

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs (Tier 4)	20% up to \$75 copay /prescription (retail & home delivery 30 days)	Not covered	In-network Federally required preventive drugs will be provided at no charge.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	None
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Out-of-network services are paid at the in-network cost share and deductible .
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network air ambulance services are paid at the in-network cost share and deductible .
	Urgent care	20% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	None
	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance /office visit 20% coinsurance /all other services	Not covered	Includes medical services for MH/SA diagnoses.
	Inpatient services	20% coinsurance	Not covered	Includes medical services for MH/SA diagnoses.

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	Hospice services	20% coinsurance /inpatient services 20% coinsurance /outpatient services	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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
Dental care (Children)	Private-duty nursing		Weight loss programs
Eye care (Children)			

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)			
Acupuncture (12 days)	Chiropractic care (combined with Rehabilitation Services)		Infertility treatment
Bariatric surgery	Hearing aids (2 (one per ear) devices per 36 months, through age 17)		

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: Cigna at 1-800-Cigna24, Colorado Division of Insurance at 1-800-930-3745 and Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 or call 1-800-318-2596.

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 assi425.63899953 (for any r1 nCruor a)-16.mook gn

