HOW YOUR CIGNA HEALTH SAVINGS ACCOUNT WORKS

This product combines traditional medical coverage with a savings account and investment options. Both you and your employer can make tax-free contributions to the savings account up to federal limits.

Your annual contribution is limited to

- $3,050 for individuals and $6,150 for families.

You can choose how you pay for medical expenses until you meet your plan deductible.

- You may pay for medical expenses on a claim-by-claim basis using your debit card or checkbook that are tied to your HSA.
- You may choose to cover your expenses using your own personal funds. This allows you to save your HSA dollars for future years.

Only covered services count toward the deductible. Once your deductible has been met, your plan begins providing coverage for eligible services as described below.

Any dollars remaining in your savings account at the end of the year carry over to the next year. If you change employers or retire, you may take any dollars in your savings account with you.

Health Savings Account	Employee	Employee + One	Employee + Children	Family
Employer Contribution	$	$	$	$

KEY BENEFIT INFORMATION	IN-NETWORK	OUT-OF-NETWORK
Plan Contract Year Deductible – Collective (combined Medical and Pharmacy)		
Individual (Employee Only – no covered dependents)	$2,000	$4,000
Family Maximum – (Employee + Family)	$4,000	$8,000
Family Collective Deductible: *All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.*		
Plan Contract Year Out-of-Pocket Maximum – Collective (combined Medical and Pharmacy)	Including Plan Deductible	Including Plan Deductible
Individual (Employee Only – no covered dependents)	$4,000	$12,000
Family Maximum (Employee + Family)	$8,000	$24,000
Family Collective Out-of-Pocket Maximum: *All family members contribute towards the family out-of-pocket maximum. An individual cannot have claims covered at 100% until the total family out-of-pocket maximum has been satisfied.*		
Coinsurance	CIGNA HealthCare pays 90% of eligible charges. You pay 10% of charges after the plan deductible.	CIGNA HealthCare pays 70% of eligible charges. You pay 30% of charges after the plan deductible.
Precertification -Inpatient – PHS+ (required for all inpatient admissions)	Coordinated by your physician	Participant must obtain approval for inpatient admission; subject to penalty/reduction or denial for non-compliance
Precertification – Outpatient – PHS+ (required for selected outpatient procedures and diagnostic testing or outpatient services)	Coordinated by your physician	Participant must obtain approval for selected outpatient procedures and diagnostic testing; subject to penalty/reduction or denial for non-compliance.
Lifetime Maximum ***Note****: In addition to the combined medical and pharmacy deductible and out-of-pocket maximum, the plan's lifetime maximum will also be combined*	$3,000,000#	$3,000,000#
Pre-existing Condition Limitation	Yes	Yes

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician Services		
Primary Care Physician (PCP) Office Visit	10% of charges*; 10% of charges* if only x-ray and/or lab services are performed and billed.	30% of charges**
Specialty Physician Office Visit	10% of charges*; 10% of charges* if only x-ray and/or lab services are performed and billed.	30% of charges**
Consultant and Referral Physician Services		
Allergy Treatment/Injections - PCP or Specialty Physician	10% of charges*	30% of charges**
Allergy Serum (dispensed by physician in office)	10% of charges*	30% of charges**
Second Opinion Consultations (provided on voluntary basis)	10% of charges*	30% of charges**
Surgery Performed in the Physician's Office- PCP or Specialty Physician	10% of charges*	30% of charges**
Preventive Care		
Routine Preventive Care – Well Baby Care, Well Child Care and Adult Preventive Care Unlimited maximum per contract year	No charge, no plan deductible; No charge, no plan deductible, for x-ray and/or lab services when billed by a separate outpatient diagnostic facility.	30% of charges**
Immunizations	No charge, no plan deductible	30% of charges**
Mammograms, PSA, Pap Test	No charge, no plan deductible	30% of charges**
Inpatient Hospital Services including*:* *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*	10% of charges*	30% of charges* per admission Pre-certification required
Inpatient Hospital Doctor's Visits/Consultations	10% of charges*	30% of charges**
Inpatient Hospital Professional Services	10% of charges*	30% of charges**
Outpatient Facility Services includes*:* *Operating Room, Recovery Room, Procedure Room and Treatment Room and Observation Room including:* *Diagnostic/Therapeutic Lab and X-rays* *Anesthesia and Inhalation Therapy*	10% of charges*	30% of charges**
Physician & Outpatient Professional Services	10% of charges*	30% of charges**
Laboratory and Radiology Services (includes preadmission testing)		
Physician's Office	10% of charges*	30% of charges**
Outpatient Hospital Facility	10% of charges*	30% of charges**
Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit)	10% of charges*	10% of charges*; *if not a true emergency, then 30% of charges***
Independent X-Ray and/or Lab Facility		
Independent X-Ray and/or Lab Facility (in conjunction with an Emergency Room visit)	10% of charges* 10% of charges*	30% of charges** 10% of charges*; *if not a true emergency, then 30% of charges***
Advanced Radiological Imaging *(MRIs, MRAs, CAT Scans, PET Scans, etc.)*		
Inpatient Facility	Same as inpatient hospital facility benefit	Same as inpatient hospital facility benefit
Outpatient Facility	10% of charges*	30% of charges**
Emergency Room (billed by facility as part of the Emergency Room visit)	10% of charges*	10% of charges*; *except if not a true emergency, then 30% of charges***
Physician's Office	10% of charges*	30% of charges**

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Short-Term Rehabilitative Therapy and Chiropractic Services *(includes physical, speech, occupational, chiropractic, 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.*	10% of charges*; 10% of charges* if only x-ray and/or lab services are performed and billed.	30% of charges**
Outpatient Cardiac Rehabilitation up to 36 days maximum per calendar year#	10% of charges*	30% of charges**
Emergency and Urgent Care Services *Physician's Office – PCP or Specialty Physician*	10% of charges*; 10% of charges* if only x-ray and/or lab services are performed and billed.	*Care will be provided at in-network levels if it meets the "prudent layperson" definition of an emergency. Otherwise 30% of charges*****
Hospital Emergency Room	10% of charges*	
Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician)	10% of charges*	
Urgent Care Facility or Outpatient Facility	10% of charges*	
Ambulance	10% of charges*	
Maternity Care Services *Initial Office Visit to Confirm Pregnancy*	10% of charges* for initial office visit; 10% of charges* if only x-ray and/or lab services are performed and billed	30% of charges**
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (total maternity fee)	10% of charges*	30% of charges**
Office Visits not included in the total maternity fee performed by OB or Specialty Physician	10% of charges*; 10% of charges* if only x-ray and/or lab services are performed and billed.	30% of charges**
Delivery - Facility (Inpatient Hospital/Birthing Center Charges)	10% of charges*	30% of charges*, precertification required
Inpatient Services at Other Health Care Facilities *Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities* - 60 days maximum per contract year# combined for all facilities listed	10% of charges*	30% of charges**
Home Health Services *– Includes outpatient private duty nursing when approved as medically necessary* 80 days maximum per contract year#; 16 hour maximum per day#	10% of charges*	25% of charges**
Family Planning Services *Office Visits (lab & radiology tests, counseling)*	10% of charges* per office visit; 10% of charges* for x-ray/lab if billed by separate outpatient diagnostic facility	30% of charges**
Vasectomy/Tubal Ligation (excludes reversals)		
Inpatient Facility	10% of charges*	30% of charges*, pre-certification required
Outpatient Facility	10% of charges*	30% of charges**
Physician's Services – Inpatient or Outpatient	10% of charges*	30% of charges**
Physician's Office	10% of charges*; 10% of charges* if only x-ray and/or lab services are performed and billed	30% of charges**
Infertility Services *Office Visit (lab & radiology tests, counseling)-PCP or Specialty Physician* *Treatment/Surgery (includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.). Subject to the following maximums:* *Four cycles of ovulation induction per lifetime. Three cycles of intrauterine insemination per lifetime. Two cycles of low tubal ovum transfer, IVF, GIFT and/or ZIFT per lifetime, with not more than two transfers per cycle.*	10% of charges* per office visit; 10% of charges* for x-ray/lab if billed by separate outpatient diagnostic facility	30% of charges**
Inpatient Facility	10% of charges*	30% of charges*, pre-certification required
Outpatient Facility	10% of charges*	30% of charges**
Physician's Services	10% of charges*	30% of charges**

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
TMJ - Surgical and Non-Surgical	Not covered	Not covered
Mental Health Services and Substance Abuse Treatment *Inpatient* – Unlimited days maximum per contract year **Mental Health** Acute: Based on a ratio of 1:1 Partial: Based on ratio of 2:1 Residential: Based on a ratio of 2:1 **Substance Abuse** Acute Detox: requires 24-hour nursing; based on a ratio of 1:1 Acute Inpatient Rehab: requires 24-hour nursing; based on a ratio of 1:1 Partial: Based on ratio of 2:1 Residential: Based on a ratio of 2:1 *Outpatient* - Unlimited maximum per contract year *Group Therapy* – subject to mental health outpatient individual visits maximum per contract year based on a 1:1 ratio *Intensive Outpatient Mental Health and Substance Abuse*	10% of charges* 10% of charges* 10% of charges*	30% of charges*, pre-certification required 30% of charges** 30% of charges**
Durable Medical Equipment $700 maximum per contract year#	10% of charges*	30% of charges**
External Prosthetic Appliances $1,000 maximum per contract year#	10% of charges*	30% of charges**

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Prescription Drugs-		
CIGNA Pharmacy Retail Drug Program		
*Generic*** drugs on the Prescription Drug List for a 30-day supply*	30% of charges* per prescription/refill	30% of charges* per prescription/refill
*Brand Name*** drugs designated as preferred on the Prescription Drug List with no Generic equivalent for a 30-day supply*	40% of charges* per prescription/refill	30% of charges* per prescription/refill
*Brand Name*** drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List for a 30-day supply*	50% of charges*per prescription/refill	30% of charges* per prescription/refill
CIGNA Tel-Drug Mail Order Drug Program		
*Generic*** drugs on the Prescription Drug List for a 90-day supply*	30% of charges* per prescription/refill	Covered in-network only
*Brand Name*** drugs designated as preferred on the Prescription Drug List with no Generic equivalent for a 90-day supply)*	40% of charges* per prescription/refill	Covered in-network only
*Brand Name*** drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List for a 90-day supply*	50% of charges*per prescription/refill	Covered in-network only
****Designated as per generally-accepted industry sources and adopted by CG*		

**Services are subject to contract year deductible*
***Services are subject to contract year deductible and reasonable and customary charge/maximum reimbursable charge limitations.*
 # In-network and out-of-network services apply to the same treatment or dollar maximum.

Footnotes:

Regarding In-Network and Out-of-Network Services:

- *Once the plan's out-of-pocket maximum is reached, the plan pays 100% of eligible charges for the remainder of the plan year.*
- *All inpatient hospital admissions and certain outpatient procedures and diagnostic testing require Preadmission Certification and Continued Stay Review. Failure to obtain Preadmission Certification and 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.*

Regarding In-Network Services:

- *All services must be provided by one of the preferred providers on our list in order to be covered.*

Regarding Out-of-Network Services:

- *Your out-of-pocket costs will be higher than with a preferred provider.*
- *All out-of-network hospital admissions and certain outpatient surgical and diagnostic procedures must be precertified and are subject to Continued Stay Review (CSR). A penalty applies to admissions which are not precertified. Non-approved admissions/days result in denial of benefits. The precertification penalty or cost of denied benefits does not apply to deductible or out-of-pocket maximum.*

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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. Treatment of TMJ disorder; however medically necessary treatment for craniofacial disorders is covered.
6. 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
7. 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. [
8. 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.
9. Court ordered treatment or hospitalizations.
10. Infertility donor services and charges.
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 plan.
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 medically necessary appliances and supplies such as collection devices, irrigation equipment and supplies, skin barriers and skin protectors which are related to an ostomy, colostomy, ileostomy or urostomy surgery and urinary catheters.
15. Private hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
16. Artificial aids, including but not limited to hearing aids for insureds age 13 years of age or older, semi-implantable hearing devices, audiant bone conductors, bone anchored hearing aids, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs (other than wigs prescribed by an oncologist for an insured being treated for cancer).
17. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
18. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
19. Non-prescription drugs and investigational and experimental drugs, except as provided in the plan.]
20. Routine foot care, however, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.
21. Genetic screening or pre-implantation genetic screening.
22. Fees associated with the collection or donation of blood or blood products.
23. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
24. All nutritional supplements and formulae are excluded, except infant formula needed for the treatment of inborn errors of metabolism or cystic fibrosis, and medically necessary specialized infant formulas.
25. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
26. 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.
27. 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.
28. 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; 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 affordable 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.

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