SUMMARY OF BENEFITS

Your CIGNA HealthCare Open Access InNetwork Plan

CIGNA HealthCare

Features that Add Value

- The convenience of **referral-free access** to physicians, and the option to select a **personal Primary Care Physician (PCP)** as your source for routine care and guidance when you need specialized care. As your needs change, so may your choice of doctors. That's why you can change your PCP for any reason.
- 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 often 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 the Language Line Services so that you can **talk with us** in 140 different languages. Just call Customer Service, and ask for an interpreter to assist you.

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 to age 19 and any additional preventive care benefits described in the Benefits Highlights.

You Can Depend on CIGNA HealthCare

- **Quality comes first**. We select "participating providers" carefully. And we make sure you have a **wide range** of doctors to choose from.
- **Emergency and urgent care are covered** wherever you go, worldwide, **24 hours a day**. Urgent care centers can take care of your urgent care needs, and your cost is lower.

It's Your Choice

- When you visit network providers, you get access to quality care at the lowest out-of-pocket costs available under your plan.

New York OAP IN Network1500 Plan

This Plan **EXCLUDES** coverage for Biologically-based Mental Illness and Serious Emotional Disturbances of Children

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician Services ***Primary Care Physician (PCP) Office Visit***	$30 copayment per office visit. No charge after the per visit copay if only x-ray and/or lab services performed *in the office* and billed *by the physician*.	N/A
Specialty Physician Office Visit *Consultant and Referral Physician Services*	$60 copayment per office visit. No charge after the per visit copay if only x-ray and/or lab services performed *in the office* and billed *by the physician*.	N/A
Allergy Treatment/Injections - PCP or Specialty Physician	$30 or $60 copayment per office visit or actual charge, whichever is less	N/A
Allergy Serum (dispensed by physician in office)	No charge	N/A
Second Opinion Consultations (provided on voluntary basis)	$30 or $60 copayment per office visit	N/A
Surgery Performed in the Physician's Office- PCP or Specialty Physician	$30 or $60 copayment per office visit	N/A
Preventive Care ***Note****: Charges for routine preventive care for children through age 18, mammograms,, PSA and Pap test and osteoporosis screening are NOT subject to the preventive care annual maximum of $500* *Routine Preventive Care for Children through age 18*		
Office Visit and examinations	$30 or $60 copayment per office visit.	N/A
x-ray and lab service	100% no plan deductible	N/A
Immunizations (including routine immunizations)	100% no plan deductible	N/A
Mammograms, PSA, Pap Test, Osteoporosis Screening	100% no plan deductible	N/A
Routine Preventive Care for Children and Adults from age 19 (including routine immunizations) $500 maximum per calendar year	100% no plan deductible	N/A
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*	20% of charges* Precertification required	N/A
Inpatient Hospital Doctor's Visits/Consultations *Inpatient Hospital Professional Services*	20% of charges* 20% of charges*	N/A N/A

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
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*	20% of charges*	N/A
Physician & Outpatient Professional Services	20% of charges*	N/A
Laboratory and Radiology Services (includes preadmission testing)		
Advanced Radiological Imaging *(MRIs, CAT Scans, PET Scans, etc.)*	20% of charges*	N/A
Other Laboratory and Radiology Services		
Physician's Office	$30 or $60 copayment per office visit	N/A
Outpatient Hospital Facility	20% of charges*	N/A
Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit)	Included in ER/UC Copay	Included in ER/UC Copay (except if not a true emergency, then not covered)
Independent X-Ray and/or Lab Facility	20% of charges*	N/A
Independent X-Ray and/or Lab Facility (in conjunction with an Emergency Room visit)	Included in ER Copay	Included in ER Copay (except if not a true emergency, then not covered)
Short-Term Rehabilitative (includes physical, speech, occupational rehab & cognitive therapy)- 30 visits maximum per calendar year# for all therapies combined	$60 copayment per office visit. No charge after the per visit copay if only x-ray and/or lab services performed *in the office* and billed *by the physician*.	N/A
Chiropractic Services- Unlimited maximum per calendar year#	$60 copayment per office visit. No charge after the per visit copay if only x-ray and/or lab services performed *in the office* and billed *by the physician*.	N/A
Cardiac/Pulmonary Rehab - 36 visits per year (not subject to Short-Term Rehab maximum.) ***<u>Note</u>***: *therapy sessions provided as part of Home Health Care accumulate to the Short-Term Rehab Therapy or Cardiac/Pulmonary Rehab maximum*	$60 copayment per office visit. No charge after the per visit copay if only x-ray and/or lab services performed *in the office* and billed *by the physician*	N/A
Emergency and Urgent Care Services		
Physician's Office – PCP or Specialty Physician	$30 or $60 copayment per office visit. No charge after the per visit copay if only x-ray and/or lab services performed *in the office* and billed *by the physician*.	$30 or $60 copayment per office visit. No charge after the per visit copay if only x-ray and/or lab services performed *in the office* and billed *by the physician*. (except if not a true emergency, then not covered)
Hospital Emergency Room	$150 copayment per visit (*copay waived if admitted*)	$150 copayment per visit (*copay waived if admitted*) (except if not a true emergency, then not covered)
Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician)	$150 copayment per visit (*copay waived if admitted*)	$150 copayment per visit (*copay waived if admitted*) (except if not a true emergency, then not covered)
Urgent Care Facility or Outpatient Facility	$75 copayment per visit (*copay waived if admitted)*	$75 copayment per visit (*copay waived if admitted)* (except if not a true emergency, then not covered)
Ambulance	20% of charge*	20% of charge* (except if not a true emergency, then not covered)

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Maternity Care Services *Initial Office Visit to Confirm Pregnancy*	$30 or $60 copayment per office visit. No charge after the per visit copay if only x-ray and/or lab services performed *in the office* and billed *by the physician*.	N/A
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (total maternity fee)	20% of charge*	N/A
Office Visits not included in the total maternity fee performed by OB or Specialty Physician	$30 or $60 copayment per office visit. No charge after the per visit copay if only x-ray and/or lab services performed *in the office* and billed *by the physician*.	N/A
Delivery - Facility (Inpatient Hospital/Birthing Center Charges)	20% of charges* precertification required	N/A
Inpatient Services at Other Health Care Facilities Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities-60 days maximum per calendar year combined for all facilities listed	20% of charge*	N/A
Home Health Services (Does not include outpatient private duty nursing) – 60 visits maximum per calendar year#; 16 hour maximum per day	20% of charge	N/A
Family Planning Services *Office Visits (lab & radiology tests, counseling) (Subject to Preventive Care dollar maximum)*	$30 or $60 copayment per office visit. No charge after the per visit copay if only x-ray and/or lab services performed *in the office* and billed *by the physician*.	N/A
Vasectomy/Tubal Ligation (excludes reversals)		
Inpatient Facility	20% of charge*, precertification required	N/A
Outpatient Facility	20% of charge*	N/A
Physician’s Services – Inpatient or Outpatient	20% of charge*	N/A
Physician’s Office	$30 or $60 copayment per office visit. No charge after the per visit copay if only x-ray and/or lab services performed *in the office* and billed *by the physician*.	N/A

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Mental Health *Inpatient* - 30 days maximum per calendar year# *Acute:* Based on a ratio of 1:1 *Partial:* Based on a ratio of 2:1 *Residential:* Based on a ratio of 2:1	20% of charge*, precertification required	N/A
*Outpatient – 2*0 visits maximum per calendar year	$60 copayment per office visit	N/A
Group Therapy Mental Health – combined maximum with Outpatient Individual Mental Health services based on a ratio of 1:1	$60 copayment per office visit	N/A
Intensive Outpatient Mental Health – combined maximum with Outpatient Individual Mental Health services based on a ratio of 1:1	$60 copayment per office visit	N/A
Substance Abuse		
Acute Detox: Based on a ratio of 1:1 (requires 24 hour nursing)	20% of charge*, precertification required	N/A
Acute Inpatient Rehab: Based on a ratio of 1:1 (requires 24 hour nursing) *Partial:* Based on a ratio of 2:1 *Residential:* Based on a ratio of 2:1	Not Covered	N/A
Outpatient - 60 visits maximum per calendar year#; (includes 20 visits for counseling and education for insured family members)	20% of charge*	N/A
Intensive Outpatient Substance Abuse – combined maximum with Outpatient Individual Substance Abuse services based on a ratio of 1:1	20% of charge*	N/A
Durable Medical Equipment $5,000 maximum per calendar year#	20% of charge*	N/A
External Prosthetic Appliances	20% of charge*	N/A
Prescription Drugs ***Pharmacy Deductible (does not apply to Generic)*** ***Note****: this is a separate deductible that applies to preferred and non-preferred brand name drugs. The Pharmacy Deductible is not included in the medical deductible and does not contribute to the plan's calendar year out of pocket maximum.*	$2000	
CIGNA Pharmacy Retail Drug Program – *Includes oral contraceptives and contraceptive devices*	$10 per 30-day supply for generic drugs 50% per 30-day supply for preferred brand-name drugs 50% per 30 day supply for non-preferred brand-name drugs	N/A
CIGNA Tel-Drug Mail Order Drug Program	$25 per 90-day supply for generic drugs 50% per 90-day supply for preferred brand-name drugs 50% per 90-day supply for non-preferred brand-name drugs	N/A

OTHER BENEFIT INFORMATION	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Plan Deductible *Individual* *Family*	 $1,500 $3,000	 N/A N/A
Calendar Year Out-of-Pocket Maximum *Individual* *Family*	Excluding Plan Deductible, copays, pharmacy charges $5,000 $10,000	 N/A N/A
Coinsurance	CIGNA HealthCare pays 80% of eligible charges. You pay 20% of charges after plan deductible.	N/A
Precertification -Inpatient – PHS+ *(required for all inpatient admissions)* ***Precertification – Outpatient – PHS+*** *(required for selected outpatient procedures and diagnostic testing or outpatient services)*	Coordinated by your physician Coordinated by your physician	N/A N/A
Lifetime Maximum	$5,000,000	
Pre-existing Condition Limitation	Yes	

**Services are subject to calendar year deductible*
 # In-network and out-of-network services apply to the same treatment or dollar maximum.

<u>Footnotes:</u>
***Regarding In-Network and Out-of-Network Services**:*

- *Once the out-of-pocket maximum is reached, the plan pays 100% of eligible charges for the remainder of the calendar year.*
- *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.*

***Regarding In-Network Services**: All services must be provided by one of the participating providers on our list in order to be covered.*
***Regarding Out-of-Network Services:** Out of network services are covered for emergencies only.*

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, unless medically necessary. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute (NHLBI) guideline is covered only at approved centers if the services are demonstrated, through existing peer-reviewed, evidence-based, scientific literature and scientifically based guidelines, to be safe and effective for treatment of the condition. Clinically severe obesity is defined by the NHLBI as a BMI of 40 or greater without comorbidities, or 35–39 with comorbidities. The following are specifically excluded: 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. Any requests for coverage of storage of sperm for artificial insemination (including donor fees) and cryopreservation of donor sperm and eggs will be subject to Medical Necessity review.
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. Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
18. 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. Genetic screening or pre-implantation genetic screening.
20. Fees associated with the collection or donation of blood or blood products.
21. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
22. All nutritional supplements and formulae are excluded, except infant formula needed for the treatment of inborn errors of metabolism.
23. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
24. Expenses incurred for medical treatment by a person age 65 or older, who is covered by Medicare, when payment is denied by the Medicare plan because treatment was not received from a participating provider of the Medicare plan.
25. 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.
26. Coverage will not be provided for the following, unless medically necessary: 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.

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