

# SUMMARY OF BENEFITS

## Your CIGNA HealthCare Point-of-Service plan



CIGNA HealthCare

### Features that Add Value

- The CIGNA HealthCare 24-Hour Health Information Line<sup>SM</sup> 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<sup>®</sup>** 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](http://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](http://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<sup>SM</sup>**. 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 Health<sup>SM</sup> can **help you manage** chronic conditions like asthma or diabetes.
- The CIGNA HealthCare Healthy Babies<sup>®</sup> 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.

### It's Your Choice

When your PCP coordinates your care and you visit network providers, you get access to quality care and lower out-of-pocket costs. Your plan also offers the **freedom to choose** the providers you prefer — even if they aren't part of the network. Your benefits are higher when you see participating providers, but you're still covered for visits to other providers.

**TEIGIT**

**CIGNA HealthCare of Illinois, Inc.**

## **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.)

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|--|--|
|  | Plan: CIGNA HealthCare of Illinois, Inc.<br>Address: 525 West Monroe St., Suite 300,<br>Chicago, IL, 60661-3629<br>Toll Free Telephone Number: <i>The toll-free number<br/>         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  |   |                                |   |
|  |   | <b>Description of Coverage</b>  | <b>Health Care Plan Covers</b> | <b>You Pay</b>  |
| 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<br><br>\$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**  |

|                  |                         |                                      | <b>Description of Coverage</b>   | <b>Health Care Plan Covers</b> | <b>You Pay</b>   |
|------------------|-------------------------|--------------------------------------|--|--------------------------------|--|
| 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<br>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                       | Same as Outpatient Rehabilitation Services Copayment   |
|                  |                         | 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<br><br>\$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/<br>Independent Facility<br>Emergency Room<br>Physician's Office                               |                                      | \$200 copayment per type of scan per day, plus 10% of charges<br>\$200 copayment per type of scan per day<br>\$200 copayment per type of scan per day |
|  |  |           | Other Laboratory and Radiology Services<br>Outpatient hospital Facility<br>Independent X-ray/Lab Facility |                                      | No charge<br><br>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<br><br>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<br><i>60 days maximum per contract year, 16 hours per day maximum</i> |
|                | Transplant Travel Services     | Travel expenses incurred related to a pre-approved organ or tissue transplant   | \$10,000 max                  | No Copayment  |
|                |                                |   |                               |   |

|  |                              | <b>Description of Coverage</b>  | <b>Health Care Plan Covers</b> | <b>You Pay</b>                   |
|--|------------------------------|---|--------------------------------|----------------------------------|
|  | 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.

## **Service Area**

The Service Area is the geographic area, as described in the Provider Directory applicable to your plan, where the Healthplan is authorized to provide services. Updates to the Service Area are subject to regulatory approval.

## **Exclusions and Limitations**

Any Services and Supplies which are not described as covered in "Section IV Covered Services and Supplies" or in an attached Rider or are specifically excluded in "Section IV Covered Services and Supplies", or "Section V Exclusions and Limitations", or an attached Rider are not covered under this Agreement.

Circumstance Beyond the Healthplan's Control. To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within our control results in our facilities, personnel, or financial resources being unavailable to provide or arrange for the provisions of a basic or supplemental health service or supplies in accordance with this Agreement, we will make a good faith effort to provide or arrange for the provision of the services or supplies, taking into account the impact of the event.

## **Pre-certification and Utilization Review**

Prior Authorization is obtained from the Healthplan Medical Director by the Participating Provider, for those services that require Prior authorization. Services that require Prior Authorization include, but are not limited to, inpatient hospital services, inpatient services at any Other Participating Health Care Facility, outpatient facility services, magnetic resonance imaging, non-emergency ambulance, and organ transplant services.

## **Emergency Care**

Emergency Services are defined as the medical, psychiatric, surgical, hospital and related health care services and testing, including ambulance service, which are required to treat a sudden unexpected onset of a bodily injury or a serious illness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the hospital on the UB92 claim form or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency. You are covered for Emergency Care both in and out of the Service Area. Please refer to "Section IV, Covered Services and Supplies" in your Group Service Agreement for a complete description of Emergency Care services.

**Continuing or Follow-up Treatment.** Continuing or follow-up treatment, whether in or out of the Service Area, is not covered unless it is provided or arranged for by your PCP or upon Prior Authorization of the Healthplan Medical Director.

## **Primary Care Physician Selection**

When you enroll as a Member, you choose a Primary Care Physician (PCP). Each covered Member of your family also chooses a PCP. Your PCP is your personal doctor and serves as your health care manager. Please refer to the provision entitled "Choosing a Primary Care Physician" of "Section III, Agreement Provisions" for a complete description of the procedures and requirements for primary care physician selection.

Your choice of a PCP may affect the specialists and facilities from which you may receive services. Your choice of a specialist may be limited to specialists in your PCP's medical group or network. Therefore, you may not have access to every specialist or Participating Provider in your Service Area. Before you select a PCP, you should check to see if that PCP is associated with the specialist or facility you prefer to use. If the Referral is not possible, you should ask the specialist or facility about which PCPs can make Referrals to them, and then verify the information with the PCP before making your selection.

You have the right to request: (a) a description of the financial relationships between the Healthplan and any health care provider; (b) the percent of copayments, deductibles and total premiums spent on health care related and administrative expenses; and (c) health care provider information from your provider regarding: (i) the provider's educational background, experience, training, specialty, and board certification, if applicable; (ii) the names of licensed facilities on the provider panel where the provider currently has privileges for the treatment, illness, or procedure that is the subject of the request; and (iii) information regarding the provider's participation in continuing education programs and compliance with any licensure, certification, or registration requirements, if applicable.

### **Access to Specialty Care**

In most cases, you must obtain a Referral from your PCP before visiting any provider other than your PCP in order for the visit to be covered. However, there are a number of exceptions to the referral process when you do not need to obtain a referral in order for the visit to be covered. Please refer to the provisions of provision 9, "Referrals to Specialists", of "Section III, Agreement Provisions" in your Group Service Agreement for a complete description of the referral policies, including standing referrals to specialists.

### **Out-of-Area Coverage**

Emergency Care and Urgent Care are covered when the enrollee is out of the area as described in "Section IV, Covered Services and Supplies". In addition, for enrollees under the age of twenty-three (23), who are full-time registered students in regular attendance at an accredited secondary school or an accredited college or university are eligible for covered Emergency Services and Urgent Care benefits while at school if the school is located outside of the Service Area.

### **Financial Responsibility**

This Description of Coverage describes out-of-pocket expenses, including copayments, and deductibles. When the entire premium is not paid directly by you, then you may need to contact the benefit administrator for your level of contribution and premiums payable under the policy. In addition, you will be responsible for payments on a fee-for-service basis for Services and Supplies under the conditions described in the "Reimbursement" provision of "Section VI, Other Sources of Payment for Services and Supplies".

### **Continuity of Treatment**

There may be instances in which your PCP becomes unaffiliated with the Healthplan's network of Participating Providers. In such cases, you will be notified and provided assistance in selecting a new PCP. However, in special circumstances, you may be able to continue seeing your doctor, even though he or she is no longer affiliated with the Healthplan. Please refer to the "Transition Care" provision of "Section III, Agreement Provisions" for a description of such circumstances.

### **Appeals Process**

We want you to be completely satisfied with the Healthplan and the care you receive. That's why we've established a process for addressing your concerns and solving your problems. Please refer to the "When You Have a Concern or Complaint" provision of "Section III, Agreement Provisions" for a detailed description of the member appeal process. In addition, any enrollee not satisfied with the health care plan's resolution of any complaint, may appeal the final plan decision to the Department of Insurance, through the Consumer Services Section, at one of the following locations:

|                            |    |                              |
|----------------------------|----|------------------------------|
| 320 West Washington Street | OR | 100 West Randolph Street     |
| Springfield, Illinois      |    | Suite 15-100                 |
| 62767-0001                 |    | Chicago, Illinois 60601-3251 |

You may also contact the Department electronically at <http://www.state.il.us/ins>.

Note: External grievance determinations in most cases are not appealable through the Department of Insurance.

**IMPORTANT: In the event of any inconsistency between your Description of Coverage and Group Service Agreement, the terms of the Group Service Agreement will control.**

### Description of Coverage (Out-of-Network)

|                                    |  |   |                                |   |
|------------------------------------|--|---|--------------------------------|---|
| Basics                             | Annual Deductible  | Individual  | \$1,500                        |   |
|                                    | (if applicable)  | Family  | \$3,000                        |   |
|                                    | Out-of-Pocket Maximum *                                    | Individual  | \$3,000                        |   |
|                                    |  | Family  | \$6,000                        |   |
|                                    | Lifetime Lifetime Maximum                                  | \$1,000,000   |                                |   |
| Pre-existing Condition Limitations | Yes  |   |                                |   |
|                                    |  | <b>Description of Coverage</b>  | <b>Health Care Plan Covers</b> | <b>You Pay</b>  |
| 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                       | \$600 copayment per day up to 5 days, plus 30% of charges** |
| Other Health Care Facilities       | Room & Board   | Semi-private room   |                                | Included above  |
|                                    | Surgeon's Fees   |   |                                | Included above  |
|                                    | Doctor's Visits  |   |                                | Included above  |
|                                    | Medications  |   |                                | Included above  |
|                                    | 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  | 30% of charges**  |
|                                    | Skilled Nursing Facility and Sub-Acute Facilities          | Same as above   | Same as above                  | Same as above<br>Precertification applies                   |

|                        |  | <b>Description of Coverage</b>  | <b>Health Care Plan Covers</b> | <b>You Pay</b>   |
|------------------------|--|---|--------------------------------|--|
| 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<br><br>Treatment in an ER<br><br>Treatment in an Urgent Care Facility |                                | Care will be covered at in-network levels if it meets the “prudent layperson” definition of an emergency. Same as in-network |
| Emergency Care (cont.) | Emergency Post-stabilization services  | Medically necessary services and supplies   |                                | Same above   |
| In the Doctor's Office | Doctor's Office Visits   | Diagnostic and treatment services   |                                | 30% of charges**   |
|                        | Routine Physical Exams   | Periodic Physical exams for adults in accordance with accepted medical practices                        |                                | Covered in-network only  |
|                        | Diagnostic Tests and X-rays  | As needed   |                                | Covered in-network only  |
|                        | Immunizations  | Routine immunizations provided in accordance with accepted medical practices                            |                                | Covered in-network only  |
|                        | Allergy Treatment & Testing  | As needed   |                                | 30% of charges**   |
|                        | Wellness Care  | Well-child care   |                                | Covered in-network only  |

|                  |                         |                                      | <b>Description of Coverage</b>   | <b>Health Care Plan Covers</b>                               | <b>You Pay</b>  |                           |
|------------------|-------------------------|--------------------------------------|--|--|---|---------------------------|
| Medical Services | Outpatient Surgery      |                                      | Surgical services which can be appropriately provided on an outpatient basis   | No limit   | \$600 copayment per facility use, plus 30% of charges**<br>Precertification applies |                           |
|                  | Infertility Services    |                                      | Physician visits and Surgical services for diagnosis and treatment   |  | Covered in-network only   |                           |
|                  | Mental Health           | Outpatient                           | Treatment on an individual or group basis (Group visits may be substituted on a 2-for-1 basis for individual visits) |  | Covered in-network only   |                           |
|                  |                         | Inpatient                            | Services rendered by a Hospital for evaluation and treatment   |  | Covered in-network only   |                           |
|                  |                         | Intensive Outpatient Mental Health   | 3 times the physician's copayment per program  |  | 30% of charges**  |                           |
|                  | 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) |  | Covered in-network only   |                           |
|                  |                         | Intensive Outpatient Substance Abuse | 3 times the physician's copayment per program  |  | 30% of charges**  |                           |
|                  |                         | Detoxification Services              | Outpatient   |  |   | Same as any other illness |
|                  |                         | Substance Abuse (SA)                 | Inpatient  | Services rendered by a Hospital for evaluation and treatment |   | Covered in-network only   |
|                  | Detoxification Services | Inpatient                            |  |  | Same as inpatient hospital  |                           |

|  |                                    |   |                               |                         |
|--|------------------------------------|---|-------------------------------|-------------------------|
|  | Outpatient Rehabilitation Services | Includes physical, speech, cardiac, occupational, and pulmonary | 20 days max per contract year | 30% of charges**        |
|  | Self-Referred Chiropractic care    | Diagnosis and treatment by a Chiropractic physician             |                               | Covered in-network only |

|                |  | <b>Description of Coverage</b>   | <b>Health Care Plan Covers</b> | <b>You Pay</b>  |
|----------------|--|--|--------------------------------|---|
|                | Outpatient Laboratory and Radiology Services | <p>MRIs, MRAs, CAT Scans and PET Scans</p> <p>Outpatient/ Independent Facility<br/>Emergency Room<br/>Physician's Office</p> <p>Other Laboratory and Radiology Services</p> <p>Outpatient hospital Facility<br/>Independent X-ray/Lab Facility</p> |                                | <p>\$200 Deductible per type of scan per day, plus 30% of charges**</p> <p>\$200 per type of scan per day</p> <p>\$200 Deductible per type of scan per day, plus 30% of charges**</p> <p>30% of charges**</p> <p>30% of charges**</p> |
| Other Services | Durable Medical Equipment                    | Purchase or rental of equipment ordered/prescribed by a Physician and provided by an approved vendor   |                                | Covered in-network only   |
|                | External Prosthetic Appliances               | Initial purchase and fitting of external prosthetic devices used as replacement or substitute for a missing body part  |                                | Covered in-network only   |
|                | Hospice                                      | Inpatient or outpatient services for the terminally ill (6 months or less to live)   |                                | Covered in-network only   |
|                | Home Health Care                             | Skilled health care services provided during intermittent visits of 2 hours or less  | No limit                       | 30% of charges**; 40 visits maximum per contract year#  |

|  | <b>Description of Coverage</b>   | <b>Health Care Plan Covers</b>  | <b>You Pay</b>   |
|--|--|---|--|
|  | Prescription Drugs<br>CIGNA Pharmacy Plus Retail Drug Program<br>Tel-Drug Rx Mail Order Drug Program |   | Covered in-network only<br><br>Covered in-network only |
|  | Organ Transplant Travel Services   | Travel expenses incurred related to a pre-approved organ or tissue transplant     | Covered in-network only                                |
|  | Dental Services  | Services and supplies in connection with accidental injury to sound natural teeth | Covered in-network only                                |
|  | Vision and Hearing Screening   | Vision and hearing screenings   | Covered in-network only                                |

\*\* Out-of network services are subject to annual deductible and reasonable and customary charge limitations

# Out-of-network treatment maximums are reduced by in-network services used.

Regarding Out-of-network services:

The out-of-network inpatient copayment does not apply to the out-of-network annual deductible or out-of-pocket maximum.

All out-of-network hospital admissions, outpatient surgeries and MRI's must be precertified. Penalty for non-compliance with precertification is 50%. Hospital admissions are subject to Continued Stay Review (CSR). Non-certified admissions/days result in denial of benefits. The 50% penalty or cost of denied benefits does not apply to deductible or out-of-pocket maximum.

Additional services which are not covered out-of-network are: Organ Transplant, TMJ, Chiropractic Services. Once the out-of-pocket maximum for Out-of-Network is reached, the plan pays 100% of eligible charges for the remainder of the plan year. The Out-of-Network inpatient copayment continues to apply, however Pre-existing conditions are not covered unless twelve months of continuous coverage (including the waiting period) has elapsed.

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; 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.

*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.*

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