



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> ?                                | \$4,000 person/ \$8,000 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> , office visits, <a href="#">Prescription drugs</a> , <a href="#">Urgent care</a> visits subject to a <a href="#">copayment</a> and eye exam/glasses for children are covered before you meet your <a href="#">deductible</a> . | 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> ? | \$7,550 person/ \$15,100 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        | \$0 <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                        | \$90 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply. | Not covered.                                       | None.                                                                                                                                                                                 |
|                                                                        | <a href="#">Preventive care/screening</a> /immunization | No charge.                                                                        | 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. |
| If you have a test                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)     | 25% <a href="#">coinsurance</a>                                                   | Not covered.                                       | None.                                                                                                                                                                                 |
|                                                                        | Imaging (CT/PET scans, MRIs)                            | 25% <a href="#">coinsurance</a>                                                   | Not covered.                                       | None.                                                                                                                                                                                 |

| 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)                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="http://www.cigna.com/ifp-drug-lists">prescription drug coverage</a> is available at <a href="http://www.cigna.com/ifp-drug-lists">www.cigna.com/ifp-drug-lists</a> | Generic drugs                                             | Preventive drugs:<br>No charge (retail/home delivery).<br>Generic:<br>\$20 <a href="#">copayment</a> (retail)/<br>\$60 <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>Specialty Drugs: 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 877.826.7657 to talk to a representative. |
|                                                                                                                                                                                                                                                                   | Preferred brand drugs                                     | \$90 <a href="#">copayment</a> (retail)/<br>\$270 <a href="#">copayment</a> (home delivery); <a href="#">deductible</a> does not apply.                                                                      | Not covered.                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                   | Non-preferred drugs                                       | 50% <a href="#">coinsurance</a> (retail/home delivery)                                                                                                                                                       | Not covered.                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                   | <a href="#">Specialty drugs</a> and other high cost drugs | 50% <a href="#">coinsurance</a> (retail)/40% <a href="#">coinsurance</a> (home delivery)                                                                                                                     | Not covered.                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                                             | Facility fee (e.g., ambulatory surgery center)            | 25% <a href="#">coinsurance</a>                                                                                                                                                                              | Not covered.                                                                      | None.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                                                                   | Physician/surgeon fees                                    | 25% <a href="#">coinsurance</a>                                                                                                                                                                              | Not covered.                                                                      | None.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>If you need immediate medical attention</b>                                                                                                                                                                                                                    | <a href="#">Emergency room care</a>                       | \$600 <a href="#">copayment</a> /visit.                                                                                                                                                                      | \$600 <a href="#">copayment</a> /visit.                                           | You pay the same level as In-network if it is an emergency as defined in your <a href="#">plan</a> , otherwise Not covered.                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                   | <a href="#">Emergency medical transportation</a>          | 25% <a href="#">coinsurance</a>                                                                                                                                                                              | 25% <a href="#">coinsurance</a>                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                   | <a href="#">Urgent care</a>                               | \$50 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply.                                                                                                                            | \$50 <a href="#">copayment</a> /visit; <a href="#">deductible</a> does not apply. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>If you have a hospital stay</b>                                                                                                                                                                                                                                | Facility fee (e.g., hospital room)                        | 25% <a href="#">coinsurance</a>                                                                                                                                                                              | Not covered.                                                                      | None.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                                                                   | Physician/surgeon fees                                    | 25% <a href="#">coinsurance</a>                                                                                                                                                                              | Not covered.                                                                      | None.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

| 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 need mental health, behavioral health, or substance abuse services | Outpatient services                       | Office Visit: 25% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply. All other outpatient services: 25% <a href="#">coinsurance</a> .                    | Not covered.                                       | Includes medical services for MH/SA diagnoses.                                                                                                                                                                                                                  |
|                                                                           | Inpatient services                        | 25% <a href="#">coinsurance</a>                                                                                                                                                | Not covered.                                       | Includes medical services for MH/SA diagnoses.                                                                                                                                                                                                                  |
| If you are pregnant                                                       | Office visits                             | 25% <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 | 25% <a href="#">coinsurance</a>                                                                                                                                                | Not covered.                                       |                                                                                                                                                                                                                                                                 |
|                                                                           | Childbirth/delivery facility services     | 25% <a href="#">coinsurance</a>                                                                                                                                                | Not covered.                                       |                                                                                                                                                                                                                                                                 |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>          | 25% <a href="#">coinsurance</a>                                                                                                                                                | Not covered.                                       | Coverage is limited to 28 hours per week.                                                                                                                                                                                                                       |
|                                                                           | <a href="#">Rehabilitation services</a>   | \$0 <a href="#">copayment</a> /visit for physical and occupational therapy; <a href="#">deductible</a> does not apply; 25% <a href="#">coinsurance</a> for all other services. | Not covered.                                       | Speech Therapy is limited to 20 visits annual max.                                                                                                                                                                                                              |
|                                                                           | <a href="#">Habilitation services</a>     | 25% <a href="#">coinsurance</a>                                                                                                                                                | Not covered.                                       | Coverage is limited to 20 visits annual max per therapy.                                                                                                                                                                                                        |
|                                                                           | <a href="#">Skilled nursing care</a>      | 25% <a href="#">coinsurance</a>                                                                                                                                                | Not covered.                                       | Coverage is limited to 100 days annual max.                                                                                                                                                                                                                     |
|                                                                           | <a href="#">Durable medical equipment</a> | 25% <a href="#">coinsurance</a>                                                                                                                                                | Not covered.                                       | None.                                                                                                                                                                                                                                                           |
|                                                                           | <a href="#">Hospice services</a>          | 25% <a href="#">coinsurance</a>                                                                                                                                                | Not covered.                                       | None.                                                                                                                                                                                                                                                           |
| If your child needs dental or eye care                                    | Children's eye exam                       | No charge.                                                                                                                                                                     | Not covered.                                       | Children up to age 19. Coverage limited to one exam/year.                                                                                                                                                                                                       |
|                                                                           | Children's glasses                        | No charge.                                                                                                                                                                     | Not covered.                                       | Children up to age 19. 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.                                       | Coverage is available through a stand-alone dental policy.                                                                                                                                                                                                      |

## 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](#).)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child) (coverage available through a stand-alone dental policy)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- 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.)

- Acupuncture (unlimited visits annual max)
- Bariatric surgery
- Chiropractic care (unlimited visits annual max)
- Hearing aids (limited to 1 hearing aid per ear every 3 years, to age 18)
- Infertility Treatment
- Private-duty nursing

**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.**

## 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): Dinek'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> | \$4,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$90    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 25%     |
| ■ Other <a href="#">coinsurance</a>                             | 25%     |

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:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$4,000        |
| <a href="#">Copayments</a>        | \$10           |
| <a href="#">Coinsurance</a>       | \$2,100        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$6,170</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> | \$4,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$90    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 25%     |
| ■ Other <a href="#">coinsurance</a>                             | 25%     |

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:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$900          |
| <a href="#">Copayments</a>        | \$600          |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| 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> | \$4,000 |
| ■ <a href="#">Specialist copayment</a>                          | \$90    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 25%     |
| ■ Other <a href="#">coinsurance</a>                             | 25%     |

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:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,700        |
| <a href="#">Copayments</a>        | \$300          |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,000</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>                                  | <b>Cigna Connect Flex Silver 5750</b>                                                                                                           |
| <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                                                                                              |
| <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.

## Medical coverage

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

### Cigna Healthcare:

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

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



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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, or sex, you can file a grievance by sending an email to **ACAGrievance@Cigna.com** or by writing to the following address:

### Cigna Healthcare

Nondiscrimination Complaint Coordinator  
P.O. Box 188016 Chattanooga, TN 37422

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

### U.S. Department of Health and Human Services

200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, DC 20201  
**1.800.368.1019, 800.537.7697 (TDD)**

Complaint forms are available at  
<http://www.hhs.gov/ocr/office/file/index.html>

## Proficiency of Language Assistance Services

**English** – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

**Spanish** – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

**Chinese** – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224（聽障專線：請撥 711）。

**Vietnamese** – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên của quý vị. Các trường hợp khác, xin gọi số 1.800.244.6224 (TTY: Quay số 711).

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

**Tagalog** – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

**Russian** – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

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

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

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

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

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

**Japanese** – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224 (TTY: 711)まで、お電話にてご連絡ください。

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

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

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