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BENEFIT	IN NETWORK	OUT OF NETWORK
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.		
Annual Individual Deductible	$3,000	$6,000
Annual Family Deductible	$6,000	$12,000
All benefits listed below are subject to the deductible unless otherwise noted		
Coinsurance*	You pay 20%	You pay 40%
Individual Out of Pocket Maximum	$4,000	$8,000
Family Out of Pocket Maximum	$8,000	$16,000
Individual/Family Copays, Deductibles, and pharmacy charges do not apply to the out of pocket maximum		
Lifetime Maximum	Unlimited	
PHYSICIAN SERVICES		
Office Visit Primary Care Physician Specialist Physician	You pay 20%	You pay 40%
Surgery (in any setting)	You pay 20%	You pay 40%
PREVENTIVE CARE		
Preventive Care for All Ages Routine physicals and other routine preventive services	You pay 0%[1]	You pay 40%
INPATIENT SERVICES		
Facility Services *(Inpatient Room and Board, Pharmacy, Lab & X-ray, Operating Room, etc.)*	You pay 20%	You pay 40%
Physician Services	You pay 20%	You pay 40%
OUTPATIENT SERVICES		
Lab, X-ray Physician's Office Independent Lab, X-ray Facility	You pay 0% , for the first $200 of covered services, combined for Physician's Office, Independent Lab, and X-ray Facility Services then You pay 20% after plan Deductible	You pay 40%
Ultrasound, CT/PET Scans, and MRI	You pay 20%	You pay 40%
Cardiac & Pulmonary Rehabilitation *Calendar year maximum of 36 visits, combined in- and out- of-network*	You pay 20%	You pay 40%
Short Term Rehabilitative Therapy (Including Physical and Occupational Therapy)	You pay all but $40 per visit	You pay all but $40 per visit
Outpatient Surgery	You pay 20%	You pay 40%

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EMERGENCY & URGENT CARE SERVICES		
Hospital Emergency Room	You pay 20%	You pay 20%
Outpatient Professional Services *(Including Radiology, Pathology and ER Physician)*	You pay 20%	You pay 20%
Urgent Care Services	You pay 20%	You pay 20%
Ambulance	You pay 20%	You pay 20%
OTHER HEALTH CARE FACILITIES		
Skilled Nursing Facility, Rehabilitation Hospital & Sub Acute Facilities	You pay all but $400 per day	You pay all but $400 per day
Home Health *Calendar year maximum of 80 visits, combined in- and out- of-network*	Annual Deductible waived, $50 Home Health Deductible applies then You pay 20%	Annual Deductible waived, $50 Home Health Deductible applies then You pay 25%
Hospice	You pay 20%	You pay 40%
DURABLE MEDICAL EQUIPMENT (DME)		
Durable Medical Equipment	You pay 20%	You pay 40%
MENTAL HEALTH		
Inpatient *(Includes Acute, Partial & Residential Treatment)*	You pay 20%	You pay 40%
Outpatient *(Includes Individual, Group & Intensive Outpatient Treatment)*	You pay 20%	You pay 40%
PRESCRIPTION DRUGS		
Prescription Drug Deductible *Combined Retail & Home Delivery Pharmacy Deductible only applies to Brand Name Drugs*	$500 per member per year	
RETAIL PHARMACY		
Generic	You pay $10 per 30-day supply	You pay 50%
Brand Name	You pay $30 per 30-day supply	You pay 50%
Non-Preferred Brand Name	You pay $40 per 30-day supply	You pay 50%
Self-Administered Injectable Drugs	You pay 30%	You pay 50%
HOME DELIVERY PHARMACY		
Generic	You pay $25 per 90-day supply	Not Applicable
Brand Name	You pay $75 per 90-day supply	Not Applicable
Non-Preferred Brand Name	You pay $100 per 90-day supply	Not Applicable
Self-Administered Injectable Drugs	You pay 30%	Not Applicable

* Amount you pay for covered medical services. Out-of-network, you may pay more if the provider's charges exceed the amount Cigna reimburses for billed services.

[1] Deductible waived

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EXCLUSIONS:

Your plan does not provide coverage for the following except as required by law:

- 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** in this Policy as Covered Services.
- Services or supplies that are **not Medically Necessary**.
- Services or supplies that Cigna considers to be for **Experimental Procedures or Investigative Procedures**.
- Services received **before the Effective Date** of coverage.
- Services received **after coverage 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.
- For or in connection with an Injury or Illness arising out of, or in the course of, any employment for wage or profit. For Medical Benefits, this will not apply to any of the Policyholder's partners, proprietors or corporate officers. However, if payment is made for expenses in the event that third-party liability is determined and satisfied (whether by settlement, judgment, arbitration or otherwise), Cigna shall be refunded the lesser of: (a) the amount of Cigna's payment for such expenses; or (b) the amount actually received from the third party for such expenses. In the event that a workers' compensation claim is filed, Cigna shall have a lien on the proceeds of any award or settlement to the extent of its payment of benefits.
- Any services provided by a local, state or federal **government agency,** except (a) when payment under this Policy is expressly required by federal or state law.
- If the Insured Person is enrolled in **Medicare** for part A or B 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). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.
- 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 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 convalescent care.

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- 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.
- **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 provided in this Policy.
- Routine **hearing tests** except as provided under Well Baby and Well Child Care and Newborn Hearing Benefits.
- **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).
- Outpatient **speech therapy**, expect as specifically provided in this Policy.
- **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. 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 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, carinosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, rolfing, pryotherapy 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.
- **Reversal** of male or female voluntary Sterilization.
- **Infertility services** such as Donor charges and services; Gestational carriers and surrogate parenting arrangements; and experimental, investigational or unproven infertility procedures or therapies.

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- All **non-prescription** Drugs, devices and/or supplies that are available over the counter or without a prescription,
- **Cryopreservation** of sperm or eggs.
- **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 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**.
- 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 except as specifically provided in the treatment of cancer, 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 provided under the benefits for Physical and/or Occupational Therapy/Medicine.
- **Self-administered Injectable Drugs**, except as stated in the Prescription Drug Benefits section of this Policy.
- **Syringes**, except as stated in the Policy.
- **All Foreign Country Provider** charges are excluded under this Policy except as specifically stated under Treatment received from Foreign Country Providers in the Benefits section of this Policy.
- **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 **Normal Pregnancy or Maternity Care**, including normal delivery, elective abortions or elective/non-emergency cesarean sections except as specifically stated under 'Complications of Pregnancy' in the 'Comprehensive Benefits' section of this Policy.
- **Claims** received by Cigna after 15 months from the date service was rendered, except in the event of a legal incapacity.

These Are Only the Highlights
This summary contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations including legislated benefits are contained in the Summary Plan Description or Insurance Certificate. This plan is insured and/or administered by Connecticut General Life Insurance Company, a Cigna Company.

Rates will vary by plan design including the amount of plan deductibles, coinsurance, and out-of-pocket maximums. Rates may vary based on age, gender, geographic location, and the plan and plan deductible selected.

Medical rates are guaranteed for a rating period of twelve months effective when the insurance policy is issued with the exception of any policy amendment activities, such as any benefit changes, switching to a different plan, adding or dropping dependents and moving to a different rating area. Eligibility for medical rates is based upon residential zip code. After the initial guarantee for medical rates, rates are subject to change upon 30 days notice.

These rates are the Cigna standard rates. Enrollment in a Cigna Open Access, Open Access Value or Health Savings Plan is subject to medical underwriting guidelines established by the health plan, and your rate may vary based upon tobacco usage and the results of the medical underwriting risk assessment process. You may be declined coverage because of a health condition. If you are issued a policy, and are 19 years of age or older, certain medical conditions may not be covered for a specified length of time if those conditions are related to a medical condition that existed prior to the date of coverage.

This medical insurance policy (CTIND062010) has exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued. For costs and additional details about coverage, contact Connecticut General Life Insurance Company at 900 Cottage Grove Road, Hartford, CT 06152 or call 1-866-GET-CIGNA.