Connecticut General Life Insurance Company

MAJOR MEDICAL EXPENSE COVERAGE

INDIVIDUAL PLAN CONNECTICUT HEALTH SAVINGS PLAN 2500

OUTLINE OF COVERAGE

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.

READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and Connecticut General Life Insurance Company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

Major Medical Expense Coverage – Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles, co-payment provisions, or other limitations which may be set forth in the policy. Basic hospital or basic hospital medical insurance coverage is not provided.

BENEFIT	IN NETWORK	OUT OF NETWORK
Annual Individual Deductible	$2,500	$5,000
Annual Family Deductible	$5,000	$10,000
All benefits listed below are subject to the Deductible unless otherwise noted		
Coinsurance	CIGNA pays 100% of eligible charges. You and Your Family Members pay 0% of Charges after the Policy Deductible.	CIGNA pays 70% of eligible charges. You and Your Family Members pay 30% after the Policy Deductible.
Individual Out of Pocket Maximum	$2,500	$5,000
Family Out of Pocket Maximum	$5,000	$10,000
Penalties and Policy Maximums do not apply to the Out of Pocket Maximum		
Pre-existing Condition Limitation applies *(but may be reduced by Insured Person's prior eligible Creditable Coverage.)*	Yes	Yes
Lifetime Maximum	$5,000,000 per member	
PHYSICIAN SERVICES		
Office Visit Primary Care Physician Specialist	CIGNA pays 100%	CIGNA pays 70%
Inpatient Physician Services and all In-Hospital Care	CIGNA pays 100%	CIGNA pays 70%
Surgery (in any setting)	CIGNA pays 100%	CIGNA pays 70%

PREVENTIVE CARE		
Babies/Children birth through age 3 Office Visit Flu Shot Lab Work Immunizations *Note:* Child Early Intervention Services do not apply toward the lifetime maximum.	CIGNA pays 100%, Deductible waived CIGNA pays 100%	CIGNA pays 70% CIGNA pays 70%
Adults and Children (age 4 and older) Office Visit, Immunizations, Flu Shot, Lab work Mammogram, PSA, Pap Smear, and Colorectal Cancer Screening and the associated office visit	100% Deductible waived, to a maximum payment of $200 combined in and out of network services, per Insured person, per calendar year. CIGNA pays 100%	70% after plan Deductible, to a maximum payment of $200 combined in and out of network services, per Insured person, per calendar year. CIGNA pays 70%
INPATIENT HOSPITAL FACILITY SERVICES		
In-Hospital Services *(semi-private inpatient room and board, pharmacy, x-ray and laboratory, operating room, surgeries, anesthesia services, etc.)*	CIGNA pays 100%	CIGNA pays 70%
OUTPATIENT SERVICES		
Lab, X-ray Physician's office Any other x-ray lab facility including outpatient facility	CIGNA pays 100% CIGNA pays 100%	CIGNA pays 70% CIGNA pays70%
Ultrasound, CT Scan and MRI	CIGNA pays 100%	CIGNA pays 70%
Cardio Pulmonary Rehab 36 visits maximum per Insured Person, per year, in- and out-of-network combined.	CIGNA pays 100%	CIGNA pays 70%
Physical, Occupational Therapy *24 visit maximum per year for combined services, both in-and out-of-network services.*	After plan Deductible, CIGNA pays a maximum of $40 per visit	After plan Deductible, CIGNA pays a maximum of $40 per visit
OUTPATIENT SERVICES		
Outpatient Surgery Facility charges (surgery and anesthesia services)	CIGNA pays 100%	CIGNA pays 70%
EMERGENCY & URGENT CARE SERVICES		
Hospital Emergency Room	CIGNA pays 100%	CIGNA pays 100%
Urgent Care Services	CIGNA pays 100%	CIGNA pays 70%
Ambulance	CIGNA pays 100% for Ground or Air transport	CIGNA pays 100% for Ground or Air Transport

OTHER HEALTH CARE FACILITIES		
Inpatient Services at Other Health Care Facilities, Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities *$400 maximum per day, 100 day maximum per year for combined services, both In and Out of Network*	100% After plan Deductible CIGNA pays $400 maximum payment per day	100% After plan Deductible CIGNA pays $400 maximum payment per day
Home Health Services *80 visit maximum per person, per calendar year. In- and out-of-network combined*	CIGNA pays 100%	CIGNA pays 75%
Hospice	CIGNA pays 100%	CIGNA pays 70%
DURABLE MEDICAL EQUIPMENT (DME)		
$5,000 maximum per year, in- and out-of-network combined	CIGNA pays 100%	CIGNA pays 70%
MENTAL HEALTH & SUBSTANCE ABUSE		
Inpatient	CIGNA pays 100%	CIGNA pays 70%
Outpatient	CIGNA pays 100%	CIGNA pays 70%
PRESCRIPTION DRUGS (30-day supply)		
Brand Name Prescription Drug Calendar Year Maximum *- (Combined In and Out of Network Services)*	$5,000 per Insured Person, per Calendar Year	
Generic	CIGNA Pays 100%	CIGNA pays 50% per Prescription Order or refill
Brand Name	CIGNA Pays 100%	CIGNA pays 50% per Prescription Order or refill
Non-Preferred Brand Name	CIGNA Pays 100%	CIGNA pays 50% per Prescription Order or refill
Self Injectables	CIGNA Pays 100%	CIGNA pays 50% per Prescription Order or refill
MAIL ORDER DRUGS (90-day supply)		
Generic	CIGNA Pays 100%	Not Applicable
Brand Name	CIGNA Pays 100%	Not Applicable
Non-Preferred Brand Name	CIGNA Pays 100%	Not Applicable
Self Injectables	CIGNA Pays 100%	Not Applicable

EXCLUSIONS AND LIMITATIONS:

- Conditions which are **pre-existing** as indicated below.
- Any **amounts in excess of maximum amounts of Covered Expenses** stated in the Policy.
- Services **not specifically listed** in the Policy as Covered Services.
- Services or supplies that are **not Medically Necessary** which is defined as follows:

Medically Necessary means health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, Physician or other heath care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For the purposes of this definition, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

- 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 the Policy is expressly required by federal or state law.
- If the Insured Person is enrolled in **Medicare** part A or B CIGNA will provide claim payment according to the 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.
- 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 the 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 the 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 the 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,** except as specifically provided in the 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** when the infertility is caused by or related to voluntary Sterilization; Donor charges and services; Gestational carriers and surrogate parenting arrangements; and experimental, investigational or unproven infertility procedures or therapies.
- 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, except as specifically stated in the Policy.
- 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 this Policy 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 the 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 the Policy.
- **Syringes**, except as stated in the Policy.
- **All Foreign Country Provider** charges are excluded under the Policy except as specifically stated under Treatment received from Foreign Country Providers in the Benefits section of the 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 the Policy.
- **Claims** received by CIGNA after 15 months from the date service was rendered, except in the event of a legal incapacity.

Pre-existing Condition is the existence of a physical or mental condition for which any medical advice, diagnosis, care or treatment was recommended or received by a Physician within a 12 month period before the Effective Date of the coverage of the Insured Person.

Routine follow-up care to determine whether a breast cancer has reoccurred in a person who has been previously determined to be breast cancer free shall not be considered as medical advice, diagnosis, care or treatment for purposes of this section unless evidence of breast cancer is found during or as a result of such follow-up. Pregnancy, and genetic information with no related treatment, will also not be considered Pre-existing Conditions.

Pre-existing Condition Periods

Any Covered Services received by the Insured Person on or within 12 months after the Effective Date of coverage will not be covered, if they are related to a Pre-existing Condition, as defined in the Definitions section of this Policy.

Credit for Coverage Under Prior Plan

If You and/or Your Family Member(s) were previously covered under a plan which qualifies as Creditable Coverage, We will reduce any Pre-existing Condition limitation period under this Policy by the number of days of prior Creditable Coverage You had under the prior plan(s). However, credit is available only if You provide proof of Your prior Creditable Coverage, and fewer than 120 days elapse between coverage under the prior plan and coverage under this Plan exclusive of any waiting period, or if coverage was terminated due to involuntary loss of employment, fewer than 150 days elapse between coverage under the prior plan and coverage under this Plan exclusive of any waiting period. Credit will be given for coverage under all prior Creditable Coverage, provided fewer than 120 days elapsed between coverage under any two plans, or if coverage was terminated due to involuntary loss of employment fewer than 150 days elapsed between coverage under any two plans. You should submit proof of prior coverage with your enrollment material.

PRIOR AUTHORIZATION FOR INPATIENT SERVICES

Prior Authorization is required for all non emergency inpatient admissions in order to be eligible for benefits. FAILURE TO OBTAIN PRIOR AUTHORIZATION PRIOR TO AN ELECTIVE ADMISSION MAY RESULT IN A PENALTY. Prior Authorization can be obtained by You, your Family Member(s) or the Provider by calling the number on the back of Your ID card.

Please call the Member Services number on the back of Your ID card for the most current listing of services that require Prior Authorization.

You, your Family Member(s) or your Provider must obtain approval for inpatient admissions or you may be subject to a Penalty for non-compliance that is the lesser of 50% of the scheduled benefit or $500.

Please note that emergency admissions will be reviewed post admission.

Inpatient Prior Authorization reviews both the necessity for the admission and the need for continued stay in the hospital.

PRIOR AUTHORIZATION OF OUTPATIENT SERVICES

Prior Authorization is also required for select outpatient procedures in order to be eligible for benefits. FAILURE TO OBTAIN PRIOR AUTHORIZATION PRIOR TO AN ELECTIVE OUTPATIENT SERVICE MAY RESULT IN A PENALTY. Prior Authorization can be obtained by You, your Family Member(s) or the Provider by calling the number on the back of Your ID card. 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.

Please call the Member Services number on the back of your ID card for the most current listing of services that require Prior Authorization.

You, your Family Member(s) or your Provider must obtain approval for selected outpatient procedures and diagnostic testing or you may be subject to a Penalty for non-compliance that is the lesser of 50% of the scheduled benefit or $60.

Prior Authorization for Certain Prescription Drugs

Coverage for certain Prescription Drugs and Related Supplies require the Physician to obtain Prior Authorization from CIGNA before prescribing the drugs or supplies. Prior Authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition.

If the Physician wishes to request coverage for Prescription Drugs or Related Supplies for which Prior Authorization is required, the Physician may call or complete the appropriate Prior Authorization form and fax it to CIGNA to request Prior Authorization for coverage of the Prescription Drugs or Related Supplies. The Physician should make this request before writing the prescription. Any drug removed from the Prescription Drug List will still be eligible for coverage if the Insured Person was using the drug for treatment of a chronic illness, and the treating Physician certifies that the drug is Medically Necessary and more medically beneficial than remaining Formulary drugs. One or more medications may require Prior Authorization (including step therapy).

If the request is approved, the Physician will receive confirmation. The Prior Authorization will be processed in our claim system to allow the Insured Person to have coverage for those Prescription Drugs or Related Supplies. The length of the Prior Authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When the Physician advises the Insured Person that coverage for the Prescription Drugs or Related Supplies has been approved, the Insured Person should contact the Pharmacy to fill the prescription(s).

PRIOR AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. Prior Authorization does not guarantee payment of benefits. Coverage is always subject to other requirements of the Policy, such as Pre-existing Conditions, limitations and exclusions, payment of premium and eligibility at the time care and services are provided.

RENEWABILITY, ELIGIBILITY, and CONTINUATION

1. The Policy will renew except for the specific events stated in the Policy. CIGNA may change the premiums of the Policy with 30 days written notice to the Insured. However, CIGNA will not refuse to renew or change the premium schedule for the Policy on an individual basis, but only for all insured's in the same class and covered under the same Policy as You.

2. The Individual Plan Connecticut Health Savings Plan is designed for residents of Connecticut who are not enrolled under or covered by any other group or individual health coverage. You must notify CIGNA of all changes that may affect any Insured Person's eligibility under the Policy.

3. You or Your Insured Family Member(s) will become ineligible for coverage:

a. When premiums are not paid according to the due dates and grace periods described in the Premium section of the Policy.

b. When the Insured's spouse is no longer married to the Insured.

c. For a dependent child – on the Policy anniversary date, which is equal to the Effective Date, that follows the date the child turns 26 or otherwise becomes ineligible due to: marriage; the child becoming covered under his or her own employee health plan; or, for children who are age 19 or older or who are **not** full-time students, the child no longer being a Connecticut resident.

d. For the Insured Person - when the Insured Person no longer meets the requirements listed in the Conditions of Eligibility section;

e. The date the Policy terminates.

4. If an Insured Person's eligibility under the Policy would terminate due to the Insured's death, divorce or other reason for the Insured's ineligibility stated in the Policy, except for the Insured's failure to pay premium, the Insured Person's insurance will be continued if the Insured Person exercising the continuation right notifies CIGNA and pays the appropriate monthly premium within 31 days following the date the Policy would otherwise terminate. Coverage will continue without evidence of insurability, and no pre-existing condition limitation will be imposed, unless unexpired prior to continuation under the Policy.

PREMIUM

The premium rates for the Policy are based on the age, place of residence, and the number and relationship of the Insured's Family Member(s) covered by the Policy. Changes in these factors may result in a change in premium.

a. The rate provided to You is for the residence shown in your application. It may not apply to a different place of residence. Your premium rates are subject to automatic adjustment upon change of residence.

b. CIGNA also has the right to change premiums with 30 days notice to you.