SUMMARY OF BENEFITS

Your CIGNA HealthCare Indemnity plan

Features that Add Value

- The CIGNA HealthCare 24-Hour Health Information Line[SM] connects you **to registered nurses** and a **library** of hundreds of recorded programs on important health topics 24 hours a day, seven days a week, from anywhere in the U.S.
- **CIGNA Healthy Rewards®** includes special offers on health and wellness programs and services not covered by traditional benefits plans. Just call 1.800.870.3470 or visit our web site at www.cigna.com.
- Prescription drug coverage is a **part of your plan**. More than 50,000 pharmacies participate nationwide, so you can have your prescription filled **wherever you go**. Mail-order service means quick, **convenient** delivery of your medications right to your home.

Quality Service Is Part of Quality Care

- **Service** is at the heart of everything we do. Our goal is to give you: fast, accurate answers; responsive, courteous and professional assistance; and ease and convenience in finding the information you need to manage your health.
- **www.cigna.com** – Visit our **interactive Web site** to learn more about your plan and get health information, 24 hours a day.
- **We Speak Many Languages[SM]** . We offer Language Line Services so that you can **talk with us** in 150 different languages. Just call Customer Service and ask for an interpreter to assist you.
- Our interactive voice response system helps you find what you need faster over the phone. Use the speech recognition feature for information on your benefits, level of coverage, claims status, and more.

It's Your Health

When you choose CIGNA HealthCare, you can take advantage of our **health and wellness** programs

- **Preventive care services** for your children through age 2 and any additional preventive care benefits described in the Benefit Highlights.
- CIGNA Well Aware for Better Health[SM] can **help you manage** certain chronic conditions.
- The CIGNA HealthCare Healthy Babies® program provides you with information to help you have a **healthy pregnancy** and **a healthy baby.**

Freedom of Choice

- You can choose any licensed doctor, specialist or hospital. However, you are required to pay a deductible each year and then a percentage of each bill after the deductible is paid.
- Once the out-of-pocket as shown in the benefit summary is reached, the plan pays 100% of eligible charges for the remainder of the year.

For Employees of North Carolina Indemnity - Basic Plan

BENEFIT HIGHLIGHTS	
Physician Services *Primary Care Physician (PCP) Office Visit*	 40% of charges* per office visit; 40% of charges* if only x-ray and/or lab services performed and billed
Specialty Physician Office Visit *Consultant and Referral Physician Services* ***Note:*** *OB/GYN physician is considered a Specialist Physician*	40% of charges* per office visit; 40% of charges* if only x-ray and/or lab services performed and billed
Allergy Treatment/Injections - PCP or Specialty Physician	40% of charges*
Allergy Serum (dispensed by physician in office)	40% of charges*
Second Opinion Consultations (provided on voluntary basis)	40% of charges*
Surgery Performed in the Physician's Office PCP or Specialty Physician	40% of charges*
Preventive Care *Routine Preventive Care for Children and Adults* *(includes Mammograms, PSA, PAP Test* *(including routine immunizations)*	 No charge up to $100 maximum, then 40% of charges* thereafter
Immunizations	No charge up to $100 maximum, then 40% of charges* thereafter
Mammograms, PSA, Pap Test *Note: Preventive care related services and diagnostic related services are paid at the same level of benefits as other x-ray and lab services.*	Included in Preventive Care benefit
Inpatient Hospital Services includes: *Semi-Private Room and Board* *Diagnostic/Therapeutic Lab and X-ray* *Drugs and Medication* *Operating and Recovery Room* *Radiation Therapy and Chemotherapy* *Anesthesia and Inhalation Therapy*	40% of charges* Precertification required
Inpatient Hospital Doctor's Visits/Consultations	40% of charges*
Inpatient Hospital Professional Services	40% of charges*
Outpatient Facility Services *Operating Room, Recovery Room, Procedure Room and Treatment Room including:* *Diagnostic/Therapeutic Lab and X-rays* *Anesthesia and Inhalation Therapy*	40% of charges*
Physician & Outpatient Professional Services	40% of charges*
***Laboratory and Radiology** Services (includes preadmission testing)* *Advanced Radiological Imaging* *(MRIs, CAT Scans, PET Scans, etc.)*	 40% of charges*
Other Laboratory and Radiology Services *Physician's Office*	 40% of charges* per office visit; 40% of charges* if only x-ray and/or lab services performed and billed
Outpatient Hospital Facility	40% of charges*
Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit)	40% of charges*
Independent X-Ray and/or Lab Facility	40% of charges*
Independent X-Ray and/or Lab Facility (in conjunction with an Emergency Room visit)	40% of charges*

BENEFIT HIGHLIGHTS	
Short-Term Rehabilitative Therapy *(includes cardiac rehab, physical, speech, occupational, pulmonary rehab & cognitive therapy) -* 20 days maximum per calendar year for all therapies combined ***Note***: *therapy sessions provided as part of Home Health Care accumulate to the Short-Term Rehab Therapy maximum.*	40% of charges* per office visit; 40% of charges* if only x-ray and/or lab services performed and billed ($40 maximum covered charge per visit)
Emergency and Urgent Care Services	
Physician's Office-PCP or Specialty Physician	40% of charges*; 40% of charges* if only x-ray and/or lab services performed and billed.
Hospital Emergency Room	$50 copayment per visit, plus 40% of charges* *(copayment waived if admitted)*
Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician)	40% of charges*
Urgent Care or Outpatient Facility	$50 copayment per visit, plus 40% of charges* *(copayment waived if admitted)*
Ambulance	40% of charges*
Maternity Care Services	
Initial Office Visit to Confirm Pregnancy ***Note:*** *OB/GYN physician is considered a Specialist Physician*	40% of charges* per office visit; 40% of charges* if only x-ray and/or lab services performed and billed
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (total maternity fee)	40% of charges*
Office Visits not included in the total maternity fee performed by OB or Specialty Physician	40% of charges*per office visit; 40% of charges* if only x-ray and/or lab services performed and billed
Delivery - Facility (Inpatient Hospital/Birthing Center Charges)	40% of charges*, Precertification required
Inpatient Services at Other Health Care Facilities *Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities*	Not covered
Home Health Services	Not covered
Family Planning Services	
Office Visits (tests, counseling)	No charge up to $100 maximum, then 40% of charges* thereafter
Vasectomy/Tubal Ligation (excludes reversals)	
Inpatient Facility	40% of charges*, Precertification required
Outpatient Facility	40% of charges*
Physician's Services – Inpatient or Outpatient	40% of charges*
Physician's Office	40% of charges* per office visit; 40% of charges* if only x-ray and/or lab services performed and billed
Infertility Services *Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.*	Not covered
TMJ – Surgical - Always excludes appliances and orthodontic treatment. Subject to medical necessity.	
Physician's Office	40% of charges* per office visit; 40% of charges* if only x-ray and/or lab services performed and billed
Inpatient Facility	40% of charges*, Precertification required
Outpatient Facility	40% of charges*
Physician's Services	40% of charges*
Mental Health and Substance Abuse ($10,000 combined lifetime maximum for treatment of Mental and Nervous Disorders (including Chemical Dependency)	
Inpatient	40% of charges*
Outpatient – $60 maximum charge per visit; 25 visit per year	50% of charges*

BENEFIT HIGHLIGHTS	
Durable Medical Equipment	Not covered
External Prosthetic Equipment Unlimited maximum per calendar year	40% of charges*
Prescription Drugs *CIGNA Pharmacy Retail Drug Program* *Generic*** drugs on the Prescription Drug List for a 30-day supply* *Brand Name*** drugs designated as preferred on the Prescription Drug List with no Generic equivalent for a 30-day supply* ***CIGNA Tel-Drug Mail Order Drug Program***	 40% per prescription/refill 40% per prescription/refill Not covered
OTHER BENEFIT INFORMATION	
Calendar Year Deductible *Individual* *Family*	 $1,000 $3,000
Calendar Year Out-of-Pocket Maximum	Excludes Plan Deductible $3,000 per individual
Coinsurance	CIGNA HealthCare pays 60% of eligible charges. You pay 40% of charges after the plan deductible.
Precertification -Inpatient – PHS+ *(required for all inpatient admissions)* ***Precertification – Outpatient – PHS+ (****required for selected outpatient procedures and diagnostic testing or outpatient services)*	Participant must obtain approval for inpatient admission; subject to penalty/reduction or denial for non-compliance Participant must obtain approval for selected outpatient procedures and diagnostic testing; subject to penalty/reduction or denial for non-compliance.
Lifetime Maximum ***Annual Maximum Per Calendar Year***	$1,000,000 $100,000 per insured
Pre-existing Condition Limitation	Yes

Services are subject to calendar year deductible and reasonable and customary charge/maximum reimbursable charge limitations.

- *Once the out-of-pocket maximum is reached, the plan pays 100% of eligible charges for the remainder of the plan year, except for Mental Health and Substance Abuse which continue to be paid at the levels specified.*
- *All inpatient hospital admissions and certain outpatient surgical and diagnostic procedures require Preadmission Certification and Continued Stay Review. Failure to obtain Preadmission Certification and/or Continued Stay Review may result in non-compliance penalties and/or reduction of benefits. Call the toll-free number on your CIGNA HealthCare ID card.*
- ♦ *Coverage for pre-existing conditions will not be covered under this plan unless continuously insured for one year.*

Case Management

Coordinated by CIGNA HealthCare. This is a service designed to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

Benefit Exclusions.

These are examples of the exclusions in your plan. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control.

1. Any service or supply not described as covered in the Covered Expenses section of the plan.
2. Any medical service or device that is not medically necessary.
3. Treatment of an illness or injury which is due to war or care for military service disabilities treatable through governmental services.
4. Any services and supplies for or in connection with experimental, investigational or unproven services.
5. Dental treatment of the teeth, gums or structures directly supporting the teeth, 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.
6. 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.
7. 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.
8. Court ordered treatment or hospitalizations.
9. Infertility services, infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
10. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction.
11. Medical and hospital care and costs for the child of a Dependent, unless this infant child is otherwise eligible under the plan.
12. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance.
13. Consumable medical supplies other than ostomy supplies and urinary catheters.
14. Private hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
15. Artificial aids, including but not limited to hearing aids, semi-implantable hearing devices, audiant bone conductors, bone anchored hearing aids, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
16. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
17. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
18. All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in the plan.
19. Routine foot care, however, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.
20. Genetic screening or pre-implantation genetic screening.
21. Fees associated with the collection or donation of blood or blood products.
22. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
23. All nutritional supplements and formulae are excluded, except infant formula needed for the treatment of inborn errors of metabolism.
24. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
25. Expenses incurred for medical treatment by a person age 65 or older, who is covered under the plan as a retiree, or his dependent, when payment is denied by the Medicare plan because treatment was not received from a participating provider of the Medicare plan.
26. Expenses incurred for medical treatment when payment is denied by the primary plan because treatment was not received from a participating provider of the primary plan.
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.

These Are Only the Highlights

As you can see, the plan is designed to combine in-depth coverage with cost-effective prices. 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.

"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.

Catalog Number: 800306
(04)
©2005 CIGNA Health Corporation