COLORADO HEALTH PLAN DESCRIPTION FORM
Connecticut General Life Insurance Company
2012 OPEN ACCESS VALUE PLANS FOR INDIVIDUALS and FAMILIES

This plan is intended to comply with the federal Patient Protection and Affordable Care Act. Provisions are subject to change as additional regulatory guidance becomes available.

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred Provider Plans.
2. OUT-OF-NETWORK CARE COVERED? [1]	Yes, but patient pays more for out-of-network care.
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plans are available throughout Colorado.

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses, or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified providers or facilities). Consult the actual policy to determine the exact terms and conditions of coverage. Coinsurance and copayment options reflect the amount the covered person will pay.

	IN-NETWORK		**OUT-OF-NETWORK**	
4. DEDUCTIBLE TYPE [2]	Calendar year		Calendar year	
4a. ANNUAL DEDUCTIBLE [2a] *(All benefits listed below are subject to the deductible unless otherwise note; Annual Deductible does not apply to out-of-pocket maximum.)*	Individual [2b]	Family [2c]	Individual [2b]	Family [2c]
Open Access Value 1500/70%	$1,500	$4,500	$4,500	$13,500
Open Access Value 2500/70%	$2,500	$7,500	$7,500	$22,500
Open Access Value 3000/70%	$3,000	$9,000	$9,000	$27,000
Open Access Value 5000/70%	$5,000	$15,000	$15,000	$45,000
Open Access Value 7500/70%	$7,500	$22,500	$15,000	$45,000
Open Access Value 10,000/70%	$10,000	$30,000	$15,000	$45,000
Open Access Value 5000/100%	$5,000	$15,000	$15,000	$45,000
5. OUT-OF-POCKET ANNUAL MAXIMUM [3] *(Copays, deductibles and pharmacy charges do NOT apply to out-of-pocket maximum.)*				
Open Access Value 1500/70%	$3,000	$10,000	$15,000	$20,000
Open Access Value 2500/70%	$5,000	$10,000	$15,000	$20,000
Open Access Value 3000/70%	$5,000	$10,000	$15,000	$20,000
Open Access Value 5000/70%	$5,000	$10,000	$15,000	$20,000
Open Access Value 7500/70%	$5,000	$10,000	$15,000	$20,000
Open Access Value 10,000/70%	$5,000	$10,000	$15,000	$20,000
Open Access Value 5000/100%	$0	$0	$15,000	$20,000
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN	Unlimited			

	IN-NETWORK	OUT-OF-NETWORK
FOR ALL CARE		
7a. COVERED PROVIDERS	Connecticut General Life Insurance Company PPO Network. See provider directory for complete list of current providers.	All providers licensed or certified to provide covered benefits.
7b. With respect to network plans, are all the providers listed in 7a. accessible to me through my primary care physician?	Yes	Not applicable
8. ROUTINE MEDICAL OFFICE VISITS [4] a) Primary Care Providers Open Access Value 1500/70% Open Access Value 2500/70% Open Access Value 3000/70% Open Access Value 5000/70% Open Access Value 7500/70% Open Access Value 5000/100%	$40 copay (*does not apply to out-of-pocket maximum)*	50% coinsurance
Open Access Value 10,000/70%	30% coinsurance	50% coinsurance
b) Specialists Open Access Value 1500/70% Open Access Value 2500/70% Open Access Value 3000/70% Open Access Value 5000/70% Open Access Value 7500/70% Open Access Value 5000/100%	$60 copay (*does not apply to out-of-pocket maximum)*	50% coinsurance
Open Access Value 10,000/70%	30% coinsurance	50% coinsurance
9. PREVENTIVE CARE a) Adult and Children's services *(Includes routine physicals and other routine preventive services.)*	Plan pays 100% (deductible waived)	Plan pays 100% (deductible waived)

	IN-NETWORK	OUT-OF-NETWORK
10. MATERNITY		
a) Pre-natal care		
Open Access Value 1500/70% Open Access Value 2500/70% Open Access Value 3000/70% Open Access Value 5000/70% Open Access Value 7500/70% Open Access Value 10,000/70%	30% coinsurance	50% coinsurance
Open Access Value 5000/100%	0% coinsurance	50% coinsurance
b) Delivery & inpatient well-baby care [5]		
Open Access Value 1500/70% Open Access Value 2500/70% Open Access Value 3000/70% Open Access Value 5000/70% Open Access Value 7500/70% Open Access Value 10,000/70%	$500 additional deductible per admission, *(does not apply to out-of-pocket maximum),* 30% coinsurance	$1,000 additional deductible per admission, *(does not apply to out-of-pocket maximum),*50% coinsurance
Open Access Value 5000/100%	$500 additional deductible per admission, *(does not apply to out-of-pocket maximum),* 0% coinsurance	$1,000 additional deductible per admission, *(does not apply to out-of-pocket maximum),*50% coinsurance
11. PRESCRIPTION DRUGS [6] *(Pharmacy charges do not apply to out-of-pocket maximum.)*	*Members must show Cigna ID card when filling prescriptions at both in- and out-of-network pharmacies. For drugs on the Cigna-approved list, contact Member Services at 1-800-244-6224.*	
Brand Name Drug Deductible *(Combined in- and out-of-network, this is a separate deductible from the Annual Deductible amount and does not apply to out-of-pocket maximum.)*		
Open Access Value 1500/70% Open Access Value 2500/70% Open Access Value 3000/70% Open Access Value 5000/70% Open Access Value 7500/70% Open Access Value 10,000/70% Open Access Value 5000/100%	$500 $500 $500 $500 $500 $500 $500	
Preventive Drugs Preventive Drugs designated by the Patient Protection and Affordable Care Act of 2010	Plan pays 100% (deductible waived)	50% coinsurance
Generic (except as noted under Preventive Drugs) (30-day supply)	$15 copay	50% coinsurance
Brand (30-day supply)	$40 copay *(subject to brand name drug deductible)*	50% coinsurance
Non-preferred (30-day supply)	$65 copay *(subject to brand name drug deductible)*	50% coinsurance
Self Injectable	30% coinsurance	50% coinsurance
Mail Order Drugs *(90-day supply)*		

	IN-NETWORK	OUT-OF-NETWORK
Preventive Drugs Preventive Drugs designated by the Patient Protection and Affordable Care Act of 2010	Plan pays 100% (deductible waived)	Not available
Generic(except as noted under Preventive Drugs)	$40 copay	Not available
Brand	$100 copay (*subject to brand name drug deductible)*	Not available
Non-preferred	$165 copay *(subject to brand name drug deductible)*	Not available
Self Injectable	30% coinsurance	Not available
12. INPATIENT HOSPITAL Open Access Value 1500/70% Open Access Value 2500/70% Open Access Value 3000/70% Open Access Value 5000/70% Open Access Value 7500/70% Open Access Value 10,000/70%	$500 additional deductible per admission, *(does not apply to out-of-pocket maximum),* 30% coinsurance	$1,000 additional deductible per admission, *(does not apply to out-of-pocket maximum),* 50% coinsurance
Open Access Value 5000/100%	$500 additional deductible per admission, *(does not apply to out-of-pocket maximum),* 0% coinsurance	$1,000 additional deductible per admission, *(does not apply to out-of-pocket maximum),* 50% coinsurance
13. OUTPATIENT/AMBULATORY SURGERY Open Access Value 1500/70% Open Access Value 2500/70% Open Access Value 3000/70% Open Access Value 5000/70% Open Access Value 7500/70% Open Access Value 10,000/70%	30% coinsurance	50% coinsurance
Open Access Value 5000/100%	0% coinsurance	50% coinsurance
14. DIAGNOSTICS a) Laboratory & X-ray Open Access Value 1500/70% Open Access Value 2500/70% Open Access Value 3000/70% Open Access Value 5000/70% Open Access Value 7500/70% Open Access Value 10,000/70%	30% coinsurance *(in any setting)*	50% coinsurance *(in any setting)*
Open Access Value 5000/100%	0% coinsurance *(in any setting)*	50% coinsurance *(in any setting)*
b) MRI, nuclear medicine, CT, CTA, MRA, and PET scans Open Access Value 1500/70% Open Access Value 2500/70% Open Access Value 3000/70% Open Access Value 5000/70% Open Access Value 7500/70% Open Access Value 10,000/70%	30% coinsurance *(in any setting)*	50% coinsurance *(in any setting)*
Open Access Value 5000/100%	0% coinsurance *(in any setting)*	50% coinsurance *(in any setting)*

	IN-NETWORK	OUT-OF-NETWORK
15. EMERGENCY CARE [7] Open Access Value 1500/70% Open Access Value 2500/70% Open Access Value 3000/70% Open Access Value 5000/70% Open Access Value 7500/70% Open Access Value 10,000/70% Open Access Value 5000/100%	$200Access Fee, waived if admitted, per visit (*does not apply to out-of-pocket maximum)*, then 30% coinsurance $200Access Fee, waived if admitted, per visit (*does not apply to out-of-pocket maximum)*, then 0% coinsurance	In-network benefit level for an Emergency Medical Condition, otherwise $200 Access Fee, waived if admitted, per visit (*does not apply to out-of-pocket maximum)*, then 50% coinsurance In-network benefit level for an Emergency Medical Condition, otherwise $200 Access Fee, waived if admitted, per visit (*does not apply t out-of-pocket maximum)*, then 50% coinsurance
16. AMBULANCE *(Emergency transport only.)* Open Access Value 1500/70% Open Access Value 2500/70% Open Access Value 3000/70% Open Access Value 5000/70% Open Access Value 7500/70% Open Access Value 10,000/70% Open Access Value 5000/100%	30% coinsurance 0% coinsurance	In-network benefit level for an Emergency Medical Condition, otherwise 50% coinsurance In-network benefit level for an Emergency Medical Condition, otherwise 50% coinsurance
17. URGENT, NON-ROUTINE, AFTER HOURS CARE Open Access Value 1500/70% Open Access Value 2500/70% Open Access Value 3000/70% Open Access Value 5000/70% Open Access Value 7500/70% Open Access Value 10,000/70% Open Access Value 5000/100%	30% coinsurance 0% coinsurance	In-network benefit level for an Emergency Medical Condition, otherwise 50% coinsurance In-network benefit level for an Emergency Medical Condition, otherwise 50% coinsurance
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE [8]	Not Covered	
19. OTHER MENTAL HEALTH CARE a) Inpatient Care b) Outpatient Care	Not Covered Not Covered	Not Covered Not Covered
20. ALCOHOL & SUBSTANCE ABUSE	Not Covered	
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY Open Access Value 1500/70% Open Access Value 2500/70% Open Access Value 3000/70% Open Access Value 5000/70% Open Access Value 7500/70%	30% coinsurance	50% coinsurance

	IN-NETWORK	OUT-OF-NETWORK
Open Access Value 10,000/70% Open Access Value 5000/100% *(Maximum 12 visits per person, per year, in-and out-of-network combined, all services combined.)*	0% coinsurance	50% coinsurance
22. DURABLE MEDICAL EQUIPMENT Open Access Value 1500/70% Open Access Value 2500/70% Open Access Value 3000/70% Open Access Value 5000/70% Open Access Value 7500/70% Open Access Value 10,000/70% Open Access Value 5000/100%	30% coinsurance *(in any setting)* 0% coinsurance *(in any setting)*	50% coinsurance *(in any setting)* 50% coinsurance *(in any setting)*
23. OXYGEN	Included under Durable Medical Equipment.	
24. ORGAN TRANSPLANTS *(Prior authorization required. Covered transplants include: liver, heart, heart/lung, lung, kidney, kidney/pancreas other single and multi-organ transplants, and autologous and allogenic bone marrow, peripheral stem cell transplant and similar procedures.)* Open Access Value 1500/70% Open Access Value 2500/70% Open Access Value 3000/70% Open Access Value 5000/70% Open Access Value 7500/70% Open Access Value 10,000/70% Open Access Value 5000/100%	Cigna Lifesource® Transplant Network Facility Plan pays 100% plus $10,000 travel benefit per person, per lifetime Non-Lifesource® in-network facility 30% coinsurance, travel benefit excluded Cigna Lifesource® Transplant Network Facility Plan pays 100% plus $10,000 travel benefit per person, per lifetime Non-Lifesource® in-network facility Plan pays 100%, travel benefit excluded	Not covered Not covered
25. HOME HEALTH CARE Open Access Value 1500/70% Open Access Value 2500/70% Open Access Value 3000/70% Open Access Value 5000/70% Open Access Value 7500/70% Open Access Value 10,000/70% Open Access Value 5000/100% *(Maximum 60 visits per person, per year, in- and out-of-network combined.)*	30% coinsurance 0% coinsurance	50% coinsurance 50% coinsurance
26. HOSPICE CARE a) Routine Home Care		

	IN-NETWORK	OUT-OF-NETWORK
Open Access Value 1500/70% Open Access Value 2500/70% Open Access Value 3000/70% Open Access Value 5000/70% Open Access Value 7500/70% Open Access Value 10,000/70%	30% coinsurance	50% coinsurance
Open Access Value 5000/100%	0% coinsurance	50% coinsurance
b) Bereavement Services Open Access Value 1500/70% Open Access Value 2500/70% Open Access Value 3000/70% Open Access Value 5000/70% Open Access Value 7500/70% Open Access Value 10,000/70%	30% coinsurance	50% coinsurance
Open Access Value 5000/100%	0% coinsurance	50% coinsurance
c) All other Hospice Services Open Access Value 1500/70% Open Access Value 2500/70% Open Access Value 3000/70% Open Access Value 5000/70% Open Access Value 7500/70% Open Access Value 10,000/70%	30% coinsurance	50% coinsurance
Open Access Value 5000/100%	0% coinsurance	50% coinsurance
27. SKILLED NURSING FACILITY CARE Open Access Value 1500/70% Open Access Value 2500/70% Open Access Value 3000/70% Open Access Value 5000/70% Open Access Value 7500/70% Open Access Value 10,000/70%	30% coinsurance	50% coinsurance
Open Access Value 5000/100% *(Maximum 30-days per person, per year, in-and out-of-network combined.)*	0% coinsurance	50% coinsurance
28. DENTAL CARE Open Access Value 1500/70% Open Access Value 2500/70% Open Access Value 3000/70% Open Access Value 5000/70% Open Access Value 7500/70% Open Access Value 10,000/70% Open Access Value 5000/100%	Not covered	
Open Access Value 1500/70% Open Access Value 2500/70%	*Hospitalization for dental procedures for minors ONLY*	

	IN-NETWORK	OUT-OF-NETWORK
Open Access Value 3000/70% Open Access Value 5000/70% Open Access Value 7500/70% Open Access Value 10,000/70%	*covered at 30% coinsurance in-network and 50% coinsurance out-of-network.*	
Open Access Value 5000/100%	*Hospitalization for dental procedures for minors ONLY* *covered at 0% coinsurance in-network and 50% coinsurance out-of-network.*	
29. VISION CARE	Not covered	
30. CHIROPRACTIC CARE	Included in Physical, Occupational and Speech Therapy benefit listed above: #21.	
31. SIGNIFICANT ADDITIONAL COVERED SERVICES 1) Cardio Pulmonary Rehabilitation Open Access Value 1500/70% Open Access Value 2500/70% Open Access Value 3000/70% Open Access Value 5000/70% Open Access Value 7500/70% Open Access Value 10,000/70%	30% coinsurance	50% coinsurance
Open Access Value 5000/100%	0% coinsurance	50% coinsurance

PART C: LIMITATIONS AND EXCLUSIONS

	BENEFIT LEVELS
32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED [9]	12 months for all pre-existing conditions unless a person is under age 19 or the covered person is a HIPAA-eligible individual as defined under federal and state law, in which there are no pre-existing conditions exclusions.
33. EXCLUSIONARY RIDERS. Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	A pre-existing condition is an injury, sickness or pregnancy for which a person age 19 and older incurred charges, received medical treatment, consulted a healthcare professional or took prescription drugs within 12 months immediate preceding effective date of coverage. A subsequent pregnancy is not subject to a pre-existing condition exclusion.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by policy. A list of exclusions is available immediately upon request from your carrier or agent. Review the list to see if a service or treatment you may need is excluded from the policy. Standard exclusions: Conditions which are **pre-existing** as defined in the Definitions section. Any **amounts in excess of maximum amounts of Covered Expenses** stated in this Policy. Services **not specifically listed** as Covered Services in this Policy. Services or supplies that are **not Medically Necessary**. Services or supplies that Cigna considers to be for **Experimental**

	BENEFIT LEVELS
	Procedures or Investigative Procedures. Services received **before the Effective Date** of coverage. Services received **after coverage under this Policy ends**. Services for which You have **no legal obligation to pay** or for which no charge would be made if You did not have health plan or insurance coverage. Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any **workers' compensation**, employer's liability law or occupational disease law, even if the Insured Person does not claim those benefits. Conditions caused by: (a) an **act of war (declared or un-declared),** except when required by state law**;** (b) the inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) an Insured Person **participating in the military service of any foreign country**; (d) an Insured Person **participating in an insurrection, rebellion, or riot;** e) services received as a direct result of an Insured Person's commission of, or attempt to commit a **felony** (whether or not charged) **or as a direct result of the Insured Person being engaged in an illegal occupation;** (f) an Insured Person **being intoxicated**, as defined by applicable state law in the state where the illness occurred or under the influence of illegal narcotics or non-prescribed controlled substances unless administered or prescribed by Physician. Any **services provided by a local, state or federal government agency,** except when payment under this Policy is expressly required by federal or state law. **If the Insured Person is eligible for Medicare part A, B or D,** Cigna will provide claim payment according to this Policy minus any amount paid by Medicare, not to exceed the amount Cigna would have paid if it were the sole insurance carrier. Any services for which payment may be obtained from any local, state or federal government agency (except Medicaid or medical assistance benefits under the Colorado Medical Assistance Act, Title 25.5, Articles 4, 5, and 6, C.R.S.). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation. **Court-ordered treatment or hospitalization**, unless such treatment is prescribed by a Physician and listed as covered in this plan. Professional **services or supplies received or purchased from Yourself**. Custodial Care. Inpatient or outpatient **services of a private duty nurse**. Inpatient room and board **charges in connection with a Hospital stay primarily for environmental change or physical therapy**; **Custodial Care or rest cures**; services provided by a rest home, a home for the aged, a nursing home or any similar facility service. **Assistance in activities of daily living**, including but not limited to: bathing, eating, dressing, or other Custodial Care, self-care activities or homemaker services, and services primarily for rest, domiciliary or

	BENEFIT LEVELS
	convalescent care. Inpatient room and board **charges in connection with a Hospital stay primarily for diagnostic tests** which could have been performed safely on an outpatient basis. Treatment of **Mental, Emotional or Functional Nervous Disorders** or psychological testing except as specifically provided in this Policy. However, medical conditions that are caused by behavior of the Insured Person and that may be associated with these mental conditions are not subject to these limitations. **Smoking cessation** programs. Treatment of **substance abuse,** except as specifically provided in this Policy. **Dental services**, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically provided in this Policy. **Orthodontic Services**, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction. **Dental Implants**: Dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants. **Hearing aids,** except as specifically stated in this Policy. **Routine hearing tests except as specifically provided in this Policy under "Comprehensive Benefits, What the Plan Pays For".** **Genetic screening or pre-implantations genetic screening: general population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.** **Optometric services**, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Policy. An **eye surgery** solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia). Any **Drugs**, medications, or other substances dispensed or administered in any outpatient setting except as specifically stated in this Policy. This includes, but is not limited to, items dispensed by a Physician. **Cosmetic surgery** or other services for beautification, to improve or alter appearance or self esteem or to treat psychological or psychosocial complaints regarding one's appearance including macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty/panniculectomy; rhinoplasty; and blepharoplasty,. This exclusion does not apply to Reconstructive Surgery to restore a bodily function or to correct a deformity caused by Injury or congenital defect of a Newborn child, or for Medically Necessary Reconstructive Surgery performed to restore symmetry incident to a mastectomy. Aids or devices that assist with nonverbal communication, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille

	BENEFIT LEVELS
	typewriters, visual alert systems for the deaf and memory books. Non-medical counseling or ancillary services, including but not limited to: education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities and developmental delays. Services for redundant skin surgery, removal of skin tags, acupressure, acupuncture, carinosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, rolfing, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, regardless of clinical indications. Procedures or treatments to change characteristics of the body to those of the opposite sex. This includes any medical, surgical or psychiatric treatment or study related to **sex change**. Treatment of **sexual dysfunction** impotence and/or inadequacy except if this is a result of an Accidental Injury, organic cause, trauma, infection, or congenital disease or anomalies. All services related to the evaluation or treatment of **fertility and/or Infertility**, including, but not limited to, all tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including sterilization reversals and In vitro fertilization, except as specifically stated in this Plan. All **non-prescription** Drugs, devices and/or supplies, except drugs designated as preventive by the Patient Protection and Affordable Care Act (PPACA), that are available over the counter or without a prescription, **Cryopreservation** of sperm or eggs. **Fees associated with the collection or donation of blood or blood products,** except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery. **Blood administration for the purpose of general improvement in physical condition** **Orthopedic shoes** (except when joined to braces) or shoe inserts, including orthotics. Services primarily for **weight reduction** or treatment of obesity including morbid obesity, or any care which involves weight reduction as a main method for treatment. This includes any morbid obesity surgery, even if the Insured Person has other health conditions that might be helped by a reduction of obesity or weight, or any program, product or medical treatment for weight reduction or any expenses of any kind to treat obesity, weight control or weight reduction. **Routine physical exams or tests that do not directly treat an actual**

	BENEFIT LEVELS
	Illness, Injury or condition, including those required by employment or government authority, including physical exams required for or by an employer, or for school, or sports physicals, except as otherwise specifically stated in this Plan. Charges by a provider for **telephone or email consultations,** except as specifically stated in this Policy. Items which are furnished primarily for **personal comfort** or convenience (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for hygiene or beautification, including wigs etc.). **Educational services** except for Diabetes Self-Management Training Program, and as specifically provided or arranged by Cigna. **Nutritional counseling or food supplements**, except as stated in this Policy. **Durable medical equipment** not specifically listed as Covered Services in the Covered Services section of this Policy. Excluded durable medical equipment includes, but is not limited to: orthopedic shoes or shoe inserts; air purifiers, air conditioners, humidifiers; exercise equipment, treadmills; spas; elevators; supplies for comfort, hygiene or beautification; disposable sheaths and supplies; correction appliances or support appliances and supplies such as stockings. **Physical, and/or Occupational Therapy/Medicine except when provided during an inpatient Hospital confinement or as specifically stated in the Benefit Schedule and under Physical and/or Occupational Therapy/Medicine in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For".** **Massage therapy**. **Self-administered Injectable Drugs**, except as stated in the Benefit Schedule and in the Prescription Drug Benefits section of this Policy. **Injectable drugs** ("self-injectable medications) **that do not require Physician supervision** are covered under the Prescription Drug benefits of this Policy. **All noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision** and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in the Prescription Drug benefits of this Policy. **Any Infusion or Injectable Specialty Prescription Drugs that require Physician supervision,** except as otherwise stated in this Policy, if not provided by an approved Participating Provider specifically designated to supply that specialty prescription. Infusion and Injectable Specialty drugs include, but are not limited to, hemophilia factor and supplies, enzyme replacements and intravenous immunoglobulin. **Syringes**, except as stated in the Policy. **All Foreign Country Provider charges are excluded under this Policy**

	BENEFIT LEVELS
	except as specifically stated under "Treatment received from Foreign Country Providers" in the section of this Policy titled "Comprehensive Benefits What the Policy Pays For". **Growth Hormone Treatment** except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured Person's condition. Routine **foot care** including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized Illness, Injury or symptoms involving the feet. **Charges for which We are unable to determine Our liability** because the Insured Person failed, within 60 days, or as soon as reasonably possible to: (a) authorize Us to receive all the medical records and information We requested; or (b) provide Us with information We requested regarding the circumstances of the claim or other insurance coverage. Charges for the services of a **standby Physician.** Charges for **animal to human organ transplants.** Charges for elective abortions Claims received by Cigna after 15 months from the date service was rendered, except in the event of a legal incapacity.

PART D: USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	No
37. Is prior authorization required for surgical procedures and hospital care (except in an emergency)?	Yes, as stated specifically in the Policy.	Yes, as stated specifically in the Policy.
38. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes, as defined in the Policy.
39. What is the main customer service number?	1-800-244-6224	
40. Whom do I write/call if I have a complaint or want to file a grievance?	Cigna Medical P.O. Box 5200 Scranton, PA 18505-5200 1-800-244-6224	
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance? [10]	Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202	
42. To assist in filing a grievance, indicate the form number of this policy.	Policy form # COIND0412	

43. Does the plan have a binding arbitration clause?	No

Endnotes

1] "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that Cigna may require in order for you to get any coverage at all under the plan, or that Cigna may encourage you to use because it may pay more of your bill if you use Cigna network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

2] "Deductible type" indicates whether the deductible period is "Calendar Year" (January 1 through December 31) or "Benefit Year" (i.e., based on a benefit year beginning on the policy's anniversary date) or if the deductible is based on other requirements such as "Per Accident or Injury" or "Per Confinement".

2a] "Deductible" means the amount you will have to pay for allowable covered expenses under a health plan during a specified time period (e.g., calendar year or benefit year) before Cigna will cover those expenses. The specific expenses that are subject to the deductible may vary by policy.

2b] "Individual" means the deductible amount you and each individual covered by the policy will pay for allowable covered expenses before Cigna will begin covering those expenses.

2c] "Family" is the maximum deductible amount that is required to be met for all family members covered by a non-HSA-qualified policy and it may be an aggregated amount (e.g., "$3,000 per family") or specified as the number of individual deductibles that must be met (e.g., "3 deductibles per family"). "non-single" is the deductible amount that must be met by one or more family members covered by an HSA-qualified plan before any covered expenses are paid.

3] "Out-of-pocket maximum" means the maximum amount you will have to pay for allowable covered expenses under a health plan, which may or may not include deductibles and copayments, depending on the contract for that plan. The specific deductibles and copayments included in the out-of-pocket maximum may vary by policy.

4] Medical office visits include physician, mid-level practitioner, and specialist visits, including outpatient psychotherapy visits for biologically-based mental illness.

5] Well baby care includes in-hospital newborn pediatric visit and newborn hearing screening.

6] Prescription drugs otherwise excluded are not covered, regardless of whether brand name, generic or non-preferred.

7] "Emergency care" means all services delivered in an emergency care facility that are necessary to screen and stabilize a covered person. The policy must cover this care if a prudent lay person having average knowledge of health services and medicine, and acting reasonably, would have believed that an emergency medical condition, or life and limb threatening emergency, existed.

8] "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

9] Waiver of pre-existing conditions exclusions. State law requires Cigna to waive some, or all, of the pre-existing condition period based on other coverage you may have had recently. Ask your carrier or agent for details.

10] Grievances. Colorado law requires all carriers to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

ACCESS PLAN

If you would like more information on:

(1) who participates in our provider network;
(2) how we ensure that the network meets the health care needs of our members;
(3) how our provider referral process works;
(4) how care is continued if providers leave our network;
(5) what steps we take to ensure medical quality and customer satisfaction;
(6) where you can go for information on other policy services and features; you may request a copy of our Access Plan.

The Access Plan is designed to disclose all the policy information required under Colorado law, and is available for your review upon request