Cigna HealthCare of Colorado, Inc.
Health Maintence Organization (HMO) Network
Access Plan

Introduction

Cigna HealthCare of Colorado, Inc., (CHC-CO), a Cigna company, hereby establishes a written Access Plan for its Health Maintence Organization (HMO) Network. The CHC-CO network is an HMO network. This means that only services provided by an in-network provider are covered (except for emergency services). Services received from a provider that is outside of the network are not covered (except for emergency services). The features of the network include but are not limited to: lower medical costs; primary care physician (PCP) selection is required; in-network coverage in the case of an emergency – nationwide; helpful decision support tools on Cigna.com and via the Cigna.com Mobile app; 24/7/365 live customer service and health information line; access to Cigna Behavioral Health network; and network comprised of quality health care providers. The service area of the CHC-CO HMO network is statewide.

The Access Plan contains information regarding the accessibility and availability of participating health care professionals as well as information on the quality of and type of services available to customers. This Access Plan shall be available for inspection of Cigna's Colorado offices and shall be made available to any interested party upon request. The Access Plan can also be accessed at the following website: https://www.cigna.com/product-disclosures/. Then select the “State-Specific Notices and Disclosures” section and “Colorado”.

Quality Assurance Standards

Cigna's Quality and Medical Management Program is integral to the Access Plan Elements described below.

Quality Program Scope
The Quality Program provides direction to management for the coordination of both quality improvement and quality management activities across all departments, matrix partners, health services affiliates and delegates. The Program outlines quality-monitoring standards and provides guidance in initiating process improvement initiatives when opportunities are identified. Quality Studies are designed and documented to objectively and systematically monitor, evaluate and improve the quality and appropriateness of care and service.

Quality Program Measurement Activities
- Reviewing performance against key indicators as specifically identified in the quality work plan.
- Promotion of quality clinical care and service, including both inpatient and outpatient services, provided by hospitals and health care professionals.
- Evaluating satisfaction information, including survey data and complaint and appeal analysis.
- Evaluating access to services provided by the plan and its contracted health care professionals.

Annual Evaluation
An annual evaluation is conducted to assess the overall effectiveness of the various organizations' quality improvement processes. The evaluation reviews all aspects of the Quality & Medical Management Programs with emphasis on determining whether the Program has demonstrated improvements in the quality of health care professional care and services that are provided through the organizations. The annual evaluation includes:
- The impact the quality improvement process had on improving health care and service to

individuals.

- An assessment of whether the year's goals and objectives were met.
- A summary of quality improvement activities and whether improvements were realized.
- Potential and actual barriers to achieving goals.
- A review of whether human and technological resources were adequate.
- An analysis of membership demographics, cultural and linguistic needs, and epidemiology is performed as needed or as required by state regulators.
- An analysis of the member population characteristics to evaluate and ensure membership needs are being met through the complex and specialty case management processes and resources
- Recommendations for program revisions and modifications for the coming year.

The annual evaluation is reviewed and approved by the appropriate quality committee and the Quality Management Governing Body. The results of the annual program evaluation are used to develop and prioritize the annual work plan for the upcoming year.

Access Plan Elements

Element 1 – Having and Maintaining Adequate Networks

Cigna recognizes our customer's needs to have an adequate number of providers and facilities, within a reasonable distance or travel time, or both. Geographic accessibility, in some circumstances may be available through the use of telehealth.

Provider and Facility Availability

Cigna adheres to a provider and facility availability policy which helps ensure that Cigna maintains an adequate network of health care professionals and facilities and monitors how effectively the network meets the needs and preferences of its clients and meets the Colorado requirements for having and maintaining an adequate network. The provider availability policy also helps ensure that the provider network meets the availability needs of clients by annually assessing three (3) aspects of availability:

- Geographic distribution - participating health care professionals are within reasonable proximity to clients.
- Number of health care professional(s) - an adequate number of participating health care professional(s) are available, and
- Cultural, ethnic, racial and linguistic needs and preferences of participating health care professional(s) meet the cultural, ethnic, racial and linguistic needs and preferences of clients.

The Cigna National Network Development Team conducts an annual audit of provider availability by state/market. The audits are conducted utilizing available software such as GEO Access or Map Xtreme, using established standards to ensure a sufficient number of participating health care professionals and facilities.. The audit is conducted to ensure that Cigna and its companies are complying with the CO network adequacy requirements. The measurements used for CO are noted below and in Appendix A.

As required by CO regulations the following availability standards are followed:

Access to Service/Waiting Time Standards

Service Type	Time Frame	Time Frame Goal

Emergency Care – Medical, Behavioral, Substance Abuse	24 hours a day, 7 days a week	Met 100% of the time
Urgent Care – Medical, Behavioral, Mental Health and Substance Abuse	Within 24 hours	Met 100% of the time
Primary Care – Routine, non-urgent symptoms	Within 7 calendar days	Met > 90% of the time
Behavioral Health, Mental Health and Substance Abuse Care-Routine, non-urgent, non-emergency	Within 7 calendar days	Met> 90% of the time
Prenatal Care	Within 7 calendar days	Met> 90% of the time
Primary Care Access to after-hours care	Office number answered 24 hrs./7 days a week by answering service or instructions on how to reach a physician	Met> 90% of the time
Preventive visit/well visits	Within 30 calendar days	Met> 90% of the time
Specialty Care – non urgent	Within 60 calendar days	Met > 90% of the time

See Appendix A for information regarding Geographic Types and driving distance.

In remote or rural areas, occasionally these geographic availability guidelines are not able to be met due to lack of, or absence of, qualified providers and/or hospital facilities. Cigna may need to alter the standard based on local availability. Supporting documentation that such situation exists must be supplied along with the proposed guideline changes to the appropriate Quality Committee for approval.

Cigna Behavioral Health also has facility, clinic and individual practitioner contracting policies in place to help ensure adequate coverage for behavioral health needs.

Pharmacy – Cigna's plans offer several options for prescription drug benefits including multi-tiered programs with varying cost-share amounts. These tiered programs are designed to offer individuals the opportunity to choose quality medications at a low cost. The pharmacy network includes many local pharmacy locations, national chain locations as well as mail-order service.

In the event that Cigna determines that the network does not meet the adequacy requirements, Cigna's medical recruitment team (MRT) is engaged. The MRT makes phone call and/or sends e-mails to viable providers. A minimum of 3 attempts are made to the Provider. Any interested Provider is sent materials to allow the Provider to join the network.

Medical Services Accessibility

Accessibility to medical care is formally assessed against standards at least annually.

Accessibility standards for customers are as follows:

- Emergency: Immediately, 24 hours a day, 7 days a week
- Urgent: Within 24 hours* (Urgent medical needs are those that are not emergencies but require prompt medical attention, such as symptomatic illness and infections).
- Symptomatic Regular and Routine Care: 7-14 days, or within the timeframe specified by treating physician
- Preventive Screenings and Physical: Within 30 days
- Obstetric Prenatal Care**:**
  - High-risk or urgent: Immediately

- Non-high risk and non-urgent: 1st trimester, within 14 days; 2nd trimester, within 7 days, 3rd trimester, within 3 days

- Routine and Symptomatic Diagnostic Testing**:** Within the timeframe specified by treating health care professional. Appointments for symptomatic testing are usually provided in shorter timeframes than routine testing
- Afterhours care: Health Care Professional provides 24-hour coverage

Element 2 – Referral Policy

The CHC-CO HMO Network plans do require referrals and a customer must obtain a referral from his or her PCP before visiting any other provider in order for the visit to be covered. Referral for access to specialty care will be made in a timely manner. The referral authorizes the specific number of visits that the customer may make to a provider within a specified period of time. If treatment is received from a provider other than a PCP without a referral from a PCP, the treatment will not be covered and the customer will be responsible for paying 100% of the associated costs. Approved referrals can't be retrospectively denied except for fraud or abuse.

Approved referrals can't be changed after the preauthorization is provided unless there is evidence of fraud or abuse. Exceptions to the Referral process include: A female customer may receive covered obstetrical and gynecological services from a qualified participating provider without a PCP referral. A customer under age 19 may receive covered pediatric dental and pediatric vision services from a network dentist or network vision without a PCP referral. A PCP referral is not needed for emergency services. A referral can be expedited if the customer's medical condition warrants an expedited referral, by having the provider request the referral to be expedited.

In a case where CHC-CO has no participating providers to provide a covered benefit, CHC-CO will arrange for a referral to a provider with the necessary expertise and ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit was obtained from participating providers.

Referral options will not be restricted to less than all the providers in the network that are qualified to provide covered specialty services,

Emergency Care
In an emergency, customers should seek help immediately by calling 911 or their local emergency service, police or fire department for assistance. Customers may go to any emergency facility or hospital, even one that is not in their plan's network. Authorization is not needed for emergency care.

A PCP referral is not needed for emergency services, but a customer will need contact his or her PCP as soon as possible for further assistance and advice on follow-up care.

Choosing a Primary Care Physician
A customer must choose a primary care physician (PCP) at the time of enrollment for him or herself and any covered dependents. The Primary Care Physician selected by the customer may be different from the Primary Care Physician selected for each covered dependent. A customer selects the PCP from the comprehensive listing, which is available to customers and primary care providers of CHC-CO's network participating providers and facilities. This comprehensive listing is available online or via a paper copy. A customer can change their PCP selection by contacting Member Services at the number on the customer's ID card.

Prior Authorization for Inpatient and Outpatient Services

In order to be eligible for benefits, prior authorization is required for all non-emergency inpatient admissions, certain other admissions, and certain outpatient services. Failure to obtain prior

authorization prior to an elective admission to a hospital or certain other facility may result in a penalty or lack of coverage for the services provided. Prior Authorization can be obtained by the customer or provider by calling the number on the back of the customer's ID card. Emergency admissions will be reviewed post admission. Inpatient prior authorization reviews are conducted for both the necessity for the admission and the need for continued stay in the hospital. Outpatient Prior Authorization should only be requested for non-emergency procedures or services, at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

Element 3 – Ongoing Monitoring

Health Care Professional Availability and Accessibility monitoring is conducted on an ongoing basis and an analysis is performed annually to ensure that established standards for reasonable geographical location, number of practitioners, hours of operation, appointment availability, provision for emergency care and after hours services are measured. Monitoring activities may include evaluation of satisfaction surveys, on-site visits, evaluation of complaint and appeal reports, geo-access surveys, evaluation of health care professionals to member ratios, and monitoring of closed primary care physician panels. An assessment of the health care professional network is also performed to ensure that the network meets the cultural, ethnic, racial and linguistic needs and preferences of individuals. Specific deficiencies are addressed with a corrective action plan, and follow up activities are conducted to reassess compliance. Data are presented to the Service Advisory Committee for evaluation and recommendations.

Element 4 – Needs of Special Populations

Cigna, through its Customer Experience Organization's Cultural and Linguistics Unit and Health Disparities Council, is strongly committed to removing cultural and language barriers that have a profound impact on the delivery of health care to all demographics, especially minorities. Removing these barriers and reducing health disparities will ultimately improve the health, well-being and sense of security of all the individuals we serve.
The Health Disparities Council's objectives are as follows:

- To increase awareness of the critical impact of cultural and linguistic differences on health outcomes and to equip Cigna employees to deliver actionable information to a diverse population.
- To pilot strategies and interventions which may reduce disparities, ultimately reducing medical costs and improving health.
- To share, leverage, and collaborate on action plans to ensure Cigna is working on a unified approach which addresses individual health care needs.
- To partner with contracted physicians, hospitals, and other health professionals to address health disparities, as opportunities arise.

The commitment to addressing the cultural and linguistic needs of individuals is demonstrated through initiatives such as:

Training

- Cultural competency and clear communication training designed to increase the knowledge and skills of staff working with diverse individual populations.
- Regular meetings with medical management staff and health management employees to discuss cases that involve specific cultural issues.
- Making resources available to staff; e.g. cultural resource center and newsletters

Pilots

- Pilot project teams in partnership with network health care professionals, employer groups, communities, or other healthcare constituents to identify barriers to testing and treatment within certain at-risk sub-populations and develop actions/initiatives to remove those barriers. If successful, the pilot projects serve as blueprints for future programs.

Data Efforts

- Indirect measurement of race/ethnicity on Cigna customer base to compare with HEDIS measures in order to identify markets that offer the greatest opportunities to reduce disparities.
- Development of central repository of cultural and linguistic activities to be used as reference point for future activities.
- Tracking and trending language program service utilization.

Communication Efforts

- Implementation of clear health communication and translation policies addressing health literacy and the needs of limited English proficient individuals.
- Development of a central repository providing access to documents translated into non-English languages.
- Language proficiency testing for bilingual staff with direct customer contact.
- Employee Resource Group (ERG) efforts '1 training and using employee resource groups to improve the individual's experience, by informing culturally appropriate communications and interventions.
- Words We Use (Spanish and Traditional Chinese) Guidelines - guidelines for staff that offer everyday Spanish or Chinese words for health care jargon commonly used.
- Translation efforts - identifying translation needs from across the company.
- Facilitating cultural reviews and translation reviews of print and electronic customer messaging based on requests from business units across Cigna.
- Cigna HealthCare Directory audit - identifying gaps in reported language for physicians and office staff and reporting back to the HealthCare Directory Book of Records team.

Element 5 – Health Needs Assessment

Satisfaction is assessed through evaluation of survey data and complaint information. Satisfaction surveys are designed to assess satisfaction with the organization's services. Survey data are used for continuous quality improvement in several key areas: 1) to establish benchmarks and monitor national and local performance, 2) to assess overall levels of satisfaction as an indication of whether the organization is meeting individual expectations, 3) to assess service performance in comparison to competitors, 4) to assess medical management program individual and health care professional satisfaction levels and 5) to assess the quality and accuracy of benefit information provided on the organization(s) web sites.

Member Satisfaction

An assessment of satisfaction is performed at least annually. Results are summarized by individual market/region and nationally. These results are reviewed by the appropriate quality committee to identify areas for improvement. Action Plans are created accordingly based on findings. Case Management Satisfaction surveys, which include various specialty programs, are distributed upon closure of a case management case. Results are trended for evaluation against an internal benchmark/goal, at the program and national levels. Results are reviewed by the Medical Management Quality Committee, the Service Advisory Committee and the Quality Management Governing Body.

Element 6 – Communication with Members

To ensure that our customers fully utilize their health care benefits, Cigna provides each customer an enrollment packet that contains, among other things, a Summary of Benefits Coverage form (SBC) and a Colorado supplement to the SBC, a Certificate, and Participating Provider information. This information guides the customer through activities such as how to access covered services (including emergency and specialty care), benefits, and special programs and how to pursue an appeal of an adverse benefit decision. Information can also be accessed on Cigna's website at www.cigna.com or www.mycigna.com.

Grievance Procedures

The following is a Grievance/Appeals procedure overview. Customers should reference their Certificate for information which may be specific to their plan.

We hope that our customers never have any difficulty or problem with their Cigna coverage. However, if they do, we encourage them to voice their concerns so that we can correct the situation. If a customer has questions or concerns with health care benefits they should take the following actions:

Call Customer Services
Call Customer Services to explain the concern. A representative will try to resolve the situation then. At any time if a customer is not satisfied with the results of a coverage decision, the customer can start the appeals procedure. Expedited review is available for qualified issues.

Level One Appeal
To appeal an adverse benefit determination, the customer can submit an oral or written request to initiate the appeal, explaining why, according to the terms of their benefit plan, he or she believes the case should be reconsidered. For pre-service medical necessity appeals, the customer will receive a written response within 15 calendar days of receipt of the letter. For post-service appeals, the customer will receive a written response within 30 calendar days of receipt of the letter. If the customer remains dissatisfied, they may initiate a Level Two Appeal or pursue External Review.

Voluntary Level Two Appeal
If a customer is a member of a group and is still dissatisfied, they may initiate a voluntary Level Two Appeal, the customer needs to submit an oral or written request to Cigna in which the reasons why the original decision should be reversed are stated. All pertinent information should be included. For medical necessity appeals, the customer will have the opportunity to present their case at a hearing. For pre-service appeals, the review will be scheduled and held within 15 calendar days of receipt of the request. For post-service appeals, the review will be scheduled and held within 30 calendar days of receipt of the request. This will be the final Cigna administrative review of the case.

External Review

When a medical necessity denial has been upheld the customer is offered an external review by an Independent Review Organization. The Independent Review Organization is not connected in any way to Cigna and Cigna will abide by the decision of the Independent Review Organization. There is no charge to the customer for this process. To initiate an external review the customer must submit a written request to Cigna. To be eligible for this program, the customer must request the review within the time criteria specified in the determination letter.

Dependent upon the plan selected by you or your employer, specialty medical services, including physical therapy, occupational therapy and rehabilitation therapy could be available.

Element 7 – Coordination Activities

Medical Continuity and Coordination of Care
To facilitate continuous and appropriate care for individuals, and to strengthen industry-wide continuity and coordination of care among health care professionals, the quality program monitors, assesses, and may identify opportunities for individuals or health care professionals to take action and improve upon continuity and coordination of care across health care network settings and transitions in those settings. Assessment of continuity and coordination of care collaboration may include, but is not limited to, measurement of the following as demonstrated through the use of surveys, committee discussions reflected in

minutes, medical record review, and data analysis. Examples of monitoring may include:

- Exchange of information in an effective, timely and confidential manner.
- Notification and movement of individuals from a terminated practitioner.
- Monitoring of individuals who qualify for continued access to a practitioner terminated for other than quality reasons.
- Encouraging individuals to forward copies of their medical records to their new primary care physician when PCP changes are made.

Behavioral and Medical Continuity and Coordination of Care

To facilitate continuity and coordination of care for individuals among behavioral and medical health care professionals, Cigna, in collaboration with our behavioral health partners, fosters and supports programs which monitor continuity and coordination of behavioral care through assessment of one or more of the following:

- Appropriate communication between behavioral and medical practitioners.
- Appropriate health care professional screening, treatment and referral of behavioral health disorders commonly seen in primary care.
- Evaluation of the appropriate uses of psychopharmacological medications.
- Management of treatment access and follow-up for individuals with coexisting medical and behavioral health disorders.
- Implementation of a primary or secondary behavioral health preventive program.

Case Management Identification

The Utilization and Case Management programs identify consumers with potential or predictable risk for needing extensive services and coordination of care services. Referral sources include Medical Directors, matrix partners, such as claim administrators, clients, disease management, the Health Information Line, the Health Advisor Program, the individual/family/caregiver, health care professionals and through the use of internal predictive modeling tools. Cases identified for complex or specialty case management are screened for the potential for assistance and impact. Cases that require intensive coordination or education to achieve optimal medical outcome are accepted into the Case Management program.

Case Management Program Definition, Goals & Purpose

Cigna's case management program is collaborative in nature, delivered telephonically, and includes a process for assessment, planning, facilitation, coordination and advocacy for individuals enrolled in the program. The populations served by the program are individuals with complex medical needs beyond the scope of our short term, wellness, chronic condition support, or advocacy programs, or an individual with a diagnosis that falls within scope of one of the Specialty Case Management programs listed below. The overall goal of the program is to promote the achievement of optimal functional and medical outcomes and to help individuals avoid preventable hospital readmissions whenever possible. Over the past several years, multiple studies have shown that patients who understand and adhere to the treatment plan prescribed by their doctor experience a reduction in acute events and subsequent hospitalizations. The goals of Cigna's Case Managers include helping individuals achieve optimal clinical outcomes and avoid hospital readmissions whenever possible.

Case Management Process

The case manager collaboratively works with the individual, the treatment team and health care professionals. They advocate for the individual and the family, within the framework of available benefits and scope of the program delivery. This may include educating the individual and health care professionals on available benefit options to assist in maximizing available benefits, working to ensure access to appropriate services, providing clinical education to enhance the individual’s understanding and management of their clinical situation and completing assessments to evaluate and ensure consumer safety.

The case management process includes:

- An introduction, disclosure, and consent process, including education on the individual’s

rights under case management.

- A comprehensive initial assessment that includes health status, clinical and medication history, activities of daily living, mental status/cognitive functions, life planning activities, cultural/linguistic needs, preferences or limitations, caregiver resources and available benefits.
- During their initial (and subsequent) assessments, Cigna's case managers use evidence-based assessment tools to address the following topics, all of which are significant in helping to avoid readmissions:
    - Confirmation that the individual has a follow-up appointment scheduled with his or her doctor within two weeks of discharge.
    - Helping the individual understand and recognize the signs and symptoms that need attention and what to do if any of these occurs and document in a written self-management plan or ”sick-day” plan.
    - Medication reconciliation that includes confirmation of medication compliance – prescribed medications have been filled and the individual is taking them strictly according to directions
    - Validation that any required DME or home health services are in place.
    - Identification of the root cause(s) that may lead to readmission so that the case manager can work to alleviate it/them.
- Development of a management plan with patient centric, prioritized, measurable goals in collaboration with individual, family, and the individual’s treatment team.
- Identification of potential barriers to the plan.
- Confirmation and communication of the management with the individual, caregiver, family, the treatment team or other health care professionals.
- Follow-up scheduling to enable monitoring of the individual’s medical, safety, and educational needs.
- Periodic evaluation of barriers to achievement of the management plan goals and update, as needed.
- Coordination/facilitation of referral, care and/or services required by the individual, within the scope of the benefit plan and/or contractual agreement with the client.
- Closure of file when the individual’s management plan goals have been achieved or the individual is no longer eligible to receive services, and initiate communication to the appropriate parties to ensure continuity of care.
- Generation of a program satisfaction survey.

Specialty Case Management

Case managers with special expertise and training in a therapeutic area deliver specialty case management services. They work collaboratively with specialty physician leads as a team to enhance care coordination, address gaps in care and help individuals be informed, active participants in the health care process. These specialized resources adhere to the same case management process noted above, and focus on high impact conditions that have proven to be at risk for complications and subsequent high health care utilization. The specialized team goals are to facilitate access to appropriate services in order to improve the medical outcomes for these individuals, and, thereby, decrease utilization and cost. Specialty Case Management Services are available depending upon contract terms and may include the following specialties:

- Transplant
- Neonate
- Oncology
- High Risk Maternity

Facilitation of Care When Benefits are Exhausted

Facilitation of care is available to assist customers in exploring alternative treatment and/or funding options when a benefit limitation and/or a maximum have been reached. The case manager assists the customer in exploring alternative options. The case manager is available to assist the customer/responsible party in identifying alternative government and community services and/or funding resources for customers who have or will exhaust available benefits.

Agency phone numbers, addresses and applications are provided as appropriate.

Element 8 – Continuity of Care

In the event a health care professional terminates from the Cigna network, Cigna strives to ensure that Affected Individuals are notified of the termination and assisted with continuing or transitioning their care. “Affected Individuals” are defined as individuals who have made one (1) or more visits to a specialty health care professional in the last twelve (12) months, in the case of a Specialist termination or an individual who has a PCP enrollment number, in the case of a PCP termination. Cigna has a mechanism in place to:

- Notify affected Individuals when a specialty health care professional or PCP is leaving the network.
- Ensure continuity of care for individuals undergoing an active course of medical treatment for an acute/chronic condition, or for individuals who are in their second or third trimester of pregnancy, when the health care professional they have been seeing is leaving the network, without compromising care. This includes individuals associated with: all primary care health care professionals, OB/GYNs and specialty health care professionals.

Cigna utilizes a standard set of system-generated letters to notify Affected Individuals that the health care professional they have seen will no longer be participating with Cigna. The appropriate letter indicates that the Affected Individuals may be able to continue to receive care from this health care professional for a defined period of time if they meet certain criteria.

Colorado law requires that coverage be extended at least 60 calendar days from the date the participating provider is terminated from the plan. For members within an inpatient facility coverage will be extended until discharge from the inpatient facility. The letter informs Affected Individuals how to obtain a Continuity of Care Request Form for their health care professional and how to complete and return the form to the Health Facilitation Center. The time frame for notification to the Affected Individual is based on state-specific mandates. If a specific state does not have a requirement, the Cigna standard is to notify the Affected Individual at least 30 calendar days prior to the termination date. Colorado law requires notification within 15 business days after receipt of or issuance of a notice of termination to all members that are patients seen on a regular basis by the terminating provider. The Colorado notice must be provided regardless of whether the termination was for cause or without cause.

Continuity of Care Services are authorized by the Health Facilitation Centers for Affected Individuals for a specified, limited period of time. Continuity of Care services will be covered until active treatment for the acute condition has been completed or transitioned to a participating health care professional, or for up to 90 days (longer if mandated by the state), whichever comes first. For pregnancies, authorizations for treatment through the post-partum period (6 weeks post-delivery or longer as mandated by the state) will be allowed.

Cigna provider contracts include a provision that either party may terminate the agreement with proper notice and that either party can immediately terminate the agreement if the other becomes insolvent. The provider contracts also include provisions regarding a provider’s obligation to continue services after termination in some circumstances. The provider contracts also include limitations on billing participants. As required by Colorado law, every contract between Cigna and a participating provider sets forth a hold harmless provision specifying that a covered person shall, in no circumstances, be liable for money owed to participating providers by the plan and that in no event a participating provider collect or attempt to collect from a covered person any money owed to the provider by Cigna.

Geographic Type

Specialty	Large Metro Max. Distance (miles)	Metro Max. Distance (miles)	Micro Max. Distance (miles)	Rural Max. Distance (miles)	CEAC Max. Distance (miles)
Primary Care	5	10	20	30	60
Gynecology, OB/GYN	5	10	20	30	60
Pediatrics - Routine/Primary Care	5	10	20	30	60
Allergy and Immunology	15	30	60	75	110
Cardiothoracic Surgery	15	40	75	90	130
Cardiovascular Disease	10	20	35	60	85
Chiropracty	15	30	60	75	110
Dermatology	10	30	45	60	100
Endocrinology	15	40	75	90	130
ENT/Otolaryngology	15	30	60	75	110
Gastroenterology	10	30	45	60	100
General Surgery	10	20	35	60	85
Gynecology only	15	30	60	75	110
Infectious Diseases	15	40	75	90	130
Licensed Clinical Social Worker	10	30	45	60	100
Nephrology	15	30	60	75	110
Neurology	10	30	45	60	100
Neurological Surgery	15	40	75	90	130
Oncology - Medical, Surgical	10	30	45	60	100
Oncology - Radiation/Radiation Oncology	15	40	75	90	130
Ophthalmology	10	20	35	60	85
Orthopedic Surgery	10	20	35	60	85
Physiatry, Rehabilitative Medicine	15	30	60	75	110
Plastic Surgery	15	40	75	90	130
Podiatry	10	30	45	60	100
Psychiatry	10	30	45	60	100
Psychology	10	30	45	60	100
Pulmonology	10	30	45	60	100
Rheumatology	15	40	75	90	130
Urology	10	30	45	60	100
Vascular Surgery	15	40	75	90	130
OTHER MEDICAL PROVIDER	15	40	75	90	130
Dental	15	30	60	75	110
Pharmacy	15	30	60	75	110
Acute Inpatient Hospitals	10	30	60	60	100
Cardiac Surgery Program	15	40	120	120	140
Cardiac Catheterization Services	15	40	120	120	140

Critical Care Services – Intensive Care Units (ICU)	10	30	120	120	140
Outpatient Dialysis	10	30	50	50	90
Surgical Services (Outpatient or ASC)	10	30	60	60	100
Skilled Nursing Facilities	10	30	60	60	85
Diagnostic Radiology	10	30	60	60	100
Mammography	10	30	60	60	100
Physical Therapy	10	30	60	60	100
Occupational Therapy	10	30	60	60	100
Speech Therapy	10	30	60	60	100
Inpatient Psychiatric Facility	15	45	75	75	140
Orthotics and Prosthetics	15	30	120	120	140
Outpatient Infusion/Chemotherapy	10	30	60	60	100
OTHER FACILITIES	15	40	120	120	140
Vision - Ophthalmology	10	20	35	60	85
Vision - Optometry	10	20	35	60	85
Vision - Other Providers	10	20	35	60	85

COLORADO COUNTY DESIGNATIONS

County	Classification	County	Classification
Adams	Metro	Kit Carson	CEAC
Alamosa	Rural	Lake	Rural
Arapahoe	Metro	La Plata	Micro
Archuleta	CEAC	Larimer	Metro
Baca	CEAC	Las Animas	CEAC
Bent	CEAC	Lincoln	CEAC
Boulder	Metro	Logan	Rural
Broomfield	Metro	Mesa	Micro
Chaffee	Rural	Mineral	CEAC
Cheyenne	CEAC	Moffat	CEAC
Clear Creek	Rural	Montezuma	Rural
Conejos	CEAC	Montrose	Rural
Costilla	CEAC	Morgan	Rural
Crowley	CEAC	Otero	Rural
Custer	CEAC	Ouray	CEAC
Delta	Rural	Park	CEAC
Denver	Large Metro	Phillips	CEAC
Dolores	CEAC	Pitkin	Rural
Douglas	Metro	Prowers	CEAC
Eagle	Micro	Pueblo	Micro
Elbert	Rural	Rio Blanco	CEAC
El Paso	Metro	Rio Grande	Rural
Fremont	Rural	Routt	CEAC
Garfield	Micro	Saguache	CEAC
Gilpin	Rural	San Juan	CEAC
Grand	CEAC	San Miguel	CEAC
Gunnison	CEAC	Sedgwick	CEAC
Hinsdale	CEAC	Summit	Rural
Huerfano	CEAC	Teller	Rural
Jackson	CEAC	Washington	CEAC
Jefferson	Metro	Weld	Metro
Kiowa	CEAC	Yuma	CEAC