

This is a summary of benefits for your POS Copay plan. Service specific maximums accumulate in one direction (in-network will accumulate to out-of-network). Lifetime maximums, out-of-pocket maximums and/or plan deductibles do not cross accumulate. All in-network services must be performed by the Primary Care Physician (PCP), referred by the PCP or approved by the local Healthplan. CIGNA Pharmacy plan deductibles, out-of-pocket maximums, copays and annual maximums do not integrate with the employer medical program. Rev092206

CIGNA HealthCare Benefit Summary TEIGIT California POS Copay Plan		
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	\$1,000,000
Coinsurance Levels	100% Note: All services will be covered at a 100% coinsurance level; with or without applicable copays	70%
Deductible Accumulators	No cross accumulation (e.g. in-network and out-of-network deductibles do no cross accumulate)	
Contract Year Deductible Individual Family Maximum Aggregate	None None Yes	\$500 per person \$1,000 per family Yes
Out-of-Pocket Maximum Accumulators Includes Copays Includes Plan Deductibles The following do not accumulate to the OOP Maximum	Includes member paid coinsurance, inpatient facility copays (including MH/SA), outpatient facility copays, office visit copays and advanced radiological imaging copays. No Copays not listed above and plan deductibles. Once the Out-of-Pocket Maximum is reached, plan coinsurance, inpatient facility copays (including MH/SA), outpatient facility copays and advanced radiological imaging copays will no longer be required.	Includes member paid coinsurance, inpatient facility deductibles, outpatient facility deductibles, advanced radiological imaging deductibles and ER/UC copays. No Non-compliance penalties, plan deductibles or charges in excess of Maximum Reimbursable Charge. Benefits for accident or sickness (excluding mental health, alcohol, and drug abuse benefits) are paid at 100% once an individual's out-of-pocket maximum has been reached.
Out-of-Pocket Maximum Individual Family Maximum Aggregate	\$2,000 per person \$4,000 per family Yes (when plan includes a family OOP maximum)	\$4,000 per person \$8,000 per family Yes
Automatic Annual Reinstatement	Not Applicable	

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Physician's Services</p> <p><i>Primary Care Physician's Office visit</i></p> <p><i>Specialty Care Physician's Office Visit Office Visits</i> <i>Consultant and Referral Physician's Services</i></p> <p>Note: OB/GYN provider is considered a Specialist.</p> <p><i>Surgery Performed In the Physician's Office</i></p> <p><i>Second Opinion Consultations (provided on a voluntary basis)</i></p> <p><i>Allergy Treatment/Injections</i></p> <p><i>Allergy Serum (dispensed by the physician in the office)</i></p>	<p>No charge after \$15 PCP per office visit copay; No charge if only x-ray and/or lab services performed and billed.</p> <p>No charge after \$15 Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed.</p> <p>No charge after the PCP or Specialist per office visit copay</p> <p>No charge after the PCP or Specialist copay</p> <p>No charge after either the PCP or Specialist per office visit copay or the actual charge, whichever is less</p> <p>No Charge</p>	<p>70% after plan deductible</p> <p>70% after plan deductible</p> <p>70% after plan deductible</p> <p>70% after plan deductible</p> <p>70% after plan deductible</p> <p>70% after plan deductible</p>
<p>Preventive Care</p> <p><i>Routine Preventive Care: Well-Baby, Well-Child, Adult and Well-Woman (including immunizations)</i></p> <p>Note: Well-woman OB/GYN visits will be subject to the plan's Specialist copay</p> <p><i>Immunizations</i></p>	<p>No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed.</p> <p>No charge</p>	<p>In-network coverage only</p>
<p>Mammograms, PSA, PAP Smear</p> <p><i>Preventive Care Related Services (i.e. "routine" services)</i></p> <p><i>Diagnostic Related Services (i.e. "non-routine")</i></p>	<p>No charge (for the procedure itself); professional reading charges are covered under the plan's Outpatient professional services benefit</p> <p>Note: The associated wellness exam is subject to the PCP or Specialist per office visit copay</p> <p>Subject to the plan's x-ray & lab benefit; based on place of service</p>	<p>70% after plan deductible</p> <p>Note: The associated wellness exam is not covered</p> <p>Subject to the plan's x-ray & lab benefit; based on place of service</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><i>Inpatient Hospital - Facility Services</i></p> <p><i>Semi-Private Room and Board</i></p> <p><i>Private Room</i></p> <p><i>Special Care Units (ICU/CCU)</i></p>	<p>No charge after \$150 per day copay up to 5 copays per admission</p> <p>Limited to the semi-private negotiated rate</p> <p>Limited to the semi-private negotiated rate</p> <p>Limited to the negotiated rate</p>	<p>70% after \$200 per day deductible and plan deductible up to 5 copays per admission Limited to the semi-private rate</p> <p>Limited to the semi-private rate</p> <p>Limited to the ICU/CCU daily rate</p>
<p><i>Outpatient Facility Services</i></p> <p><i>Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room.</i></p> <p>Note: The copay will apply as long as services billed include one or more of the facility room charges listed above.</p>	<p>No charge after \$150 per visit copay</p>	<p>70% after plan deductible</p>
<p><i>Inpatient Hospital Physician's Visits/Consultations</i></p>	<p>No charge</p>	<p>70% after plan deductible</p>
<p><i>Inpatient Hospital Professional Services</i></p> <p><i>Surgeon</i></p> <p><i>Radiologist</i></p> <p><i>Pathologist</i></p> <p><i>Anesthesiologist</i></p>	<p>No charge</p>	<p>70% after plan deductible</p>
<p><i>Multiple Surgical Reduction</i></p>		<p>Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.</p>
<p><i>Outpatient Professional Services</i></p> <p><i>Surgeon</i></p> <p><i>Radiologist</i></p> <p><i>Pathologist</i></p> <p><i>Anesthesiologist</i></p>	<p>No charge</p>	<p>70% after plan deductible</p>
<p><i>Emergency and Urgent Care Services</i></p> <p><i>Physician's Office</i></p> <p><i>Hospital Emergency Room</i></p> <p><i>Outpatient Professional Services (radiology, pathology, ER physician)</i></p> <p><i>Urgent Care Facility or Outpatient Facility</i></p> <p><i>Ambulance</i></p>	<p>No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed.</p> <p>No charge after \$100 per visit copay** (Copay waived if admitted)</p> <p>No charge</p> <p>No charge after \$50 per visit (Copay waived if admitted)</p> <p>No charge</p> <p>** If not a true emergency, services are not covered</p>	<p>No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed **</p> <p>No charge after \$100 per visit copay**</p> <p>No charge</p> <p>No charge after \$50 per visit copay**</p> <p>No charge</p> <p>**If not a true emergency, services are not covered</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><i>Inpatient Services at Other Health Care Facilities</i> <i>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</i></p> <p>No prior hospitalization required</p>	<p>No charge</p> <p>Note: If plan includes inpatient hospital copay, the copay does not apply.</p> <p>100 days maximum per contract year (combined for all facilities listed)</p>	<p>70% after plan deductible</p> <p>Note: If plan includes an inpatient hospital deductible, the deductible does not apply</p> <p>60 days maximum per contract year (combined for all facilities listed)</p>
<p><i>Laboratory and Radiology Services (includes outpatient pre-admission testing)</i></p> <p><i>Physician's Office</i></p> <p><i>Outpatient Hospital Facility</i></p> <p><i>Independent X-ray and/or Lab Facility</i></p> <p><i>Independent X-ray and/or Lab Facility in conjunction with an ER visit</i></p>	<p>No charge</p> <p>No charge</p> <p>No charge</p> <p>No charge (if ER visit is considered to be a true emergency)</p>	<p>70% after plan deductible</p> <p>70% after plan deductible</p> <p>70% after plan deductible</p> <p>No charge (if ER visit is considered to be a true emergency)</p>
<p><i>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans, etc.)</i></p> <p><i>Inpatient Facility</i></p> <p><i>Outpatient Facility</i></p> <p><i>Emergency Room</i></p> <p><i>Physician's Office</i></p> <p>Notes:</p> <ul style="list-style-type: none"> Scans are subject to the applicable place of service coinsurance and plan deductible. Associated ancillary charges are subject to the applicable place of service coinsurance level and plan deductible. Facility copay does not apply. 	<p>No charge</p> <p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>70% after plan deductible</p> <p>70% after plan deductible</p> <p>No charge (unless not true emergency, then not covered)</p> <p>70% after plan deductible</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><i>Outpatient Short-Term Rehabilitative Therapy and Chiropractic Care Services</i></p> <p>Note: Maximum applies for all therapies combined</p> <p>Includes:</p> <ul style="list-style-type: none"> Physical Therapy Speech Therapy Occupational Therapy Chiropractic Therapy (includes Chiropractors) Pulmonary Rehab Cognitive Therapy 	<p>No charge after the \$20 per visit copay; No charge if only x-ray and/or lab services performed and billed.</p> <p>Unlimited days combined maximum per contract year</p> <p>Note: The Outpatient Short Term Rehab copay does not apply to services provided as part of a Home Health Care visit.</p> <p>Note: Therapy days, provided as part of an approved Home health Care plan, accumulate to the Outpatient Short Term Rehab Therapy maximum. If multiple outpatient services are provided on the same day, they constitute one day, but separate copay will apply to the services provided by each Participating provider.</p>	<p>70% after plan deductible</p> <p>20 days per contract year (reduced by in-network days)</p> <p>Note: Chiropractic Therapy not covered</p>
<p><i>Home Health Care</i></p> <p>Note: Includes outpatient private nursing when approved as medically necessary.</p> <p>Maximum:</p> <p>Note: The maximum number of hours per day is limited to 16 hours. Multiple visits can occur in one day; with a visit defined as a period of 2 hours or less (e.g. maximum of 8 visits per day).</p>	<p>No charge</p> <p>100 days per contract year</p>	<p>70% after plan deductible</p> <p>40 days per contract year; reduced by any in-network visits</p>
<p><i>Hospice</i></p> <p><i>Inpatient Services</i></p> <p><i>Outpatient Services</i></p>	<p>No charge</p> <p>Note: If plan includes an inpatient hospital copay, the copay does not apply.</p> <p>No charge</p>	<p>In-network coverage only</p> <p>Note: If the plan includes an inpatient hospital deductible, the deductible does not apply.</p>
<p><i>Bereavement Counseling</i></p> <p><i>Services Provided as part of Hospice Care Program</i></p> <p><i>Inpatient</i></p> <p><i>Outpatient</i></p> <p><i>Services Provided by Mental Health Professional</i></p>	<p>No charge after the plan deductible</p> <p>No charge</p> <p>Covered under Mental Health benefit</p>	<p>In-network coverage only</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Maternity Care Services</p> <p><i>Initial Visit to Confirm Pregnancy</i> Note: OB/GYN visits will be subject to the plan's Specialist copay.</p> <p><i>All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)</i></p> <p><i>Office Visits in addition to the global maternity fee when performed by an OB or Specialist</i></p> <p><i>Delivery - Facility (Inpatient Hospital, Birthing Center)</i></p>	<p>No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed</p> <p>No charge</p> <p>No charge after the Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed</p> <p>No charge after \$150 per day copay up to 5 copays per admission</p>	<p>70% after plan deductible</p> <p>70% after plan deductible</p> <p>70% after plan deductible</p> <p>70% after \$200 per day deductible and plan deductible up to 5 copays per admission</p>
<p>Abortion <i>Includes elective and non-elective procedures</i></p> <p><i>Office Visit</i></p> <p><i>Inpatient Facility</i></p> <p><i>Outpatient Facility</i></p> <p><i>Inpatient Physician's Services</i></p> <p><i>Outpatient Physician's Services</i></p>	<p>No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed</p> <p>No charge after \$150 per day copay up to 5 copays per admission</p> <p>No charge after \$150 per visit copay</p> <p>No charge</p> <p>No charge</p>	<p>70% after plan deductible</p> <p>70% after \$200 per day deductible and plan deductible up to 5 copays per admission</p> <p>70% after plan deductible</p> <p>70% after plan deductible</p> <p>70% after plan deductible</p>
<p>Family Planning Services <i>Office Visit (tests, counseling)</i></p> <p><i>Surgical Sterilization Procedures for Vasectomy/Tubal Ligation (excludes reversals)</i></p> <p><i>Inpatient Facility</i></p> <p><i>Outpatient Facility</i></p> <p><i>Inpatient Physician's Services</i></p> <p><i>Outpatient Physician's Services</i></p> <p><i>Physician's Office</i></p>	<p>No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed</p> <p>Note: Charges billed by a separate outpatient diagnostic facility will be covered under the plan's Laboratory and Radiology benefit</p> <p>No charge after \$150 per day copay up to 5 copays per admission</p> <p>No charge after \$150 per visit copay</p> <p>No Charge</p> <p>No charge</p> <p>No charge after the PCP or Specialist per office visit copay</p>	<p>70% after plan deductible</p> <p>70% after \$200 per day deductible and plan deductible up to 5 copays per admission</p> <p>70% after plan deductible</p> <p>70% after plan deductible</p> <p>70% after plan deductible</p> <p>70% after plan deductible</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><i>Infertility Treatment - Standard Benefit</i></p> <p><i>Services not covered include:</i></p> <ul style="list-style-type: none"> • <i>Testing performed specifically to determine the cause of infertility.</i> • <i>Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).</i> • <i>Artificial means of becoming pregnant are (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc).</i> <p>Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.</p>	Not Covered	Not Covered
<p><i>Organ Transplant</i> <i>Includes all medically appropriate, non-experimental transplants</i></p> <p><i>Office Visit</i></p> <p><i>Inpatient Facility</i></p> <p><i>Inpatient Physician's Services</i></p> <p><i>Travel Maximum</i></p>	<p>No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed</p> <p>No charge after \$150 per day copay up to 5 copays per admission</p> <p>No charge</p> <p>\$10,000 per transplant/per Lifetime maximum (only available when using a Lifesource Facility)</p>	<p>In-network coverage only</p> <p>In-network coverage only</p> <p>In-network coverage only</p> <p>Not covered</p>
<p><i>Durable Medical Equipment</i> Note: Services accumulate to the plan's Lifetime Maximum</p>	<p>No charge \$3,500 maximum per contract year</p>	In-network coverage only
<p><i>External Prosthetic Appliances</i> Note: Services accumulate to the plan's Lifetime Maximum</p>	<p>No charge after \$200 EPA deductible \$1,000 maximum per contract year</p>	In-network coverage only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Dental Care <i>Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.</i></p> <p><i>Doctor's Office</i></p> <p><i>Inpatient Facility</i></p> <p><i>Outpatient Facility</i></p> <p><i>Physician's Services</i></p>	<p>No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed</p> <p>No charge after \$150 per day copay up to 5 copays per admission</p> <p>No charge after \$150 per visit copay No charge</p>	<p>70% after plan deductible</p> <p>70% after \$200 per day deductible and plan deductible up to 5 copays per admission</p> <p>70% after plan deductible</p> <p>70% after plan deductible</p>
<p>Surgical and Non-surgical TMJ</p> <p><i>Doctor's Office</i></p> <p><i>Inpatient Facility</i></p> <p><i>Outpatient Facility</i></p> <p><i>Physician's Services</i></p>	<p>No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed</p> <p>No charge after \$150 per day copay up to 5 copays per admission</p> <p>No charge after \$150 per visit copay No charge</p>	<p>Not Covered</p>
<p>Routine Foot Disorders</p>	<p>Not covered except for services associated with foot care for diabetes and peripheral vascular disease.</p>	<p>Not covered except for services associated with foot care for diabetes and peripheral vascular disease.</p>
<p>Pre-Existing Condition Limitation (PCL)</p>	<p>Not applicable</p>	<p>Applies to any injury or sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a physician during the 90 days before the earlier of the date a person begins an eligibility waiting period or becomes insured for these benefits. Coverage for the pre-existing condition is excluded until one year of the member being continuously insured and/or is satisfying a waiting period.</p> <p>Usually the PCL is waived for the initial group, but if not, the insured will receive credit for any portion of the PCL waiting period that was satisfied under the previous plan if they are enrolled in the subsequent plan within 63 days (or the applicable timeframe required per state law).</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><i>Pre-Admission Certification – Continued Stay Review</i></p> <p>CIGNA's PAC/CSR is not necessary for Medicare primary individuals</p> <p><i>Inpatient Pre-Admission Certification – Continued Stay Review</i> (required for all inpatient admissions)</p> <p><i>Outpatient Prior Authorization</i> (required for selected outpatient procedures and diagnostic testing)</p>	<p>Coordinated by Provider/PCP</p> <p>Coordinated by Provider/PCP</p>	<p>Mandatory: Employee is responsible for contacting CIGNA Healthcare. Penalties for non-compliance:</p> <ul style="list-style-type: none"> – 50% penalty applied to hospital inpatient charges for failure to contact CIGNA Healthcare to precertify admission. – Benefits are denied for any admission reviewed by CIGNA Healthcare and not certified. – Benefits are denied for any additional days not certified by CIGNA Healthcare. <p>Mandatory: Employee is responsible for contacting CIGNA Healthcare. Penalties for non-compliance:</p> <ul style="list-style-type: none"> – 50% penalty applied to hospital inpatient charges for failure to contact CIGNA Healthcare to precertify admission. – Benefits are denied for any outpatient procedures/diagnostic testing reviewed by CIGNA HealthCare and not certified
<p><i>Case Management</i></p>	<p>Coordinated by CIGNA HealthCare. This is a service designated 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.</p>	
<p><i>Mental Health and Substance Abuse Rehabilitative Services</i></p>	<p>Please note the following regarding Mental Health (MH) and Substance Abuse (SA) benefit administration:</p> <ul style="list-style-type: none"> • Substance Abuse includes Alcohol and Drug Abuse services. • Transition of Care benefits are provided for a 60 day time period. • All plans include Detox as any other illness; Substance Abuse coverage includes Inpatient rehab (except detox only). Inpatient rehab requires 24 hour nursing. Residential Substance Abuse is included; no Mental Health Residential is included. 	
<p><i>Option 2: Low</i></p> <p><i>Member Assistance Program</i></p>	<p>1-3 Telephonic or Face-to-Face counseling sessions, information, resources and referrals for Life Events (designated non-clinical services)</p>	<p>In-network coverage only. Out-of-network services are not covered.</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><i>Inpatient MH&SA</i></p> <p>Acute MH & SA: Based on a ratio of 1:1 with inpatient MH/SA days Partial MH & SA: Based on a ratio of 2:1 with inpatient MH/SA days Residential SA: Based on a ratio of 2:1 with inpatient MH/SA days Residential MH: Not covered</p> <p><i>Outpatient Mental Health</i></p> <p><i>Intensive Outpatient Mental Health</i></p> <p>Maximum: Up to 3 programs per contract year</p> <p>Maximum: Each visit provided as part of a program accumulates to the Outpatient MH benefit maximum on a 1:1 ratio basis with Outpatient MH visits.</p> <p><i>Mental Health Group Therapy</i> 1:1 ratio with Outpatient MH visits</p> <p><i>Outpatient Substance Abuse</i></p> <p><i>Intensive Outpatient Substance Abuse</i></p> <p>Maximum: Up to 3 programs per contract year</p> <p>Maximum: Each visit provided as part of a program accumulates to the Outpatient SA benefit maximum on a 1:1 ratio basis with Outpatient SA visits</p>	<p>\$100 copay per day, up to 8 days per contract year for Mental Health and Substance Abuse combined</p> <p>\$40 copay per outpatient visit, up to 20 visits per contract year</p> <p>Single copay per program</p> <p>No charge after a \$120 per program copay (i.e. 3X the \$40 Outpatient MH visit copay)</p> <p>\$20 copay per visit for a total of 40 visits per contract year for Mental Health</p> <p>\$15 copay per visit for first 2 outpatient visits, \$40 copay per visit thereafter, for a total of 20 outpatient visits per contract year. Includes individual therapy only</p> <p>Single copay per program</p> <p>No charge after a \$120 per program copay (i.e. 3X the \$40 Outpatient SA visit copay)</p> <p>Note: The Intensive Outpatient Substance Abuse benefit has replaced the prior Group Therapy Substance Abuse benefit</p>	
<p><i>MH/SA Utilization Review & Case Management</i></p>	<p>Inpatient and Outpatient Management (CAP):</p> <ul style="list-style-type: none"> • CBH provides utilization review and case management for In-network and Out-of-network Inpatient Services and In-network Outpatient Management services. • Includes Lifestyle Management Program (Stress & Tobacco) 	

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Prescription Drugs <i>CIGNA PharmacyPlus Retail Drug Program</i> <i>Generic Push, Incentive Prescription Drug List</i> <i>Includes optional injectables; oral contraceptives and contraceptive devices</i>	\$15 per 30-day supply for generic drugs \$30 per 30-day supply for preferred brand-name drugs \$45 per 30-day supply for non-preferred brand-name drugs	In-network coverage only
Pharmacy Deductible (Mail Order Excluded)	None	None
Pharmacy Out of Pocket Maximum (Mail Order Excluded)	None	None
CIGNA Tel-Drug Mail Order Drug Program <i>Generic Push, Incentive Prescription Drug List</i> <i>Includes oral contraceptives and contraceptive devices</i>	\$40 per 90-day supply for generic drugs \$85 per 90-day supply for preferred brand-name drugs \$130 per 90-day supply for non-preferred brand-name drugs	In-network coverage only

Medical Benefit Exclusions (by way of example but not limited to):

Your plan provides coverage for medically necessary services. Your plan does not provide coverage for the following except as required by law:

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public school system or school district.
3. Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
4. Treatment of an illness or injury which is due to war, declared or undeclared.
5. Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
6. Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
7. Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be: Not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or The subject of review or approval by an Institutional Review Board for the proposed use, except as provided in the "Clinical Trials" section of "Section IV. Covered Services and Supplies;" or The subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of "Section IV. Covered Services and Supplies."
8. Cosmetic Surgery and Therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
9. The following services are excluded from coverage regardless of clinical indications: 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; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
10. Treatment of TMJ disorder.
11. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. 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. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
12. 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.
13. 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.
14. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under "Section IV. Covered Services and Supplies."
15. Infertility services, infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
16. Reversal of male and female voluntary sterilization procedures.
17. Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
18. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
19. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.



20. Non-medical counseling or ancillary services, including, but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
21. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
22. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Inpatient Hospital Services," "Outpatient Facility Services," "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of "Section IV. Covered Services and Supplies."
23. Private hospital rooms and/or private duty nursing except as provided in the Home Health Services section of "Section IV. Covered Services and Supplies".
24. Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
25. Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
26. Hearing aids, including, but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
27. Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
28. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
29. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
30. Treatment by acupuncture.
31. All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Section IV. Covered Services and Supplies."
32. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
33. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
34. Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.
35. Dental implants for any condition.
36. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
37. Blood administration for the purpose of general improvement in physical condition.
38. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
39. Cosmetics, dietary supplements and health and beauty aids.
40. All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
41. Expenses incurred for medical treatment by a person age 65 or older, who is covered under this Agreement as a retiree, or his Dependents, when payment is denied by the Medicare plan because treatment was not received from a Participating Provider of the Medicare plan.
42. 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.
43. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
44. Telephone, e-mail & Internet consultations and telemedicine.
45. Massage Therapy



This Benefit Summary highlights some of the benefits available under your plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your Group Service Agreement or Certificate.

Benefits are insured and/or administered by Connecticut General Life Insurance 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, CIGNA Vision Care, Inc., 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. "CIGNA Tel-Drug" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C., which are also operating subsidiaries of CIGNA Corporation.



CIGNA HealthCare of California, Inc.

This page summarizes state-mandated modifications of benefit choices. There are additional benefit mandates which are not displayed below because they do not affect benefit choices.

Deductible and Coinsurance

A deductible is not allowed. Coinsurance cannot apply to physician or professional services, only facility services (market decision). Please note that if the member is seen at a capitated hospital, we would not be able to administer the coinsurance and the service would be provided at 100%.

Hospital Only Coinsurance – Available

Hospital & Physician Coinsurance – Not Available

Primary Care Physician Office Visit

The office visit copayment may not exceed \$30.

Specialist Physician Office Visit

The office visit copayment may not exceed \$50.

Laboratory and Radiology Services (MRI, MRA, CT, PET Scans)

The copay may not exceed \$250 for MRI, MRA, CT, PET Scans

Short-Term Rehabilitative Therapy and Chiropractic Care

Visit limits are not allowed on rehabilitative services, except that self-referred chiropractic care can be limited to 20 visits if the care is not connected with other rehab. Self-referred chiropractic care copay may not exceed \$10.

Prescription Drugs

Contraceptives are covered.

Lifestyle drugs are covered.

A drug deductible is not allowed.

An out-of-pocket maximum is required when any coinsurance is selected. Individual: No more than \$1,500. Family: No more than \$4,500.

Not all three and four-tier copay designs are available.

Emergency and Urgent Care Services

The emergency room copayment may not exceed \$200. The urgent care facility copayment may not exceed \$100.

Split ER/Urgent Care copay options:

\$50/\$25, \$75/\$35, \$100/\$50, \$125/\$60, \$150/\$75, \$175/\$85, \$200/\$100,

Flat ER/Urgent Care copay options:

\$50 - \$100, in \$25 increments



Home Health Care

Must provide at least 100 visits per Member per contract or calendar year. A visit is defined as a period of 4 hours or less.

Vision Services

All vision service options provide exams every 12 months (rather than 24 months)

Infertility Services

When physician services are covered, a 30% coinsurance replaces the 50% charge on physician services.

Mental Health and Substance Abuse

Services for severe mental illness and serious emotional disturbances of a child are covered at parity with physical illness.

Annual Out-of-Pocket Maximum

All copayments except Durable Medical Equipment (except for supplies for the management/treatment of diabetes), External Prosthetic Appliances, Mental Health and Substance Abuse (except for Severe Mental Illness and Serious Emotional Disturbances of a Child), Vision, and Pharmacy apply to annual out-of-pocket maximum.

Individual out-of-pocket maximum cannot exceed \$3,500, with family either 2x or 3x.

Domestic Partner

Coverage of registered domestic partners is required.

Out-of-Network (when POS is purchased)

Biologically-based Mental Illness and Serious Emotional Disturbances of a Child, and child preventive care services are covered OON.

