CIGNA HealthCare of Arizona, Inc.
Individual/Dependent Plan Summary of Benefits
Effective From January 1, 2011

This Summary of Benefits is a supplement to the Individual/Dependent Plan Service Agreement provided to members and is not intended as a complete summary of the services and benefits covered and excluded. Members must review their Individual & Family Plan Service Agreement for an exact description of the services and benefits which are covered, those which are excluded or limited and other terms and conditions of coverage.

What's Covered	***What You Pay***
Primary Care Physician Services • Office Visit	$25 Copay per office visit
Specialty Care Physician Services • Office Visit • Consultation and Referral Physician Services • Allergy Testing & Treatment • Obstetrical/Gynecological Visit	$50 Copay per office visit
Preventive Care Services (any age) • Preventive Care • Periodic Physical Evaluation for Adults • Well Child Care • Routine Immunizations and Injections	No Charge
Other Medical Services • Laboratory & X-ray • Blood Pressure Checks • Casting & Dressing	No Charge
Chiropractic Care Services 12 self-referral chiropractic visits for medically necessary treatment of neck and back pain within the scope of chiropractic practice.	$50 Copay per office visit A total of 20 days per Plan Year
Prescription Drugs • Prescription medication and diabetic supplies including insulin, syringes, and test strips (30 day supply) • Subject to Healthplan Formulary • Limited to generic drugs unless one does not exist or substitution is not permitted by law. Individuals purchasing brand-name drugs when a generic equivalent is available are responsible for the difference in cost and the copayment.	$15 Copay for generic drugs $40 Copay for brand-name drugs $60 Copay for non-preferred brand-name drugs

What's Covered	***What You Pay***
Inpatient Hospital Services • Semi-private Room & Board • Physician & Surgeon Charges • Diagnostic & Therapeutic Laboratory and X-ray Services • Drugs, Medications, & Biologicals • Special Care Units • Operating Room, Recovery Room, Oxygen, Anesthesia, Respiratory & Inhalation Therapy • Hemodialysis • Radiation Therapy & Chemotherapy	80%/20% Coinsurance* You pay 20% Plan Year deductible applies** **$1,000 Individual deductible per Plan Year**** **$3,000 Family deductible per Plan Year****
Outpatient Hospital Services • Physician Services • Operating Room & Recovery Room • Anesthesia, Respiratory Inhalation Therapy, Hemodialysis, Radiation Therapy, Chemotherapy, Therapeutic Laboratory	80%/20% Coinsurance* You pay 20% Plan Year deductible applies** **$1,000 Individual deductible per Plan Year**** **$3,000 Family deductible per Plan Year****
• Diagnostic Laboratory and X-ray (CT, MRI, MRA, PET, etc.)	$100 copay per procedure
Emergency Services • Hospital Emergency Room, Outpatient Facility, or Other Non-Contracted Facilities	$150 Copay per visit
• Ambulance	80%/20% Coinsurance* You pay 20% Plan Year deductible applies**
Urgent Care Services CIGNA HealthCare Urgent Care Facility or Other Contracted Facilities	$75 Copay per visit
Maternity Care Services • Prenatal & Postpartum Exams	No Charge
• Delivery (Maternity care is provided when delivery occurs after the contract has been in force for 21 consecutive months)	80%/20% Coinsurance* You pay 20% Plan Year deductible applies**
Family Planning Services Voluntary Surgical Sterilization	
• Inpatient & Outpatient	80%/20% Coinsurance* You pay 20% Plan Year deductible applies**
• Primary Care Physician Office Visit/Specialty Care Physician Office Visit	$25 Copay/$50 Copay
• Infertility Service	Not Covered

What's Covered	***What You Pay***
Inpatient Services at Other Participating Health Care Facilities (60 days maximum per Plan Year combined for all facilities listed below) • Skilled Nursing Facility • Extended Care & Rehabilitation	80%/20% Coinsurance* You pay 20% Plan Year deductible applies**
Short-Term Rehabilitative Therapy • Outpatient	$50 Copay per office visit; limit of 60 combined days per Plan Year
• Inpatient	80%/20% Coinsurance* You pay 20% Plan Year deductible applies**
Substance Abuse & Detoxification Services • Outpatient	$15 Copay per office visit for the first two (2) visits; $40 per visit for each visit thereafter up to twenty (20) visits***
• Inpatient	$100 Copay per day up to eight (8) days
Mental Health Services • Outpatient	$40 Copay per one-on-one office visit*** $15 Copay per group therapy visit
• Inpatient	Not covered
Vision Services • Eye Exam • Eyeglasses *Vision benefit does not cover contact lenses*	Discount available through the Healthy Rewards® network of vision care providers
Home Health Services See Service Agreement for Benefits, Exclusions and Limitations	No Charge
Durable Medical Equipment See Service Agreement for Benefits, Exclusions and Limitations	No Charge
External Prosthetics See Service Agreement for Benefits, Exclusions and Limitations	$200 Copay per member per Plan Year
Out-of-Pocket Limits	$3,000 Individual per Plan Year* $9,000 Family per Plan Year*
Plan Year Deductibles	$1,000 Individual per Plan Year** $3,000 Family per Plan Year**
Lifetime Maximum Benefit	Unlimited

*Out-of-Pocket Limits apply to Coinsurance paid by you. Notify Member Services when you have reached the Out-of-Pocket Limit for the Plan Year. Copayments and deductibles do not apply towards Out-of-Pocket Limits.
**Deductibles for the various services listed in this Summary of Benefits are combined to meet the Plan Year deductible requirement. Coinsurance amounts will apply after the deductible is met.
***Services for Outpatient Substance Abuse Detoxification and Outpatient Mental Health are limited to a combined benefit of 20 visits per Plan Year.

Definition of terms:

Copayment (copay)*:* A predetermined fee for physician office visits, prescriptions or hospital services that the member pays at the time of service.
Coinsurance: The portion of a covered claim (usually a percentage of the total cost) that the member pays.
Deductible: A dollar amount that a member pays before the plan begins to pay toward the cost of covered medical expenses.