Civil Rights Coordinator

P.O. Box 188016, Chattanooga, TN 37422,  
877.822.6561 (TTY: Dial 711)

[ACAGrievance@CignaHealthcare.com](mailto:ACAGrievance@CignaHealthcare.com)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

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  
<https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html>

## Proficiency of Language Assistance Services

**English – ATTENTION:** If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-244-6224 (TTY: Dial 711) or speak to your provider.

**Spanish – ATENCIÓN:** Si habla español, los servicios de asistencia lingüística gratuitos están disponibles para usted. También están disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-244-6224 (TTY: Marque 711) o hable con su proveedor.

**Chinese – 注意:** 如果您讲中文，我们提供免费的语言援助服务。适当的辅助设备和服务也可以免费提供，以提供无障碍格式的信息。请拨打 1-800-244-6224 (TTY: 拨打 711) 或与您的服务提供者联系。

**Vietnamese – XIN LƯU Ý:** Nếu bạn nói tiếng Việt, dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho bạn. Các thiết bị và dịch vụ hỗ trợ phù hợp để cung cấp thông tin ở định dạng có thể tiếp cận cũng có sẵn miễn phí. Gọi số 1-800-244-6224 (TTY: Gọi 711) hoặc nói chuyện với nhà cung cấp của bạn).

**Korean – 주의:** 한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 기기 및 서비스도 무료로 제공됩니다. 1-800-244-6224 (TTY: 711 로 전화) 로 전화하시거나 제공자에게 문의하십시오.

**Tagalog – PAUNAWA:** Kung ikaw ay nagsasalita ng Tagalog, ang mga libreng serbisyo ng tulong sa wika ay magagamit para sa iyo. Ang mga angkop na pantulong na kagamitan at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay magagamit din ng libre. Tumawag sa 1-800-244-6224 (TTY: Tumawag sa 711) o makipag-usap sa iyong tagapagbigay.

**Russian – ВНИМАНИЕ:** Если вы говорите на русском, доступны бесплатные услуги языковой помощи. Также бесплатно предоставляются соответствующие вспомогательные средства и услуги для предоставления информации в доступных форматах. Позвоните по телефону 1-800-244-6224 (TTY: Наберите 711) или обратитесь к вашему провайдеру.

**Arabic - تنبيه:** إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا مساعدات قابلة للوصول إليها، وذلك مجانًا. اتصل بالرقم 1-800-244-6224 (TTY: اطلب 711) أو تحدث إلى مقدم الخدمة الخاص بك (اطلب 711).

**French Creole – ATANSYON:** Si ou pale Kreyòl Ayisyen, sèvis asistans lang gratis yo disponib pou ou. Ekipman ak sèvis adisyonèl ki apwopriye pou bay enfòmasyon nan fòm ki aksesib yo disponib tou gratis. Rele 1-800-244-6224 (TTY: Rele 711) oswa pale ak founisè ou a.

**French – ATTENTION :** Si vous parlez français, des services d'assistance linguistique gratuits sont disponibles pour vous. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-244-6224 (TTY : composez le 711) ou parlez à votre fournisseur.

**Portuguese – ATENÇÃO:** Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Auxílios e serviços apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-244-6224 (TTY: disque 711) ou fale com seu prestador de serviços.

**Polish – UWAGA:** Jeśli mówisz po polsku, dostępne są bezpłatne usługi pomocy językowej. Odpowiednie pomoce i usługi wspierające w celu dostarczenia informacji w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-800-244-6224 (TTY: wybierz 711) lub skontaktuj się ze swoim dostawcą usług.

**Japanese – 注意:** 日本語を話す場合は、無料の言語支援サービスが利用できます。アクセス可能な形式で情報を提供するための適切な補助機器やサービスも無料で利用できます。1-800-244-6224 (TTY: 711 にダイヤル) に電話するか、提供者に話してください。

**Italian – ATTENZIONE:** Se parli italiano, sono disponibili per te servizi gratuiti di assistenza linguistica. Sono disponibili gratuitamente anche ausili e servizi appropriati per fornire informazioni in formati accessibili. Chiama il numero 1-800-244-6224 (TTY: componi il 711) o parla con il tuo fornitore.

**German – Achtung:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Geeignete Hilfsmittel und Dienste, um Informationen in barrierefreien Formaten bereitzustellen, sind ebenfalls kostenlos verfügbar. Rufen Sie 1-800-244-6224 an (TTY: Wählen Sie 711) oder sprechen Sie mit Ihrem Anbieter.

**Persian (Farsi) - همچنین،** وسایل و خدمات کمکی مناسب برای در دسترس است. خدمات رایگان کمک زبان برای شما صحبت می‌کنند، توجه: اگر به فارسی تماس بگیرید یا با (شماره 711 را بگیرید (TTY: ارائه اطلاعات در قالبهای قابل دسترس به صورت رایگان در دسترس هستند. با شماره 1-800-244-6224. ارائه‌دهنده خود صحبت کنید