SUMMARY OF BENEFITS

Your CIGNA HealthCare Network plan

CIGNA HealthCare

Features that Add Value

- You choose a Primary Care Physician (PCP) – your **personal doctor** – to coordinate your care and provide advice and guidance. 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 Line[SM] 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 health and wellness programs and services often not covered by many traditional benefits plans. Just call 1.800.870.3470 or visit our web site at www.cigna.com.
- Our Guest Privileges program **brings** your CIGNA HealthCare **benefits along** when you temporarily relocate or send kids to schools away from home. Call CIGNA HealthCare Member Services to learn more.
- CIGNA Behavioral Health offers you access to **professional consultation** over the phone to **help you** with problems that affect you, your family, or your work.

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 web site that combines WebMD® tools with personalized benefits information to help you make the most of your plan.
- **We Speak Many Languages[SM]** . 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.
- 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® can **help you manage** certain chronic conditions.
- 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.** 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.
- **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.

For Employees of Cypress-Fairbanks I.S.D.

BENEFIT HIGHLIGHTS	
Physician Services ***Primary Care Physician (PCP) Office Visit***	$25 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.
Specialist Physician Office Visit *Consultant and Referral Physician Services* ***Note****: OB/GYN physician is considered a Specialist Physician*	$35 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.
Allergy Treatment/Injections - PCP or Specialist Physician	$25 or $35 copayment per office visit or actual charge, whichever is less
Allergy Serum (dispensed by physician in office)	No charge
Second Opinion Consultations (provided on voluntary basis)	$25 or $35 copayment per office visit
Surgery Performed in the Physician's Office- PCP or Specialist Physician	$25 or $35 copayment per office visit
Preventive Care *Routine Preventive Care – Well Baby,Well Child Care, Adult and Well Woman (including immunizations)* ***Note****: Well Woman OB/GYN visits are subject to the Specialist Physician's office visit copay*	$25 or $35 copayment per office visit; No charge if only x-ray and/or lab services performed and billed
Routine Immunizations and Injections	The office visit copayment will be waived when immunization is the only service provided.
Mammograms, PSA, Pap Test ***(Preventive Care Related Routine Services)*** ***(Note: Diagnostic Related Services are subject to the plan's x-ray & lab benefit; based on place of service)***	No charge for the procedure itself; **Note**: $25 or $35 copayment per office visit for associated wellness exam
Inpatient Hospital Services – includes *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*	$500 copayment per confinement
Inpatient Hospital Doctor's Visits/Consultations *Inpatient Hospital Professional Services*	No charge No charge
Outpatient Facility Services *Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room including:* *Diagnostic/Therapeutic Lab and X-rays* *Anesthesia and Inhalation Therapy* *Physician and Outpatient Professional Services*	$250 copayment per facility visit No charge
Laboratory and Radiology Services *(includes preadmission testing)* *Physician's Office* *Outpatient Hospital Facility*	 No charge No charge for facility charges; No charge for outpatient professional charges
Emergency Room (billed by facility as part of the Emergency Room visit)	No charge
Independent X-Ray and/or Lab Facility *Independent X-Ray and/or Lab Facility (in conjunction with an Emergency Room visit)*	No charge No charge *(if ER visit is considered to be a true emergency)*
Advanced Radiological Imaging *(MRIs, MRAs, CAT Scans, PET Scans, etc.)* *Inpatient Facility*	 No charge
Outpatient Facility	$50 scan copayment
Emergency Room	$50 scan copayment
Physician's Office ***Note****: The scan copayment will be administered on a per type of scan per day basis*	$50 scan copayment

BENEFIT HIGHLIGHTS	
Short-Term Rehabilitative Therapy, Cardiac Rehabilitation and Chiropractic Care Services--(includes cardiac rehab, physical, speech, occupational, chiropractic, pulmonary rehab & cognitive therapy) **60 days** maximum per calendar year for all therapies combined ***Note****: therapy sessions provided as part of Home Health Care accumulate to the Short-Term Rehab Therapy maximum.*	$25 or $35 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.
Emergency and Urgent Care Services	
Physician's Office – PCP or Specialist Physician	$25 or $35 copayment per office visit; No charge if only x-ray and/or lab services performed and billed
Hospital Emergency Room	$100 copayment per visit (*copay waived if admitted*)
Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician)	No charge
Urgent Care Facility or Outpatient Facility	$50 copayment per visit (*copay waived if admitted)*
Ambulance	No charge ***Note****: if not a true emergency, services are not covered*
Maternity Care Services	
Initial Office Visit to Confirm Pregnancy	$25 or $35 copayment for initial office visit
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (total maternity fee)	No charge
Office Visits not included in the total maternity fee performed by OB or Specialist Physician	$35 copayment per office visit; No charge if only x-ray and/or lab services performed and billed
Delivery - Facility (Inpatient Hospital/Birthing Center Charges)	$500 copayment per confinement
Inpatient Services at Other Health Care Facilities *Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities* 60 days maximum per calendar year combined for all facilities listed	No charge
Home Health Services - *Includes outpatient private duty nursing when approved as medically necessary* 60 days maximum per calendar year; 16 hour maximum per day	No charge
Family Planning Services	
Office Visits (tests, counseling) – PCP or Specialist Physician	$25 or $35 copayment per office visit; No charge if only x-ray and/or lab services performed and billed
Vasectomy/Tubal Ligation (excludes reversals)	
Inpatient Facility	$500 copayment per confinement
Outpatient Facility	$250 copayment per facility visit
Physician's Services – Inpatient or Outpatient	No charge
Physician's Office	$25 or $35 copayment per office visit
Infertility Services	
Office Visit (lab & radiology tests, counseling)-PCP or Specialist Physician	$25 or $35 copayment per office visit; No charge if only x-ray and/or lab services performed and billed
Treatment/Surgery (excludes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.)	$200 surgical copayment
Inpatient Facility	$500 copayment per confinement
Outpatient Facility	$250 copayment per facility visit
Physician's Services - Inpatient or Outpatient	No charge
TMJ - Surgical and Non-Surgical-case-by-case basis*. Always excludes appliances & orthodontic treatment. Subject to medical necessity.*	
Physician's Office	$25 or $35 copayment per office visit; No charge if only x-ray and/or lab services performed and billed
Inpatient Facility	$500 copayment per confinement
Outpatient Facility	$250 copayment per facility visit
Physician's Services - Inpatient or Outpatient	No charge

BENEFIT HIGHLIGHTS	
Mental Health and Substance Abuse ***Inpatient*** - 8 days combined maximum per calendar year for inpatient Mental Health and inpatient Substance Abuse ***<u>Inpatient Mental Health</u>*** ***Acute**:* Based on a ratio of 1:1 ***Partial:*** Based on a ratio of 2:1 ***Residential**:* Based on a ratio of 2:1 ***<u>Inpatient Substance Abuse</u>*** ***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*– 25 visits combined maximum per calendar year for outpatient Mental Health and outpatient Substance Abuse ***Outpatient Group Therapy Mental Health*** – maximum is combined with Outpatient Individual Mental Health services based on a ratio of 1:1 ***Intensive Outpatient Mental Health*** – up to 3 programs maximum per calendar year based on a ratio of 1:1 with outpatient Mental Health visits	 $500 copayment per confinement $35 copayment per office visit $15 copayment per session $35 per program copayment
Durable Medical Equipment $3,500 maximum benefit per calendar year	No charge
External Prosthetic Appliances $1,000 maximum benefit per calendar year	$200 EPA deductible
Prescription Drugs-	Carved out
OTHER BENEFIT INFORMATION	
Calendar Year Deductible *Individual* *Family Maximum*	 None None
Calendar Year Out-of-Pocket (OOP) Maximum *Individual* *Family Maximum*	Includes inpatient facility copays, outpatient facility copays and advanced radiological imaging copays. Other copays do not accumulate $2,000 $4,000
Coinsurance	No (except where noted above)
Precertification -Inpatient – PHS+ (required for all inpatient admissions) ***Precertification – Outpatient – PHS+ (required for selected outpatient procedures and diagnostic testing)***	Coordinated by your physician Coordinated by your physician
Lifetime Maximum	Unlimited
Pre-existing Condition Limitation	No

All services, except for emergency services, routine care provided by a participating OB/GYN, and inpatient Mental Health and Substance Abuse services authorized by CIGNA Behavioral Health, Inc. must be provided by or authorized by your Primary Care Physician (PCP) in order to be covered.

Mental Health

All inpatient Mental Health and Substance Abuse benefits are authorized by CIGNA Behavioral Health, Inc., or its affiliates.

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, 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.
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. Medical and hospital care and costs for the child of a Dependent, unless this infant child is otherwise eligible under the plan.
11. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance.
12. Consumable medical supplies other than ostomy supplies and urinary catheters.
13. Private hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
14. 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.
15. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
16. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
17. 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 the plan.
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; 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.

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.
"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.

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