

SUMMARY OF BENEFITS

Your CIGNA Choice FundSM Health Reimbursement Arrangement-Open Access Plus plan



CIGNA HealthCare

Features that Add Value

- **CIGNA Choice Fund** combines conventional health coverage with health funds to help you pay for the cost of your health care services. See the next page for more information.
- Your plan offers the **convenience of referral-free access to doctors**, and the option to select a **personal Primary Care Physician (PCP)**, as your source for routine care and guidance when you need specialized care. As your needs change, so may your choice of doctors. That's why you can change your PCP for any reason.
- The CIGNA HealthCare 24-Hour Health Information LineSM connects you to **trained 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 programs and services designed to enhance your health and wellness. Just call 1.800.870.3470 or visit our web site at www.cigna.com.
- **CIGNA Behavioral Advantage** emphasizes the mind-body connection. The program provides support from medical and mental health case managers, as well as a number of tools and resources, to help you take control of your health and wellness.

Quality Service Is Part of Quality Care

- **Service** is at the heart of everything we do. Our goal is to give you: fast, accurate answers; responsive, courteous and professional assistance; and ease and convenience in finding the information you need to manage your health.
- **www.cigna.com** – Visit our **interactive Web site** to learn more about your plan and get health information, 24 hours a day. Once you enroll, register for myCIGNA.com, our convenient, secure website that combines helpful easy-to-use tools with personalized benefits information to help you make the most of your plan.
- **We Speak Many LanguagesSM**. We offer Language Line Services so that you can **talk with us** in 150 different languages. Just call Customer Service, and ask for an interpreter to assist you.

It's Your Health

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

- We encourage you to use a **PCP** as a valuable resource and personal health advocate.
- **Preventive care services** for every covered family member.
- **CIGNA Well Informed** provides members with customized medical and wellness information to help them make healthier choices, better understand a diagnosis or treatment, and manage their health. The program includes personalized letters and other educational information to help you improve your health. Only you, your doctor and CIGNA have access to this information.
- CIGNA Well-Aware for Better Health[®] can **help you manage** certain chronic conditions.
- The CIGNA HealthCare Healthy Babies[®] program provides you with information to help you have a **healthy pregnancy and a healthy baby**.

You Can Depend on CIGNA HealthCare

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

It's Your Choice

- When you visit network providers, you get access to quality care at the lowest out-of-pocket costs available under your plan. Your plan also offers the **freedom to choose** the providers you prefer — even if they aren't part of the network. Your benefits are the highest when you see “participating providers”, but you're still covered for visits to other providers. Participating providers charge a discounted rate for CIGNA members. If you use a non-network provider, the provider may bill you for the difference between the billed charge and the allowed amount under your benefit plan, in addition to applicable (higher than in-network) deductibles and coinsurance amounts.

*For Employees of Cypress-Fairbanks
I.S.D. - Effective 09/01/2009*

HRA-OAP - ASO

HOW YOUR CIGNA CHOICE FUND WORKS

Employer Contribution

- Your employer establishes a health fund that can be used to pay for any covered health care expenses during that year. Amounts paid by the fund for services covered by the health plan are applied toward the plan deductible.

Your Contribution

- Once you have used the dollars in your health fund, you pay your expenses up to the remaining plan deductible.

Your Employer and You

- Once your deductible is met, your medical plan begins providing coverage for eligible services, as described below.

Health Reimbursement Arrangement

	Employee	Employee + One	Family
<i>Employer Contribution</i>	\$750	\$1,500	\$1,500

BENEFIT HIGHLIGHTS

IN-NETWORK

OUT-OF-NETWORK

Contract Year Deductible – Non-Collective

Family Deductible: Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance. If the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.

<i>Individual</i>	\$2,500	\$5,000
<i>Family Maximum</i>	\$5,000	\$10,000

Contract Year Out-of-Pocket Maximum-Non-Collective

Family Out-of-Pocket Maximum: Family members meet only their individual out-of-pocket maximum and then their claims will be covered at 100%. If the family out-of-pocket maximum has been met prior to their individual out-of-pocket maximum being met their claims will be paid at 100%.

<i>Individual</i>	Includes Plan Deductible \$4,250	Includes Plan Deductible \$7,000
<i>Family Maximum</i>	\$8,500	\$14,000

Coinsurance

Your plan pays 90% of eligible charges. You pay 10% of charges after plan deductible.

Your plan pays 50% of eligible charges. You pay 50% of charges after plan deductible.

Precertification -Inpatient – PHS (required for all inpatient admissions)

Coordinated by your physician

Participant must obtain approval for inpatient admission; subject to penalty/reduction or denial for non-compliance

Lifetime Maximum

Unlimited

Unlimited

Pre-existing Condition Limitation

No

No

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Physician Services Primary Care Physician (PCP) Office Visit</p> <p>Specialty Physician Office Visit Consultant and Referral Physician Services</p> <p>Allergy Treatment/Injections - PCP or Specialty Physician Allergy Serum (dispensed by physician in office) Second Opinion Consultations (provided on voluntary basis) Surgery Performed in the Physician's Office- PCP or Specialty Physician</p>	<p>Plan Pays: 90% of charges*; 90% of charges* if only x-ray and/or lab services are performed and billed. 90% of charges*; 90% of charges* if only x-ray and/or lab services are performed and billed. 90% of charges* 90% of charges* 90% of charges* 90% of charges*</p>	<p>Plan Pays: 50% of charges** 50% of charges** 50% of charges** 50% of charges** 50% of charges**</p>
<p>Preventive Care Routine Preventive Care – Well Baby Care, Well Child Care through age 2</p> <p>Immunizations (0-6) Routine Preventive Care –Children and Adults from age 3 Unlimited maximum per contract year#</p> <p>Immunizations (7 & Over)</p>	<p>100% of charges; 100% of charges if only x-ray and/or lab services are performed and billed. 100% of charges 100% of charges; 100% of charges if only x-ray and/or lab services are performed and billed. 100% of charges</p>	<p>50% of charges** 100% of charges 50% of charges** 50% of charges**</p>
<p>Preventive Mammograms, PSA, Pap Test</p> <p>Diagnostic Mammograms, PSA, Pap Test (<u>Note:</u> Diagnostic Related Services are subject to the plan's laboratory & radiology benefit; based on place of service)</p>	<p>100% of charges, if billed by independent diagnostic facility or outpatient hospital 90% of charges*</p>	<p>50% of charges** 50% of charges**</p>
<p>Inpatient Hospital Services including: Semi-Private Room and Board Diagnostic/Therapeutic Lab and X-ray Drugs and Medication Operating and Recovery Room Radiation Therapy and Chemotherapy Anesthesia and Inhalation Therapy MRIs, MRAs, CAT Scans, PET Scans, etc.</p>	<p>90% of charges*</p>	<p>50% of charges* Precertification required</p>
<p>Inpatient Hospital Doctor's Visits/Consultations Inpatient Hospital Professional Services</p>	<p>90% of charges* 90% of charges*</p>	<p>50% of charges** 50% of charges**</p>
<p>Outpatient Facility Services Operating Room, Recovery Room, Procedure Room and Treatment Room including: Diagnostic/Therapeutic Lab and X-rays Anesthesia and Inhalation Therapy Physician and Outpatient Professional Services</p>	<p>90% of charges* 90% of charges*</p>	<p>50% of charges** 50% of charges**</p>
<p>Laboratory and Radiology Services (includes preadmission testing) Physician's Office Outpatient Hospital Facility Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit)</p> <p>Independent X-Ray and/or Lab Facility Independent X-Ray and/or Lab Facility (in conjunction with an Emergency Room visit)</p>	<p>90% of charges* 90% of charges* 90% of charges* 90% of charges* 90% of charges*</p>	<p>50% of charges** 50% of charges** 90% of charges*; <i>except if not a true emergency, then 50% of charges**</i> 50% of charges** 90% of charges*</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Advanced Radiological Imaging (MRIs, MRAs, CAT Scans, PET Scans, etc.) Outpatient Facility Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit) Physician's Office</p>	<p>90% of charges* 90% of charges* 90% of charges*</p>	<p>50% of charges** 90% of charges*; except if not a true emergency, then 50% of charges** 50% of charges**</p>
<p>Short-Term Rehabilitative Therapy and Cardiac Rehabilitation and Chiropractic Services – (includes cardiac rehab, physical, speech, occupational, chiropractic, pulmonary rehab & cognitive therapy) Unlimited days maximum per contract year# for all therapies combined</p>	<p>90% of charges*; 90% of charges* if only x-ray and/or lab services are performed and billed.</p>	<p>50% of charges**</p>
<p>Emergency and Urgent Care Services Physician's Office – PCP or Specialty Physician Hospital Emergency Room Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician) Urgent Care Facility or Outpatient Facility Ambulance</p>	<p>90% of charges*; 90% of charges* if only x-ray and/or lab services are performed and billed. 90% of charges* 90% of charges* 90% of charges* 90% of charges*</p>	<p>Care will be provided at in-network levels if it meets the “prudent layperson” definition of an emergency. Otherwise 50% of charges**</p>
<p>Maternity Care Services Initial Office Visit to Confirm Pregnancy All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (total maternity fee) Office Visits not included in the total maternity fee performed by OB or Specialty Physician Delivery - Facility (Inpatient Hospital/Birthing Center Charges)</p>	<p>90% of charges*; 90% of charges* if only x-ray and/or lab services are performed and billed. 90% of charges* 90% of charges*; 90% of charges* if only x-ray and/or lab services are performed and billed. 90% of charges*</p>	<p>50% of charges** 50% of charges** 50% of charges** 50% of charges* Precertification required</p>
<p>Inpatient Services at Other Health Care Facilities Skilled Nursing, Rehabilitation and Sub-Acute Facilities 120 days maximum per contract year# combined for all facilities listed</p>	<p>90% of charges*</p>	<p>50% of charges**</p>
<p>Home Health Services - Includes outpatient private duty nursing when approved as medically necessary, 40 days maximum per contract year#; 16 hour maximum per day#</p>	<p>90% of charges*</p>	<p>50% of charges**</p>
<p>Family Planning Services Office Visits (lab & radiology tests, counseling) Vasectomy/Tubal Ligation (excludes reversals) Inpatient Facility Outpatient Facility Services Physician's Services – Inpatient or Outpatient Physician's Office</p>	<p>90% of charges*; 90% of charges* if only x-ray and/or lab services are performed and billed. 90% of charges* 90% of charges* 90% of charges* 90% of charges*; 90% of charges* if only x-ray and/or lab services are performed and billed.</p>	<p>Covered in-network only 50% of charges* Precertification required 50% of charges** 50% of charges** 50% of charges**</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Infertility Services Office Visit (lab & radiology tests, counseling) – PCP or Specialty Physician</p> <p>Treatment/Surgery (excludes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.) Inpatient Facility</p> <p>Outpatient Facility Services Physician's Services – Inpatient or Outpatient</p>	<p>90% of charges*; 90% of charges* if only x-ray and/or lab services are performed and billed.</p> <p>90% of charges*</p> <p>90% of charges*</p> <p>90% of charges*</p>	<p>50% of charges**</p> <p>50% of charges* Precertification required 50% of charges** 50% of charges** 50% of charges**</p>
<p>Obesity/Bariatric Surgery-(Covered only at approved centers through the precertification process) Physician's Office</p> <p>Inpatient Facility Outpatient Facility Physician's Services – Inpatient or Outpatient</p>	<p>90% of charges*; 90% of charges* if only x-ray and/or lab services are performed and billed.</p> <p>90% of charges*</p> <p>90% of charges*</p> <p>90% of charges*</p>	<p>Covered in network only</p> <p>Covered in-network only Covered in-network only Covered in-network only</p>
<p>TMJ – Surgical and Non-surgical: case-by-case basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity. Physician's Office</p> <p>Inpatient Facility</p> <p>Outpatient Facility Services Physician's Services – Inpatient or Outpatient</p>	<p>90% of charges*; 90% of charges* if only x-ray and/or lab services are performed and billed.</p> <p>90% of charges*</p> <p>90% of charges*</p> <p>90% of charges*</p>	<p>50% of charges**</p> <p>50% of charges* Precertification required 50% of charges** 50% of charges**</p>
<p>Mental Health Inpatient – 30 days maximum per contract year# Acute: Based on a ratio of 1:1 Partial: Based on a ratio of 2:1 Residential: Based on a ratio of 2:1 Outpatient Individual – 30 visits maximum per contract year# Group Therapy Mental Health – combined maximum with Outpatient Individual Mental Health services based on a ratio of 1:1 Intensive Outpatient Mental Health– 3 programs maximum per contract year# based on a ratio of 1:1 with outpatient Mental Health visits</p>	<p>90% of charges*</p> <p>90% of charges*</p> <p>90% of charges*</p> <p>90% of charges*</p>	<p>50% of charges* Precertification required</p> <p>50% of charges**</p> <p>50% of charges**</p> <p>50% of charges**</p>
<p>Substance Abuse Treatment/Chemical Dependency Note: Lifetime maximum of 3 series of treatment is covered. One treatment series is when the member is discharged on medical advice from a treatment facility or the member fails to comply with a planned treatment program for a period of thirty (30) consecutive days. Inpatient – Unlimited days maximum per contract year# Acute Detox: Based on a ratio of 1:1 (requires 24 hour nursing) Acute Inpatient Rehab: Based on a ratio of 1:1 (requires 24 hour nursing) Partial: Based on a ratio of 2:1 Residential: Based on a ratio of 2:1 Outpatient Individual – Unlimited visits maximum per contract year# Intensive Outpatient Substance Abuse – 3 programs maximum per contract year# based on a ratio of 1:1 with outpatient Substance Abuse visits</p>	<p>90% of charges*</p> <p>90% of charges*</p> <p>90% of charges*</p>	<p>50% of charges* Precertification required</p> <p>50% of charges**</p> <p>50% of charges**</p>
<p>Durable Medical Equipment Unlimited maximum per contract year#</p>	<p>90% of charges*</p>	<p>50% of charges**</p>
<p>External Prosthetic Appliances Unlimited maximum per contract year#</p>	<p>90% of charges*</p>	<p>50% of charges**</p>
<p>Perscription Drugs</p>	<p>Carved out to PTRx</p>	<p>Carved out to PTRx</p>

Footnotes

- * *Services are subject to contract year deductible.*
- ** *Out-of-network services are subject to the contract year deductible and maximum reimbursable charge limitations. Providers may bill the member the difference between their billed charge and the maximum reimbursable charge as determined by the benefit plan.*
- # *In-network and out-of-network services apply to the same treatment or dollar maximum.*

Regarding In-Network Services:

- *All services must be provided by one of the participating providers on our list in order to be covered.*
- *Once the out-of-pocket maximum is reached for In-network services; the plan pays 100% of eligible charges for the remainder of the plan year, except for Mental Health and Substance Abuse which continue to be paid at the levels specified.*

Regarding Out-of-Network Services:

- *Your out-of-pocket costs will be higher than with a participating provider.*
- *All out-of-network hospital admissions must be precertified and are subject to Continued Stay Review (CSR). A penalty applies to admissions which are not precertified. Non-approved admissions/days result in denial of benefits. The precertification penalty or cost of denied benefits does not apply to deductible or out-of-pocket maximum.*
- *Once the out-of-pocket maximum is reached for Out-of-Network services; the plan pays 100% of eligible charges for the remainder of the plan year, except for Mental Health and Substance Abuse which continue to be paid at the levels specified.*

Case Management

Coordinated by CIGNA HealthCare. This is a service designed 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.

Benefit Exclusions

These are examples of the exclusions in your plan. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control.

1. Any service or supply not described as covered in the Covered Expenses section of the plan.
2. Any medical service or device that is not medically necessary.
3. Treatment of an illness or injury which is due to war or care for military service disabilities treatable through governmental services.
4. Any services and supplies for or in connection with experimental, investigational or unproven services.
5. Dental treatment of the teeth, gums or structures directly supporting the teeth, however, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within 6 months of the accident.
6. Medical and surgical services, initial and repeat, intended for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute (NHLBI) guideline is covered only at approved centers if the services are demonstrated, through existing peer-reviewed, evidence-based, scientific literature and scientifically based guidelines, to be safe and effective for treatment of the condition. Clinically severe obesity is defined by the NHLBI as a BMI of 40 or greater without comorbidities, or 35–39 with comorbidities. The following are specifically excluded: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.
7. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
8. Court ordered treatment or hospitalizations.
9. 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.
10. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction.
11. Medical and hospital care and costs for the child of a Dependent, unless this infant child is otherwise eligible under the plan.
12. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance.
13. Consumable medical supplies other than ostomy supplies and urinary catheters.
14. Private hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
15. Artificial aids, including but not limited to hearing aids, semi-implantable hearing devices, audiant bone conductors, bone anchored hearing aids, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
16. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
17. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.

Benefit Exclusions (continued)

18. Routine foot care, however, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.
19. Genetic screening or pre-implantation genetic screening.
20. Fees associated with the collection or donation of blood or blood products.
21. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
22. All nutritional supplements and formulae are excluded, except infant formula needed for the treatment of inborn errors of metabolism.
23. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
24. The following services are excluded from coverage regardless of clinical indications: Massage Therapy; Cosmetic Surgery and Therapies; Surgical Treatment of Varicose Veins; Rhinoplasty; Abdominoplasty/Panniculectomy; 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 Acupunctures; Dental implants for any condition; Telephone Consultations; E-mail & Internet Consultations; Telemedicine; Health Club Membership fees; Weight Loss Program fees; Smoking Cessation Program fees; Reversal of male and female voluntary sterilization procedures; and Extracorporeal Shock Wave Lithotripsy for musculoskeletal and orthopedic conditions.

These Are Only the Highlights

As you can see, the plan is designed to combine in-depth coverage with cost-effective prices. This summary contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations including legislated benefits are contained in the Summary Plan Description or Insurance Certificate. This plan is insured and/or administered by Connecticut General Life Insurance Company, a CIGNA Company.

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