

BENEFIT HIGHLIGHTS

Primary Care Physician (PCP) Office Visit <i>Preventive Care Well Child Care Periodic Physical Exams (Children and Adults) Routine Immunizations Adult/Child Medical Care for Illness or Injury Surgery performed in a Physician's Office</i>	\$30 copayment per office visit The office visit Copayment will be waived when immunization is the only service provided
Specialty Physician Office Visit <i>Office Visits Surgery Performed in Physician's Office</i>	\$45 copayment per office visit
Child Early Intervention Services <i>From birth to 36 months</i>	Same as any other illness \$5,000 maximum per member per contract year
Inpatient Hospital Services <i>Semi-Private Room and Board Physician and Surgeon Services Diagnostic/Therapeutic Lab and X-ray Drugs and Medication Operating and Recovery Room Radiation Therapy and Chemotherapy Anesthesia and Inhalation Therapy</i>	\$300 copayment per day for the first 5 days of an inpatient admission*
Outpatient Facility Services <i>Operating Room, Recovery Room, Procedure Room and Treatment Room including: Physician Services Diagnostic/Therapeutic Lab and X-rays Anesthesia and Inhalation Therapy</i>	\$300 copayment per facility use*
Laboratory and Radiology Services <i>Advanced Radiological Imaging (MRIs, MRAs, CAT Scans and PET Scans) Other Laboratory and Radiology Services Outpatient hospital Facility Independent X-ray/Lab Facility</i>	\$200 copayment per procedure No charge* No charge
Short-Term Rehabilitative Therapy and Chiropractic Services	\$45 copayment per office visit 20 visits maximum per contract year
Emergency and Urgent Care Services <i>Physician's Office Hospital Emergency Room Participating Urgent Care Facility or Hospital Outpatient Facility Ambulance</i>	PCP or Specialty Physician Office Visit Copayment \$150 Copayment per visit, copayment waived if admitted \$75 Copayment per visit, copayment waived if admitted No charge
Maternity Care Services <i>Initial Office Visit to Confirm Pregnancy All subsequent Prenatal visits, Postnatal visits and Physician's Delivery charges Inpatient Hospital/Birthing Center Charges</i>	PCP or Specialty Physician Office Visit Copayment No charge \$300 copayment per day for the first 5 days of an inpatient admission*
Inpatient Services at Other Health Care Facilities <i>Skilled Nursing, Rehabilitation and Sub-Acute Facilities</i>	No charge 60 days maximum per contract year*

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Home Health Services	No charge, 80 days per contract year maximum
Family Planning Services <i>Office Visits (tests, counseling)</i> <i>Vasectomy/Tubal Ligation</i> <i>Inpatient Facility</i> <i>Outpatient Facility</i> <i>Surgery in Physician's Office</i>	PCP or Specialty Physician Office Visit Copayment \$300 copayment per day for the first 5 days of an inpatient admission* \$300 copayment per facility use* PCP or Specialty Physician Office Visit Copayment
Infertility Services <i>Office Visit (tests/counseling)</i> <i>Inpatient Facility</i> <i>Outpatient Facility</i> <i>Physician's Office</i>	PCP or Specialty Physician Office Visit Copayment \$300 copayment per day for the first 5 days of an inpatient admission* \$300 copayment per facility use* Specialty Physician Office Copayment
Mental Health and Substance Abuse <i>Inpatient Mental Health Services</i> <i>Outpatient Individual Mental Health Services</i> <i>Outpatient Mental Health Group Therapy</i> <i>Inpatient Substance Abuse Rehabilitation Services</i> <i>Outpatient Individual Substance Abuse Rehabilitation Services</i> <i>Outpatient Group Substance Abuse Rehabilitation Services</i> <i>Inpatient Substance Abuse Detoxification Services</i> <i>Outpatient Substance Abuse Detoxification Services</i>	Same as Inpatient Hospital Copayment. Same as Specialty Physician Office Visit Copayment The greater of one-half (1/2) the Specialty Physician services copayment per visit or \$5 per session Same as Inpatient Hospital Copayment Same as Specialty Physician Office Visit Copayment The greater of one-half (1/2) the Specialty Physician services copayment per visit or \$5 per session Same as Inpatient Hospital Copayment Same as Specialty Physician Office Visit Copayment
Transplant Services Travel Maximum	Same as Inpatient Hospital Copayment \$10,000 maximum benefit per transplant/per lifetime
Durable Medical Equipment	No charge
External Prosthetic Appliances	No charge

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Vision Care <i>(no referral required)</i>	\$10 Office Visit Copayment, Eye Exam every 24 months – Eyeglasses/Contact Lenses not covered
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	\$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 \$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
Pharmacy Deductible (Individual/Family)(Mail Order excl.) Pharmacy Out of Pocket Maximum (Individual/Family)	None/None None/None

OTHER BENEFIT INFORMATION

Contract Year Deductible <i>Individual</i> <i>Family</i>	\$1,500 \$3,000
Contract Year Out-of-Pocket (OOP) Maximum <i>Individual</i> <i>Family</i> <i>Only Inpatient (including Mental Health and Substance Abuse) and Outpatient Facility copayments apply to the OOP Maximum; these copayments are no longer required once the OOP maximum is reached.</i>	\$3,000 excludes deductible \$6,000 excludes deductible
Coinsurance	No
Lifetime Maximum	Unlimited
Pre-existing Condition Limitation	No

* *Services subject to the contract year deductible*

Services, other than emergency services, routine care provided by a participating OB/GYN, and 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.

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.