COLORADO HEALTH PLAN DESCRIPTION FORM
Connecticut General Life Insurance Company
2011 HEALTH SAVINGS PLAN 1500 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 noted, Annual Deductible applies to out-of-pocket maximum.)*	Individual [2b] $1,500	Family [2c] $3,000	Individual [2b] $3,000	Family [2c] $6,000
5. OUT-OF-POCKET ANNUAL MAXIMUM [3] *(Copays, deductibles and pharmacy charges apply to out-of-pocket maximum.)*	$3,000	$6,000	$9,000	$18,000
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	Unlimited			
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 b) Specialists	 20% coinsurance 20% coinsurance		 40% coinsurance 40% coinsurance	
9. PREVENTIVE CARE 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 b) Delivery & inpatient well-baby care [5]	 20% coinsurance 20% coinsurance	 40% coinsurance 40% coinsurance
11. PRESCRIPTION DRUGS [6] *(Subject to integrated medical/pharmacy deductible, pharmacy charges apply to out-of-pocket maximum, combined in- and out-of-network, per person, per year, including in-network Mail Order.)*	*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.*	
Generic (30-day supply) *Brand (30-day supply)* *Non-preferred (30-day supply)* *Self Injectable*	\$10 copay \$35 copay \$60 copay 30% coinsurance	50% coinsurance 50% coinsurance 50% coinsurance 50% coinsurance
Mail Order Drugs *(90-day supply)* *Generic* *Brand* *Non-preferred* *Self Injectable*	 \$25 copay \$85 copay \$150 copay 30% coinsurance	 Not covered Not covered Not covered Not covered
12. INPATIENT HOSPITAL	20% coinsurance	40% coinsurance
13. OUTPATIENT/AMBULATORY SURGERY	20% coinsurance	40% coinsurance
14. DIAGNOSTICS a) Laboratory & X-ray b) MRI, nuclear medicine, CT, CTA, MRA, and PET scans.	 20% coinsurance *(in any setting)* 20% coinsurance *(in any setting)*	 40% coinsurance *(in any setting)* 40% coinsurance *(in any setting)*
15. EMERGENCY CARE [7]	20% coinsurance	20% coinsurance if true emergency, otherwise 40% coinsurance
16. AMBULANCE *(Emergency transport only.)*	20% coinsurance	20% coinsurance if true emergency, otherwise 40% coinsurance
17. URGENT, NON-ROUTINE, AFTER HOURS CARE	20% coinsurance	20% coinsurance if true emergency, otherwise 40% coinsurance
18. BIOLOGICALLY-BASED MENTAL ILLNESS CARE [8]	Included in Other Mental Health Care below, #19a and #19b.	
19. OTHER MENTAL HEALTH CARE a) Inpatient Care b) Outpatient Care *(Maximum 20 visits per person, per year, in-and out-of-network combined.)*	 20% coinsurance 20% coinsurance	 40% coinsurance 40% coinsurance
20. ALCOHOL & SUBSTANCE ABUSE	Included in Other Mental Health Care above: #19a and 19b.	
21. PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY *(Maximum 24 visits per person, per year, in-and out-of-network combined, all services combined.)*	20% coinsurance	40% coinsurance
22. DURABLE MEDICAL EQUIPMENT	20% coinsurance *(in any setting)*	40% coinsurance *(in any setting)*
23. OXYGEN	Included under Durable Medical Equipment.	

	IN-NETWORK	OUT-OF-NETWORK
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.)*	CIGNA Lifesource® Transplant Network Facility Plan pays 100% plus $10,000 travel benefit per person, per lifetime Non-Lifesource® in-network facility 20% coinsurance, travel benefit excluded	Not covered
25. HOME HEALTH CARE *(Maximum 60 visits per person, per year, in- and out-of-network combined.)*	20% coinsurance	40% coinsurance
26. HOSPICE CARE a) Routine Home Care *($100 per day maximum payment.)* b) Bereavement Services c) All other Hospice Services	20% coinsurance 20% coinsurance 20% coinsurance	40% coinsurance 40% coinsurance 40% coinsurance
27. SKILLED NURSING FACILITY CARE *(Maximum 30-days per person, per year, in-and out-of-network combined.)*	20% coinsurance	40% coinsurance
28. DENTAL CARE	Not covered *Hospitalization for dental procedures for minors ONLY covered at 20% coinsurance in-network and 40% coinsurance out-of-network.*	
29. VISION CARE	Not covered	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	20% coinsurance	40% 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 or 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.

	BENEFIT LEVELS
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.** Services or supplies that CIGNA considers to be for **Experimental Procedures or Investigative Procedures**. Services for which the Insured Person has **no legal obligation to pay** or for which no charge would be made if the Insured Person did not have a health policy 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;** (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 country; (d) an Insured Person participating in an **insurrection, rebellion, or riot.** 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**, any services covered by Medicare under parts A or B are excluded regardless of actual enrollment in Medicare or payment by Medicare for those services. However, for any Covered Services, if there is a balance remaining after the Medicare Payment, or the amount that Medicare would have paid had the Insured Person enrolled in the program, CIGNA will pay the remaining balance up to the Medicare allowable amount. In no event, however, will the actual amount CIGNA pays exceed the amount that 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). Professional services received or supplies purchased from the Insured Person, a person who lives in the Insured Person's home or who is **related to the Insured Person** by blood, marriage or adoption. 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, physical therapy or treatment of chronic pain**; Custodial Care or rest cures; services provided by a rest home, a home for the aged, a nursing home or any similar facility service. 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** except as specifically stated in the Policy. Smoking cessation programs. Treatment of substance abuse**,** except as specifically stated in the Policy. **Dental services, Orthodontic Services** and **dental implants.** **Hearing aids** and routine **hearing tests**. **Optometric services**, **eye surgery** to correct refractive defects of the eye. Any off label cancer drug that has been prescribed for a specific type of cancer for which use of the drug has not been approved by the U.S. Food and Drug Administration (US FDA) except as specifically stated in the Policy. **Cosmetic surgery**. **Sex change surgery**. Treatment of **sexual dysfunction, impotence, fertility and/or Infertility** and **Cryopreservation** of sperm or eggs. **Orthopedic shoes** (except when joined to braces) or shoe inserts, including orthotics.

	BENEFIT LEVELS
	Services primarily for **weight reduction** or treatment of obesity. **Routine physical exams** or **tests** or **tests** that do not directly treat an actual 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 for **telephone or email consultations**. Items which are furnished primarily for **personal comfort** or convenience. **Educational services** except as specifically stated in the Policy **Nutritional counseling** or food supplements. **Syringes**. **All Foreign Country Provider** charges. **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.** Charges for **animal to human organ transplants.** Charges for **elective abortions**. Claims received by CIGNA after 15 months from the date service was rendered.

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. 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 # COIND00111	
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" on an Individual HSA-qualified health plan means the deductible amount an individual covered by the policy will pay for allowable covered expenses before CIGNA will begin covering those expenses.

2c] "Family" on a Family HSA-qualified health plan is the maximum deductible amount that all family members will collectively pay for allowable covered expenses before CIGNA will begin covering those expenses (e.g., deductible is applied to allowable covered expenses for all family members until the family deductible is met).

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 plan services and features; you may request a copy of our Access Plan.

The Access Plan is designed to disclose all the plan information required under Colorado law, and can be obtained by calling Member Services at 1-800-244-6224.

Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.