

SUMMARY OF BENEFITS

Your CIGNA HealthCare HMO plan



CIGNA HealthCare

Features that Add Value

- The CIGNA HealthCare 24-Hour Health Information LineSM 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 many health and wellness programs and services often not covered by traditional benefit plans. To learn more, 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.
- You choose a Primary Care Physician (PCP) – your **personal doctor** – to coordinate your care. As your needs change, so may your choice of doctors. That's why you can change your PCP for any reason.

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
 - 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 LanguagesSM**. We offer Language Line Services so that you can **talk with us** in 150 different languages. Just call Member Services, and ask for an interpreter to assist your urgent care needs.
- Our interactive voice response system helps you find what you need faster over the phone. Use the speech recognition feature for information on your benefits, level of coverage, claims status, and more.

It's Your Health

When you choose CIGNA HealthCare, you can take advantage of our **health and wellness** programs

- **Preventive care services** for every covered family member.
- See a participating OB/GYN – **no referral** required.
- CIGNA Well Aware for Better HealthSM can **help you manage** chronic conditions like asthma or diabetes.
- The CIGNA HealthCare Healthy Babies[®] program provides you with education and support to help you have a **healthy pregnancy** and a **healthy baby**. And there's no copayment for prenatal care office visits after the first visit that confirms you're pregnant.

You Can Depend on CIGNA HealthCare

- **Quality comes first**. We select participating providers carefully. And we make sure you have a wide range of PCPs and specialists to choose from.
- We're **highly rated** by **independent evaluators** of quality, including the National Committee for Quality Assurance (NCQA).
- **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 you pay a lower copayment.

TEIGIT

CIGNA HealthCare of Illinois, Inc.
Description of Coverage

The Managed Care Reform and Patient Rights Act of 1999 established rights for enrollees in health care plans. These rights cover the following:

What emergency room visits will be paid for by your health care plan.

How specialists (both in and out of network) can be accessed.

How to file complaints and appeal health care plan decisions (including external independent reviews).

How to obtain information about your health care plan, including general information about its financial arrangements with providers.

You are encouraged to review and familiarize yourself with these subjects and the other benefit information in the attached Description of Coverage Worksheet. **SINCE THE DESCRIPTION OF COVERAGE IS NOT THE COMPLETE LEGAL DOCUMENT**, for full benefit information please refer to your Group Service Agreement, or contact your health care plan at the toll free number on the next page. In the event of any inconsistency between your Description of Coverage and Group Service Agreement, the terms of the contract or certificate will control.

For general assistance and information, please contact the Illinois Department of Insurance, Office of Consumer Health Insurance at 100 W. Randolph Street, Chicago, IL 60601 or 320 W. Washington Street, Springfield, IL 62767. (Please be aware that the Office of Consumer Health Insurance will not be able to provide specific plan information. For this type of information you should contact your health care plan directly.)

	Plan: CIGNA HealthCare of Illinois, Inc. Address: 525 West Monroe St., Suite 300, Chicago, IL, 60661-3629 Toll Free Telephone Number: <i>The toll-free number appears on your CIGNA HealthCare ID card</i>
--	--

Description of Coverage

Basics	Your Doctor (description of process for selection of physician, PCP and/or WPHCP)	Selection of your PCP and/or WPHCP is made when you submit your enrollment form. If you want to change your PCP/WPHCP, you must submit a change form.		
	Annual Deductible (if applicable)	N/A		
	Out-of-Pocket Maximum	Individual	\$1,500 per Contract Year	
		Family	\$3,000 Individual Member	
	Lifetime Maximum	Unlimited		
Pre-existing Condition Limitations	None			
		Description of Coverage	Health Care Plan Covers	You Pay
In the Hospital	Number of Days of Inpatient Care in an Acute Care Hospital	Medically Necessary services for the evaluation and/or treatment of conditions that cannot be adequately treated on an ambulatory basis	No limit	\$300 copayment per day up to 5 days, plus 10% of charges**
Other Participating Health Care Facilities	Room & Board	Semi-private room		Included in inpatient copay
	Surgeon's Fees			Included in inpatient copay
	Doctor's Visits			Included in inpatient copay
	Medications			Included in inpatient copay
	Other Miscellaneous Charges	Lab; radiology; anesthesia; special care units; radiation inhalation & therapies; chemotherapy		
	Rehabilitation Hospital	Semi-private room & board; skilled and general nursing services, physician visits; therapies; x-rays; drugs and medications	60 days max per contract year	10% of charges
	Skilled Nursing Facility and Sub-Acute Facilities	Same as above	Same as above	10% of charges

		Description of Coverage	Health Care Plan Covers	You Pay
Emergency Care	Emergency Services (medical conditions of sufficient severity such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in serious jeopardy of the person's health, serious impairment to bodily functions or serious dysfunction of any bodily organ or part).	Treatment in a Physician's Office	No limit	Same as physician's office copay
		Treatment in an ER	No limit	\$150 Copay per visit The ER Copay will be waived if you are admitted to a participating hospital directly from the emergency room
		Treatment in an Urgent Care Facility	No limit	\$75 Copay per visit
Emergency Care (cont.)	Emergency Post-stabilization services	Medically necessary services and supplies	No limit	Same as physician's office copay
In the Doctor's Office	Doctor's Office Visits	Diagnostic and treatment services provided by Participating Physicians & Other Participating Health Professionals	No limit	\$25 Copay per PCP office visit \$50 Copay per Specialist office visit
	Routine Physical Exams	Periodic Physical exams for adults in accordance with accepted medical practices		Same as above
	Diagnostic Tests and X-rays	As needed		Same as above
	Immunizations	Routine immunizations provided in accordance with accepted medical practices		Same as above (Office copay waived if immunization is only service provided)
	Allergy Treatment & Testing	As needed		Same as above
	Wellness Care	Well-child care		Same as above
Medical Services	Outpatient Surgery	Surgical services which can be appropriately provided on an outpatient basis	No limit	\$300 copayment per facility use, plus 10% of charges**

			Description of Coverage	Health Care Plan Covers	You Pay
Medical Services	Maternity Care	Hospital Care	Inpatient services during the term of pregnancy, upon delivery, and post-partum	At least 48/96 hours	Same as Inpatient Hospital copay
		Physician Care	Medical care during pregnancy/delivery/post-partum	No limit	No charge after initial visit to confirm pregnancy
	Infertility Services		Physician visits and Surgical services for diagnosis and treatment		Same as PCP Office Copay Same as Inpatient Hospital, Outpatient Facility or Physician office visit copayment, depending on facility use
	Mental Health	Outpatient	Treatment on an individual or group basis (Group visits may be substituted on a 2-for-1 basis for individual visits)	No Limit	\$50 copayment per visit
		Inpatient	Services rendered by a Participating Hospital for evaluation and treatment	No limit	Same as Inpatient Hospital Copay
		Intensive Outpatient Mental Health	3 programs maximum per member per contract year		3 times the physician's copayment per program
	Substance Abuse (SA)	Outpatient	Treatment on an individual or group basis (Group visits may be substituted on a 2-for-1 basis for individual visits)	20 visits per contract year	\$15 Copayment per visit for the first 2 visits and \$40 Copayment per visit thereafter \$20 Copayment per group visit
		Intensive Outpatient Substance Abuse	3 programs maximum per member per contract year		\$120 copayment per program
	Detoxification Services	Outpatient			Same as specialty physician office visit copayment

	Substance Abuse (SA)	Inpatient	Services rendered by a Participating Hospital for evaluation and treatment	15 days max per contract year	\$100 Copay per day
	Detoxification Services	Inpatient			Same as inpatient hospital copayment
	Outpatient Rehabilitation Services		Includes physical, speech, cardiac, occupational, and pulmonary	60 days max per contract year	\$50 office visit copay
	Self-Referred Chiropractic care		Diagnosis and treatment by a Chiropractic physician	Unlimited days max per contract year	\$50 office visit copay
	Outpatient Laboratory and Radiology Services		MRIs, MRAs, CAT Scans and PET Scans		
			Outpatient/ Independent Facility Emergency Room		\$200 copayment per type of scan per day, plus 10% of charges No charge (if ER visit is considered to be a true emergency) No charge
			Physician's Office		
			Other Laboratory and Radiology Services Outpatient hospital Facility Independent X-ray/Lab Facility		10% of charges per type of scan per day No charge

		Description of Coverage	Health Care Plan Covers	You Pay
Other Services	Durable Medical Equipment	Purchase or rental of equipment ordered/prescribed by a participating Physician and provided by an approved vendor	\$3,500 max per contract year	No charge
	External Prosthetic Appliances	Initial purchase and fitting of external prosthetic devices used as replacement or substitute for a missing body part	\$1,000 max per contract year	\$200 deductible per member per year
	Hospice	Inpatient or outpatient services for the terminally ill (6 months or less to live)	No limit	Inpatient = 10% of charges Outpatient = No charge
	Home Health Care	Skilled health care services provided during intermittent visits of 2 hours or less by other Participating Health Professionals	No limit	No charge <i>60 days maximum per contract year, 16 hours per day maximum</i>
	<p>Prescription Drugs <i>CIGNA Pharmacy Plus Retail Drug Program</i> Includes: insulin, insulin needles & syringes, diabetic test strips/lancets, lifestyle drugs, and prenatal vitamins. Generic*** drugs on the Prescription Drug List for a 30-day supply Brand Name*** drugs designated as preferred on the Prescription Drug List with no Generic equivalent for a 30-day supply Brand Name*** drugs designated as non-preferred on the Prescription Drug List for a 30-day supply</p>			<p>\$15 copayment per prescription/refill</p> <p>\$30 copayment per prescription/refill</p> <p>\$45 copayment per prescription/refill</p>

	Description of Coverage	Health Care Plan Covers	You Pay
	CIGNA Tel-Drug Rx Mail Order Drug Program Generic*** drugs on the Prescription Drug List for a 90-day supply Brand Name*** drugs designated as preferred on the Prescription Drug List with no Generic equivalent for a 90-day supply Brand Name*** drugs designated as non-preferred on the Prescription Drug List for a 90-day supply Pharmacy Deductible (Individual/Family)(Mail Order excl.) Pharmacy Out of Pocket Maximum (Individual/Family) <i>***Designated as per generally-accepted industry sources and adopted by HealthPlan</i>		\$45 copayment per prescription/refill \$90 copayment per prescription/refill \$135 copayment per prescription/refill None/None None/None
	Transplant Travel Services	Travel expenses incurred related to a pre-approved organ or tissue transplant	\$10,000 max No Copayment

		Description of Coverage	Health Care Plan Covers	You Pay
	Dental Services	Services and supplies in connection with accidental injury to sound natural teeth	No limit	Same as physician's office copay
	Vision and Hearing Screening	Vision and hearing screenings provided by your PCP		Same as physician's office copay

- Only Copayments which have been paid by a Member for Inpatient Hospital, Outpatient Hospital Facility Services and Inpatient Services at Other Participating Health Care Facilities apply to these maximums.
- Only Copayments which have been paid by a Member for Covered Services and Supplies other than Mental Health and Substance Abuse Services and Supplies apply to these maximums.
- Healthplan shall be responsible for maintaining a record of Copayments which have been paid by the Member and the Membership Unit. Upon request of the Member, Healthplan shall inform Member if he/she has reached his/her Copayment limits.

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

1. Any service or supply not described as covered in the Covered Services section of the Agreement.
2. Any medical service or device that is not medically necessary.
3. Care for health conditions that are required by state or local law to be treated in a public facility or supplied by a public school system.
4. Treatment of an illness or injury which is due to war or care for military service disabilities treatable through governmental services.
5. Any services and supplies for or in connection with experimental, investigational or unproven services.
6. Treatment of TMJ disorder.
7. 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.
8. Medical and surgical services intended primarily for the treatment or control of obesity, which are not medically necessary. Treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute guidelines is covered if the services are demonstrated, through peer-reviewed medical literature and scientifically based guidelines, to be safe and effective for the treatment of the condition..
9. 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.
10. Court ordered treatment or hospitalizations.
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 Agreement.
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 ostomy supplies and urinary catheters.
15. Private hospital rooms and/or private duty nursing except as covered under the Home Health Care provision.
16. 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.
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 member agreement.
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.
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. 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; Roling; 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.

This summary of benefits contains the highlights only. The specific benefits and exclusions are contained in your Group Service Agreement or certificate.

“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.

Some Healthy Rewards are not available in all states. Additionally, not all Healthy Rewards programs are available to members of CIGNA HealthCare of California, Inc., CIGNA Dental Health of California, Inc. and CIGNA Behavioral Health of California, Inc. A discount program is NOT insurance, and the member must pay the entire discount charge. If your CIGNA HealthCare plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. Healthy Rewards programs are separate from your medical benefits.

©2006 CIGNA Health Corporation

05