Cigna HealthCare of Colorado, Inc.
Health Maintenance 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 Maintenance 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 Evernorth 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. MDLive is available for Cigna customers for services available through telehealth. MDLive is Cigna's Telehealth (Virtual) Services Vendor. MDLive provides whole-person virtual care solutions for our customers. MDLive can be contacted through mycigna.com: Via the Virtual Care/ Telehealth Connection Page, through the myCigna app or by phone at 1(888)-MDCARE 8 or 1 (888) 632-2738.

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 customers.
- 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 analysis of provider availability by state/market/product. The analysis is conducted utilizing available software such as Quest Analytics, using established standards to ensure a sufficient number of participating health care professionals and facilities are available within Colorado's time and distance standards. The analysis 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:

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.

Evernorth 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

- o 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 or through the customer's myCigna account.
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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.

You do not need Prior Authorization from the plan or from any other person (including your Primary Care Physician) in order to obtain access to obstetrical or gynecological care from a health care professional in Our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact Customer Service at the phone number listed on the back of your ID card.

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 is 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 √ 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.
- If you have a hearing or speech loss and use Telecommunications Relay Services (TRS) or a Text Telephone (TTY), dial 711 to connect with a TRS operator.
- We expect our contracted providers to meet all applicable federal requirements for accessibility as specified in the Americans with Disabilities Act (ADA) and its regulations. In general, the ADA requires that health care providers offer individuals with disabilities full and equal access to their health care services and facilities, however there can be some exceptions. In order to ensure a provider's location meets your own access needs please contact that provider directly before scheduling an appointment to obtain care.

Cigna provides covered persons access to professional interpretation services in a timely manner, free of charge and are available to covered persons on a 24-hour basis for emergency care. The range of interpreter services allow for appropriate use for the particular point of contact and appointment type. Language services are provided by Cigna Customer Services Spanish queues, which have bilingual staff who have passed formal language proficiency testing or through contracted vendor telephonic interpreter staff that have been formally tested for proficiency.

Interpretation services are provided in all languages including sign language and TTY, and at all provider points of contact (including but not limited to physician offices, hospitals, labs, radiology centers, physical therapy offices, pharmacy services) as well as all Cigna administrative points including but not limited to customer services (operations 24 hours a day/7 days a week).

Through vendor contracts, Cigna coordinates face-to-face interpreter services, including sign language, free of charge to covered persons in the health care setting. Face-to-face interpreter services follow the same standards as that of telephonic with the adjusted scheduling timeframes of within 3 days for Spanish and 5 days for all other languages to include Sign Language. Cigna will make every attempt to accommodate emergency circumstances. Video Remote Interpreter (VRI) Services are available to accommodate language assistance service needs to include emergency circumstances.

Covered Persons may access significant documents by calling the number on their Identification Card or the number listed on the taglines. The covered person may request an oral translation and/or written translation of a significant document. Oral translations are provided immediately, with the assistance of a telephonic interpreter, if needed. Written translations of significant documents are sent within 21 calendar days of covered person's request. In addition, Summaries of Benefits and Coverage (SBC) are sent within 7 business days of covered person's request to comply with federal guidelines. In total, Cigna covers 33 languages which includes Braille as well as Audio and Language Print under its translations services.

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, Complaint and Appeal Process
For the purposes of this section, any reference to Insured Person also refers to a representative or Provider designated by the Insured Person to act on the Insured Person's behalf, unless otherwise noted.

Cigna wants the Insured Person to be completely satisfied with the coverage received. That is why Cigna established a process for addressing the Insured Person's concerns and resolving problems.

Start with Customer Service

Cigna is here to listen and help. If the Insured Person has a concern regarding a person, a service, the quality of care, contractual benefits, an initial eligibility denial or a rescission of coverage, the Insured Person can call Our toll-free number and explain the concern to one of Our Customer Service representatives. Please call Cigna at the Customer Service Toll-Free Number that appears on the Benefit Identification card, explanation of benefits or claim form.

Cigna will do their best to resolve the matter on the Insured Person's initial contact. If Cigna needs more time to review or investigate the concern, Cigna will get back to the Insured Person as soon as possible, but in any case within 30 days.

If the Insured Person is not satisfied with the results of a coverage decision, the Insured Person can start the appeals procedure.

Appeals Procedure

To initiate an appeal, the Insured Person must submit a request for an appeal in writing within 365 days of receipt of a denial notice to the following address:

[Cigna National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422]

The Insured Person should state the reason why the Insured Person feels the appeal should be approved and include any information supporting the appeal. If the Insured Person is unable or chooses not to write, the Insured Person may ask to register the appeal by telephone. The Insured Person may call Cigna at the toll-free number on their Benefit Identification card, explanation of benefits or claim form. The Insured Person may also register the appeal by an arranged appointment or walk-in interview.

Colorado law provides one level of appeals for internal appeals of an adverse determination. Adverse determination means:

- A denial of a preauthorization for a covered benefit;
- A denial of a request for benefits for an individual on the ground that the treatment or covered benefit is not medically necessary, appropriate, effective, or efficient or is not provided in or at the appropriate health care setting or level of care;
- A rescission or cancellation of coverage under a health coverage plan that is not attributable to failure to pay premiums and that is applied retroactively;
- A denial of a request for benefits on the ground that the treatment or service is experimental or investigational; or
- A denial of coverage to an individual based on an initial eligibility determination.

Requests for appeal regarding an adverse determination of the Insured Person’s issue will be conducted by a committee, if the Insured Person chooses, which consists of one or more people not previously involved in the prior decision. The Committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by Cigna’s Physician reviewer. For all other coverage plan-related appeals, a review will be conducted by someone who was a) not involved in any previous decision related to the Insured Person’s appeal, and b) not a subordinate of previous decision makers.

The Insured Person has the following rights: (1) to attend the Committee review in person, or via teleconference or video conference; (2) to present their situation to the Committee in person or in writing; (3) to submit supporting material both before and at the Committee review; (4) to ask questions of any Cigna representative prior to the review; and (5) to question any reviewer at the review; and (6) to be assisted or represented by a person of their choice.

For required medical necessity pre-service and concurrent care coverage determinations and post-service claims, the review will be completed within 30 calendar days. For administrative pre-service and concurrent care coverage determinations, the review will be completed within 30 calendar days. For administrative post-service claims the review will be completed within 60 calendar days. If more time or information is needed to make the determination, Cigna will notify the Insured Person in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the appeal, Cigna will provide this information to the Insured Person as soon as possible and sufficiently in advance of the decision, so that the Insured Person will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to the Insured Person as soon as possible and sufficiently in advance of the decision so that the Insured Person will have an opportunity to respond.

The Insured Person will be notified in writing of the decision within the following timeframes:
Medical Necessity reviews:

Pre-Service & Post-Service requests – the earlier of (a) 7 calendar days of the decision or (b) 30 calendar days of receipt of the pre-service request.

Administrative reviews:
Pre-Service – the earlier of (a) 7 calendar days of the decision or (b) 30 calendar days of receipt of the pre-service request.
Post-Service – the earlier of (a) 7 calendar days of the decision or (b) 60 calendar days of the receipt of the post-service request.

The Insured Person may request that the appeal process be expedited if the time frames under this process: (a) would seriously jeopardize the Insured Person's life, health or ability to regain maximum function or, in the opinion of your Physician would cause severe pain which cannot be managed without the requested services; or (b) the appeal involves non-authorization of an admission or continuing inpatient Hospital stay. If the Insured Person requests that the appeal be expedited based on (a) above, the Insured Person may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited internal appeal would be detrimental to the Insured Person's medical condition.

A Cigna Professional will determine if the appeal meets the criteria for processing as an expedited/urgent appeal. Cigna's Physician reviewer will have the same or similar specialty as the care under consideration to make a decision. When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.

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.

Evaluation of Efforts to Create a Culturally Responsive Network

Cigna has internal policies and procedures in place to ensure appropriate availability of all provider types including primary and perinatal care as well as MHSUD providers and facilities.

Cigna contracts with providers and facilities across all networks and all product lines to meet the availability and cultural needs and preferences of our customers. Cigna establishes availability standards and assesses its network against those standards on at least an annual basis. Additionally, customer complaints and out-of-network utilization are monitored to help inform where network gaps may exist.

In any event where an in-network provider or facility is not available to meet the customer's needs, Cigna has internal policies and procedures in place to evaluate requests for accessing care out of network at an in network benefit level.

Cigna complies with CO network adequacy regulations and meets all of the provider to customer ratio and mileage standards for primary, perinatal and behavioral health care.

Geographic Type
(Appendix A)

Specialty	Large Metro	Metro	Micro	Rural	CEAC
	Maximum Distance (miles)	**Maximum Distance** (miles)	**Maximum Distance** (miles)	**Maximum Distance** (miles)	**Maximum 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
Cardiology	10	20	35	60	85
Certified Nurse Midwives	5	10	20	30	60
Chiropractor	15	30	60	75	110
Dermatology	10	30	45	60	100
Emergency Medicine	10	30	60	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 Addiction Counselor	10	30	45	60	100
Licensed Clinical Social Worker	10	30	45	60	100
Nephrology	15	30	60	75	110
Neurology	10	30	45	60	100
Neurosurgery	15	40	75	90	130
Oncology - Medical, Surgical	10	30	45	60	100
Oncology - Radiation	15	40	75	90	130
Ophthalmology	10	20	35	60	85
Optometry for routine pediatric vision services	15	30	60	75	110
Orthopedic Surgery	10	20	35	60	85
Outpatient Clinical Behavioral Health (Licensed, accredited, or certified professionals)	5	10	20	30	60
Physical Medicine and 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
Dentist	15	30	60	75	110
Pharmacy	5	10	20	30	60
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 and Residential Behavioral Health Facility Services	15	45	75	75	140
Orthotics and Prosthetics	15	30	120	120	140
Outpatient Infusion/Chemotherapy	10	30	60	60	100
Urgent Care Facilities	10	30	60	60	100
Opioid Treatment Program	10	30	60	60	100
OTHER FACILITIES	15	40	120	120	140

COLORADOCOUNTY DESIGNATIONS

County	Classification	County	Classification
Adams	Metro	Kit Carson	CEAC
Alamosa	Rural	Lake	Rural
Arapahoe	Metro	La Plata	Micro
Archuleta	Rural	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	Rural
Garfield	Micro	Saguache	CEAC
Gilpin	Rural	San Juan	CEAC
Grand	CEAC	San Miguel	CEAC
Gunnison	CEAC	Sedgwick	CEAC
Hinsdale	CEAC	**Summit**	**Micro**
Huerfano	CEAC	Teller	Rural
Jackson	CEAC	Washington	CEAC
Jefferson	Metro	Weld	Metro
Kiowa	CEAC	Yuma	CEAC