### Health Savings 5000

**GEORGIA**

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>IN NETWORK</th>
<th>OUT OF NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Individual Deductible</td>
<td>$5,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Annual Family Deductible</td>
<td>$10,000</td>
<td>$20,000</td>
</tr>
</tbody>
</table>

All benefits listed below are subject to the deductible unless otherwise noted.

#### Coinsurance*
- You pay 0%
- You pay 30%

#### Individual Out of Pocket Maximum
- $5,000
- $15,000

#### Family Out of Pocket Maximum
- $10,000
- $30,000

Lifetime Maximum
- Unlimited

### PHYSICIAN SERVICES

#### Office Visit
- Primary Care Physician: You pay 0%
- Specialist Physician: You pay 30%

#### Surgery (in any setting)
- You pay 0%
- You pay 30%

### PREVENTIVE CARE

#### Preventive Care for All Ages
- Routine physicals and other routine preventive services: You pay 0%
- You pay 30%

### INPATIENT SERVICES

#### Facility Services
- (Inpatient Room and Board, Pharmacy, X-ray and Laboratory, Operating Room, etc.): You pay 0%
- You pay 30%

#### Physician Services
- You pay 0%
- You pay 30%

### OUTPATIENT SERVICES

#### Lab, X-ray and Ultrasound
- You pay 0%
- You pay 30%

#### CT/PET Scans and MRI
- You pay 0%
- You pay 30%

#### Cardiac & Pulmonary Rehabilitation
- You pay 0%
- You pay 30%

#### Short Term Rehabilitative Therapy
- (Including Physical, Occupational and Speech Therapy)
- Calendar year maximum of 24 visits combined in- and out-of-network: You pay 0%
- You pay 30%

#### Outpatient Surgery
- You pay 0%
- You pay 30%
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<tr>
<th>BENEFIT</th>
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<tbody>
<tr>
<td><strong>EMERGENCY &amp; URGENT CARE SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
<td>You pay 0%</td>
<td>You pay the same level as In-Network if it is an emergency as defined in your plan, otherwise You pay 30%</td>
</tr>
<tr>
<td>Outpatient Professional Services (including Radiology, Pathology and ER Physician)</td>
<td>You pay 0%</td>
<td></td>
</tr>
<tr>
<td>Urgent Care Services</td>
<td>You pay 0%</td>
<td></td>
</tr>
<tr>
<td>Ambulance</td>
<td>Emergency transport only.</td>
<td>You pay 0%</td>
</tr>
<tr>
<td><strong>OTHER HEALTH CARE FACILITIES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility, Rehabilitation Hospital &amp; Sub-acute Facilities Calendar year maximum of 30 days combined in- and out-of-network</td>
<td>You pay 0%</td>
<td>You pay 30%</td>
</tr>
<tr>
<td>Home Health Calendar year maximum of 60 visits combined in- and out-of-network</td>
<td>You pay 0%</td>
<td>You pay 30%</td>
</tr>
<tr>
<td>Hospice</td>
<td>You pay 0%</td>
<td>You pay 30%</td>
</tr>
<tr>
<td><strong>DURABLE MEDICAL EQUIPMENT (DME)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>You pay 0%</td>
<td>You pay 30%</td>
</tr>
<tr>
<td><strong>MENTAL HEALTH</strong></td>
<td></td>
<td></td>
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<tr>
<td>Inpatient (Includes Acute, Partial &amp; Residential Treatment) Calendar year maximum of 30 days combined in- and out-of-network</td>
<td>You pay 0%</td>
<td>You pay 30%</td>
</tr>
<tr>
<td>Outpatient (Includes Individual, Group &amp; Intensive Outpatient Treatment) Calendar year maximum of 48 visits, combined in- and out-of-network</td>
<td>You pay 0%</td>
<td>You pay 30%</td>
</tr>
<tr>
<td><strong>PRESCRIPTION DRUGS</strong></td>
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</tr>
<tr>
<td>Prescription Drug Deductible</td>
<td>Subject to integrated medical/pharmacy deductible</td>
<td></td>
</tr>
<tr>
<td><strong>RETAIL PHARMACY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>You pay 0%</td>
<td>You pay 0%</td>
</tr>
<tr>
<td>Brand Name</td>
<td>You pay 0%</td>
<td>You pay 0%</td>
</tr>
<tr>
<td>Non-Preferred Brand Name</td>
<td>You pay 0%</td>
<td>You pay 0%</td>
</tr>
<tr>
<td>Self Injectables</td>
<td>You pay 0%</td>
<td>You pay 0%</td>
</tr>
<tr>
<td><strong>HOME DELIVERY PHARMACY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>You pay 0%</td>
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* 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
EXCLUSIONS:

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

- Conditions which are pre-existing.
- Any amounts in excess of maximum amounts of Covered Expenses.
- Services or supplies not specifically listed as Covered Expenses.
- Services or supplies that are not Medically Necessary.
- Services or supplies that are Experimental or Investigational.
- Services received before the Effective Date of coverage.
- Services received after coverage under the Policy ends.
- Services for which You have no legal obligation to pay or for which no charge would be made if You did not have a health plan or insurance coverage.
- Any condition for which benefits are recovered or can be recovered.
- Conditions caused by: (a) an act of war (declared or undeclared); (b) the inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) an Insured Person participating in the military service of any country; (d) an Insured Person participating in an insurrection, rebellion, or riot; (e) services received as a direct result of an Insured Person’s commission of, or attempt to commit a felony (whether or not charged) or as a direct result of the Insured Person being engaged in an illegal occupation; (f) an Insured Person being intoxicated, as defined by applicable state law in the state where the illness occurred or under the influence of illegal narcotics or non-prescribed controlled substances unless administered or prescribed by Physician.
- Any services provided by a local, state or federal government agency.
- If the Insured Person is eligible for Medicare part A, B or D, 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.
- Court-ordered treatment or hospitalization.
- Professional services or supplies received or purchased directly or on Your behalf by anyone, including a Physician, from any of the following:
  - Yourself or Your employer;
  - A person who lives in the Insured Person’s home, or that person’s employer;
  - A person who is related to the Insured Person by blood, marriage or adoption, or that person’s employer
- Non-Duplication of Medicare: Any services for which Medicare benefits are actually paid. Any services for which payment may be obtained from any local, state or federal government agency. Veteran's Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.
- 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.
- 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.
- Treatment of Mental, Emotional or Functional Nervous Disorders or psychological testing. However, medical conditions that are caused by behavior of the Insured Person and that may be associated with these mental conditions are not subject to these limitations.
- Smoking cessation programs.
- Treatment of substance abuse.
- Dental services.
- Orthodontic Services.
- Dental Implants.
- Hearing aids.
- Routine hearing tests.
- Optometric services.
- 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.
- Cosmetic surgery.
- 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.
- Services for redundant skin surgery, removal of skin tags, acupressure, acupuncture, carinosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, rolfing, prolotherapy 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.
- All services related to the treatment of fertility and/or infertility.
- All non-prescription Drugs, devices and/or supplies, except drugs designated as preventive by the Patient Protection and Affordable Care Act (PPACA), that are available over the counter or without a prescription,
- Injectable drugs (*self-injectable medications) that do not require Physician supervision.
- All noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs.
- Any Infusion or Injectable Specialty Prescription Drugs that require Physician supervision.
- Cryopreservation of sperm or eggs.
- Fees associated with the collection or donation of blood or blood products.
- Blood administration for the purpose of general improvement in physical condition
- Orthopedic shoes (except when joined to braces) or shoe inserts, including orthotics.
- Services primarily for weight reduction or treatment of obesity.
- Routine physical exams or tests required by employment or government authority.
- Therapy or treatment intended primarily to improve or maintain general physical condition.
Telephone, e-mail, and Internet consultations.

Items which are furnished primarily for personal comfort or convenience.

Massage therapy

Educational services except for Diabetes Self-Management Training Program.

Nutritional counseling or food supplements.

Durable medical equipment not meeting the criteria outlined in the “Benefits: What the Policy Pays For” section of the Policy.

Physical, and/or Occupational Therapy/Medicine except when provided during an inpatient Hospital confinement or as specifically stated in the Policy.

Self-administered Injectable Drugs.

Any Drugs, medications, or other substances dispensed or administered in any outpatient setting except as specifically stated in this Policy. This includes, but is not limited to, items dispensed by a Physician.

Syringes.

All Foreign Country Provider charges.

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.

Charges for which We are unable to determine Our liability.

Charges for the services of a standby Physician.

Charges for animal to human organ transplants.

Charges for Normal Pregnancy or Maternity Care.

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 60 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 (INDGA022012) 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.

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