

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Primary Care Physician (PCP) Office Visit <i>Preventive Care</i> <i>Well Child Care</i> <i>Periodic Physical Exams for Children</i> <i>Routine Immunizations</i></p> <p><i>Adult/Child Medical Care for Illness or Injury</i> <i>Surgery performed in a Physician's Office</i></p>	<p>\$30 copayment per office visit</p> <p>The office visit Copayment will be waived when immunization is the only service provided</p>	<p>Covered in-network only, except for certain services as required by law.</p> <p>Covered in-network only, except for children, from birth through age 6 – 50% of charges</p> <p>50% of charges* 50% of charges*</p>
<p>Specialty Physician Office Visit <i>Office Visits</i> <i>Surgery Performed in Physician's Office</i></p>	<p>\$45 copayment per office visit</p>	<p>50% of charges*</p>
<p>Child Early Intervention Services <i>From birth to 36 months</i></p>	<p>Same as any other illness \$5,000 maximum per member per contract year</p>	<p>Covered in-network only</p>
<p>Inpatient Hospital Services <i>Semi-Private Room and Board</i> <i>Physician and Surgeon Services</i> <i>Diagnostic/Therapeutic Lab and X-ray</i> <i>Drugs and Medication</i> <i>Operating and Recovery Room</i> <i>Radiation Therapy and Chemotherapy</i> <i>Anesthesia and Inhalation Therapy</i></p>	<p>\$300 copayment per day for the first 5 days of an inpatient admission**</p>	<p>\$300 deductible per day for the first 5 days of an inpatient admission, plus 50% of charges* Precertification applies</p>
<p>Outpatient Facility Services <i>Operating Room, Recovery Room, Procedure Room and Treatment Room including:</i> <i>Physician Services</i> <i>Diagnostic/Therapeutic Lab and X-rays</i> <i>Anesthesia and Inhalation Therapy</i></p>	<p>\$300 copayment per facility use**</p>	<p>\$300 deductible per facility use, plus 50% of charges* Precertification applies</p>
<p>Laboratory and Radiology Services <i>Advanced Radiological Imaging (MRIs, MRAs, CAT Scans and PET Scans)</i> <i>Other Laboratory and Radiology Services</i> <i>Outpatient hospital Facility</i> <i>Independent X-ray/Lab Facility</i></p>	<p>\$200 copayment per procedure</p> <p>No charge** No charge</p>	<p>\$0 Deductible per office visit, plus 50% of charges*</p> <p>50% of charges* 50% of charges*</p>
<p>Short-Term Rehabilitative Therapy and Chiropractic Services</p>	<p>\$45 copayment per office visit 20 visits maximum per contract year</p>	<p>50% of charges* 20 visits maximum per contract year# Chiropractic Services covered in-network only</p>
<p>Prescription Drugs CIGNA Pharmacy Plus Retail Drug Program (Generic Push, Incentive Formulary Plan) <i>Includes oral contraceptives and devices, oral fertility drugs, prenatal vitamins and diabetic supplies (lancets, glucose test strips and insulin syringes)</i> Tel-Drug Rx Mail Order Drug Program</p> <p>Pharmacy Deductible (Individual/Family)(Mail Order excl.) Pharmacy Out of Pocket Maximum (Individual/Family)</p>	<p>\$15 per 30-day supply for generic drugs \$25 per 30-day supply for preferred brand name drugs \$40 per 30-day supply for non-preferred brand name drugs</p> <p>\$30 per 90-day supply for generic drugs \$50 per 90-day supply for preferred brand name drugs \$80 per 90-day supply for non-preferred brand name drugs</p> <p>None/None None/None</p>	<p>Covered in-network only</p> <p>Covered in-network only</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Emergency and Urgent Care Services <i>Physician's Office</i></p> <p><i>Hospital Emergency Room</i> <i>Participating Urgent Care Facility or Hospital Outpatient Facility</i> <i>Ambulance</i></p>	<p>PCP or Specialty Physician Office Visit Copayment</p> <p>\$150 Copayment per visit, waived if admitted \$75 Copayment per visit</p> <p>No charge</p>	<p><i>Care will be covered at in-network levels if it meets the "prudent layperson" definition of an emergency. Copayment same as in-network.</i></p>
<p>Maternity Care Services <i>Initial Office Visit to Confirm Pregnancy</i></p> <p><i>All subsequent Prenatal visits, Postnatal visits and Physician's Delivery charges</i> <i>Inpatient Hospital/Birthing Center Charges</i></p>	<p>PCP or Specialty Physician Office Visit Copayment</p> <p>No charge</p> <p>\$300 copayment per day for the first 5 days of an inpatient admission**</p>	<p>50% of charges* 50% of charges*</p> <p>\$300 deductible per day for the first 5 days of an inpatient admission, plus 50% of charges* Precertification applies</p>
<p>Inpatient Services at Other Health Care Facilities <i>Skilled Nursing, Rehabilitation and Sub-Acute Facilities</i></p>	<p>No charge <i>60 days maximum per contract year**</i></p>	<p>50% of charges*, Precertification applies; <i>60 days maximum per contract year#</i></p>
<p>Home Health Services</p>	<p>No charge, <i>80 days per contract year maximum</i></p>	<p>25% of charges; <i>80 days maximum per contract year#*</i></p>
<p>Family Planning Services <i>Office Visits (tests, counseling)</i> <i>Vasectomy/Tubal Ligation</i> <i>Inpatient Facility</i></p> <p><i>Outpatient Facility</i></p> <p><i>Surgery in Physician's Office</i></p>	<p>PCP or Specialty Physician Office Visit Copayment</p> <p>\$300 copayment per day for the first 5 days of an inpatient admission**</p> <p>\$300 copayment per facility use**</p> <p>PCP or Specialty Physician Office Visit Copayment</p>	<p>50% of charges*</p> <p>\$300 deductible per day for the first 5 days of an inpatient admission, plus 50% of charges* Precertification applies</p> <p>\$300 deductible per facility use, plus 50% of charges* Precertification applies</p> <p>50% of charges* Precertification applies</p>
<p>Infertility Services <i>Office Visit (tests, counseling)</i></p> <p><i>Inpatient Facility</i></p> <p><i>Outpatient Facility</i></p> <p><i>In Physician's Office</i></p>	<p>PCP or Specialty Physician Office Visit Copayment</p> <p>\$300 copayment per day for the first 5 days of an inpatient admission**</p> <p>\$300 copayment per day for the first 5 days of an inpatient admission**</p> <p>Specialty Physician Office Copayment</p>	<p>Covered in network only</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><i>Mental Health and Substance Abuse</i> <i>Inpatient Mental Health Services</i> <i>Outpatient Individual Mental Health Services</i></p> <p><i>Outpatient Mental Health Group Therapy</i></p> <p><i>Inpatient Substance Abuse Rehabilitation Services</i> <i>Outpatient Individual Substance Abuse Rehabilitation Services</i></p> <p><i>Outpatient Group Substance Abuse Rehabilitation Services</i></p> <p><i>Inpatient Substance Abuse Detoxification Services</i> <i>Outpatient Substance Abuse Detoxification Services</i></p>	<p>Same as Inpatient Hospital Copayment. Same as Specialty Physician Office Visit Copayment</p> <p>The greater of one-half (1/2) the Specialty Physician services copayment per visit or \$5 per session</p> <p>Same as Inpatient Hospital Copayment Same as Physician Office Visit Copayment</p> <p>The greater of one-half (1/2) the Specialty Physician services copayment per visit or \$5 per session</p> <p>Same as Inpatient Hospital Copayment Same as Specialty Physician Office Visit Copayment</p>	<p>Same as Inpatient Hospital Same as Specialty Physician Office Visit Same as Specialty Physician Office Visit</p> <p>Same as Inpatient Hospital Same as Specialty Physician Office Visit</p> <p>Same as Specialty Physician Office Visit</p> <p>Same as Inpatient Hospital Same as any other illness</p>
<p><i>Transplant Services</i> <i>Travel Maximum</i></p>	<p>Same as Inpatient Hospital Copayment \$10,000 maximum benefit per transplant/per lifetime</p>	<p>Covered in-network only</p>
<p><i>Durable Medical Equipment</i></p>	<p>No charge</p>	<p>\$500 maximum benefit per contract year (maximum does not apply to diabetic DME)</p>
<p><i>External Prosthetic Appliances</i></p>	<p>No charge</p>	<p>\$500 maximum benefit per contract year</p>
<p><i>Vision Care</i> (no referral required)</p>	<p>\$10 Office Visit Copayment, Eye Exam every 24 months – Eyeglasses/Contact Lenses not covered</p>	<p>Covered in-network only</p>

OTHER BENEFIT INFORMATION

Contract Year Deductible		
<i>Individual</i>	\$1,500	\$3,000
<i>Family</i>	\$3,000	\$6,000
Contract Year Out-of-Pocket (OOP) Maximum		
<i>Individual</i>	\$3,000 excludes deductible	\$6,000 excludes deductible
<i>Family</i>	\$6,000 excludes deductible	\$12,000 excludes deductible
Coinsurance	No	CIGNA HealthCare pays 50% of eligible charges. You pay 50% of charges after the plan deductible.
Precertification (Inpatient, Outpatient, and MRI's)	Handled by your physician	Participant must obtain approval
Lifetime Maximum	Unlimited	\$1,000,000
Pre-existing Condition Limitation	No	Yes

** *In-network services are subject to contract year deductible.*

* *Out-of-network services are subject to annual deductible and reasonable and customary charge limitations.*

Out-of-network treatment maximums are reduced by in-network services used.

Regarding In-Network Services:

- *All services, except for emergency services, routine care provided by a participating OB/ GYN, and Inpatient mental health and substance abuse services authorized by CIGNA Behavioral Health, Inc. must be provided by or authorized by your Primary Care Physician (PCP) in order to be covered.*
- *Only Inpatient (including Mental Health and Substance Abuse) and Outpatient Facility copayments apply to the out-of-pocket maximum. These copayments are no longer required once out-of-pocket maximum is reached.*

Regarding Out-of-Network Services:

- *All out-of-network hospital admissions, outpatient surgeries and MRI's must be precertified. Penalty for non-compliance with precertification is 50%. Hospital admissions are subject to Continued Stay Review (CSR). Non-certified admissions/days result in denial of benefits. The 50% penalty or cost of denied benefits does not apply to deductible or out-of-pocket maximum.*
- *Once the out-of-pocket maximum for out-of-network is reached, the plan pays 100% of eligible charges for the remainder of the plan year. The out-of-network inpatient copayment continues to apply.*
- *Pre-existing conditions are not covered unless twelve months of continuous coverage (including the waiting period) has elapsed.*

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

1. Any service or supply not described as covered in the Covered Services section of the Agreement.
2. Any medical service or device that is not medically necessary.
3. Care for health conditions that are required by state or local law to be treated in a public facility or supplied by a public school system.
4. Treatment of an illness or injury which is due to war or care for military service disabilities treatable through governmental services.
5. Any services and supplies for or in connection with experimental, investigational or unproven services.
6. Treatment of TMJ disorder.
7. Dental treatment of the teeth, gums or structures directly supporting the teeth, except medically necessary for craniofacial disorders. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within 6 months of the accident.
8. Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, including clinically severe (morbid) obesity, including: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.
9. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
10. Court ordered treatment or hospitalizations.
11. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction.
12. Medical and hospital care and costs for the child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
13. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance.
14. Consumable medical supplies other than ostomy supplies and urinary catheters.
15. Private hospital rooms and/or private duty nursing except as covered under the Home Health Care provision.
16. Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
17. Hearing aids, including but not limited to standard hearing aids, semi-implantable hearing devices, audiant bone conductors, bone anchored hearing aids, except for hearing aids for children.
18. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
19. Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
20. Non-prescription drugs, and investigational and experimental drugs, except as provided in the member agreement.
21. Routine foot care, however, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
22. Genetic screening or pre-implantation genetic screening.
23. Fees associated with the collection or donation of blood or blood products.
24. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
25. All nutritional supplements and formulae are excluded, except infant formula needed for the treatment of inborn errors of metabolism and nutritional formula for inherited metabolic diseases and specialized infant formula.
26. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
27. The following services are excluded from coverage regardless of clinical indications: Massage Therapy; Cosmetic Surgery and Therapies; Macromastia or Gynecomastia Surgeries; Surgical Treatment of Varicose Veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Orthognathic Surgeries; Redundant Skin Surgery; Removal of Skin Tags; Acupressure; Craniosacral/cranial therapy; Dance Therapy, Movement Therapy; Applied Kinesiology; Rolfing; Prolotherapy; Transsexual Surgery; Non-medical counseling or ancillary services; Assistance in the activities of daily living; Cosmetics; Personal or Comfort Items; Dietary Supplements; Health and Beauty Aids; Aids or devices that assist with non-verbal communications; Treatment by Acupuncture; Dental implants for any condition; Telephone Consultations; E-mail & Internet Consultations; Telemedicine; Health Club Membership fees; Weight Loss Program fees; Smoking Cessation Program fees; Reversal of male and female voluntary sterilization procedures; and Extracorporeal Shock Wave Lithotripsy for musculoskeletal and orthopedic conditions.

This summary of benefits contains the highlights only. The specific benefits and exclusions are contained in your Group Service Agreement or certificate.

“CIGNA HealthCare” refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include 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.

Some Healthy Rewards are not available in all states. Additionally, not all Healthy Rewards programs are available to members of CIGNA HealthCare of California, Inc., CIGNA Dental Health of California, Inc. and CIGNA Behavioral Health of California, Inc. A discount program is NOT insurance, and the member must pay the entire discount charge. If your CIGNA HealthCare plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. Healthy Rewards programs are separate from your medical benefits.

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