

SUMMARY OF BENEFITS

Your CIGNA HealthCare Open Access Plus plan



CIGNA HealthCare

Features that Add Value

- The convenience of **referral-free access** to physicians, 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 **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.

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 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.
- 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 your children through age 2 and any additional preventive care benefits described in the Benefits Highlights.
- 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 “preferred 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 “preferred providers,” but you're still covered for visits to other providers.

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

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Physician Services Primary Care Physician (PCP) Office Visit</p> <p>Specialty Care Physician Office Visit <i>Consultant and Referral Physician Services</i> <u>Note:</u> OB/GYN physician is considered a Specialist Physician</p> <p>Allergy Treatment/Injections - PCP or Specialist Physician</p> <p>Second Opinion Consultations (provided on voluntary basis)</p> <p>Surgery Performed in the Physician's Office- PCP or Specialist Physician</p>	<p>100% of charges after \$25 copayment per office visit; 100% of charges after office visit copay if only x-ray and/or lab services are performed and billed within the office.</p> <p>100% of charges after \$35 copayment per office visit; 100% of charges after office visit copay if only x-ray and/or lab services are performed and billed within the office.</p> <p>100% of charges after \$25 or \$35 copayment per office visit or actual charge, whichever is less</p> <p>100% of charges after \$25 or \$35 copayment per office visit</p> <p>80% of charges*</p>	<p>70% of charges**</p> <p>70% of charges**</p> <p>70% of charges**</p> <p>70% of charges**</p> <p>60% of charges**</p>
<p>Preventive Care Routine Preventive Care for Children through age 2 (including routine immunizations)</p> <p>Immunizations</p> <p>Routine Preventive Care for Children and Adults from age 3 (including routine immunizations) Unlimited maximum per calendar year <u>Note:</u> Well-woman OB/GYN office visits are subject to the Specialist Physician office visit copay</p> <p>Immunizations</p>	<p>100% of charges after \$25 or \$35 copayment per office visit; 100% of charges after office visit copay if only x-ray and/or lab services are performed and billed within the office.</p> <p>100% of charges, no plan deductible</p> <p>100% of charges after \$25 or \$35 copayment per office visit; 100% of charges after office visit copay if only x-ray and/or lab services are performed and billed within the office.</p> <p>100% of charges, no plan deductible</p>	<p>70% of charges**</p> <p>70% of charges**</p> <p>70% of charges**</p> <p>70% of charges**</p>
<p>Mammograms, PSA, Pap Test <u>Note:</u> Preventive care related services and diagnostic related services are paid at the same level of benefits as other x-ray and lab services based on place of service.</p>	<p>100% of charges if billed by independent diagnostic facility or outpatient hospital; 100% of charges after \$25 or \$35 copayment per visit for associated wellness exam</p>	<p>70% 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</p>	<p>80% of charges* after \$200 copayment per admission</p>	<p>60% of charges* after \$200 deductible per admission</p> <p>Precertification required</p>
<p>Inpatient Hospital Doctor's Visits/Consultations Inpatient Hospital Professional Services</p>	<p>80% of charges* 80% of charges*</p>	<p>60% of charges** 60% of charges**</p>
<p>Outpatient Facility Services includes: Operating Room, Recovery Room, Procedure Room and Treatment Room and Observation Room including: Diagnostic/Therapeutic Lab and X-rays Anesthesia and Inhalation Therapy Physician & Outpatient Professional Services <u>Note:</u> Non-surgical treatment procedures are not subject to the facility copay.</p>	<p>80% of charges* after \$100 copayment per facility visit</p> <p>80% of charges*</p>	<p>60% of charges** after \$150 deductible per facility visit</p> <p>60% of charges**</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Laboratory and Radiology Services <i>Physician's Office</i></p> <p><i>Outpatient Hospital Facility</i></p> <p><i>Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit)</i></p> <p><i>Independent X-Ray and/or Lab Facility</i> <i>Independent X-Ray and/or Lab Facility (in conjunction with an Emergency Room visit)</i></p>	<p>100% of charges after \$25 or \$35 copayment per office visit</p> <p>80% of charges*</p> <p>80% of charges*</p> <p>80% of charges*</p> <p>80% of charges*</p>	<p>70% of charges**</p> <p>60% of charges**</p> <p>80% of charges*; <i>except if not a true emergency, then 60% of charges**</i></p> <p>60% of charges**</p> <p>80% of charges*</p>
<p>Advanced Radiological Imaging (MRIs, MRAs, CAT Scans, PET Scans, etc.) <i>Inpatient Facility</i></p> <p><i>Outpatient Facility</i></p> <p><i>Emergency Room (billed by facility as part of the Emergency Room visit)</i></p> <p><i>Physician's Office</i></p>	<p>Same as inpatient hospital facility benefit</p> <p>80% of charges*</p> <p>80% of charges*</p> <p>100% of charges</p>	<p>Same as inpatient hospital facility benefit</p> <p>60% of charges**</p> <p>80% of charges; <i>except if not a true emergency, then 70% of charges**</i></p> <p>70% of charges**</p>
<p>Short-Term Rehabilitative Therapy, Cardiac Rehabilitation and Chiropractic Services--(includes cardiac rehab, physical, speech, occupational, chiropractic, pulmonary rehab & cognitive therapy) Unlimited days maximum per calendar year for all therapies combined</p>	<p>100% of charges after \$25 or \$35 copayment per office visit; 100% of charges after office visit copay if only x-ray and/or lab services are performed and billed within the office.</p>	<p>70% of charges**</p>
<p>Emergency and Urgent Care Services <i>Physician's Office – PCP or Specialist Physician</i></p> <p><i>Hospital Emergency Room</i></p> <p><i>Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician)</i></p> <p><i>Urgent Care Facility or Outpatient Facility</i></p> <p><i>Ambulance</i></p>	<p>100% of charges after \$25 or \$35 copayment per office visit; 100% of charges after office visit copay if only x-ray and/or lab services are performed and billed within the office.</p> <p>80% of charges* after \$100 copayment per visit (<i>copay waived if admitted</i>)</p> <p>80% of charges*</p> <p>80% of charges* after \$50 copayment per visit (<i>copay waived if admitted</i>)</p> <p>80% of charges*</p>	<p><i>Care will be provided at in-network levels if it meets the "prudent layperson" definition of an emergency. Except if not a "true emergency" then \$100 copayment plus 50% of charges for Emergency Room care. All other charges are 60% of charges**</i></p>
<p>Maternity Care Services <i>Initial Office Visit to Confirm Pregnancy</i> Note: <i>OB/GYN physician is considered a Specialist Physician</i></p> <p><i>All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (total maternity fee)</i></p> <p><i>Office Visits not included in the total maternity fee performed by OB or Specialist Physician</i></p> <p><i>Delivery - Facility (Inpatient Hospital/Birthing Center Charges)</i></p> <p><i>Well-Newborn Hospital Charges</i></p>	<p>100% of charges after \$25 or \$35 copayment for initial office visit; 100% of charges after office visit copay if only x-ray and/or lab services are performed and billed within the office.</p> <p>80% of charges*</p> <p>100% of charges after \$25 or \$35 copayment per office visit; 100% of charges after office visit copay if only x-ray and/or lab services performed and billed within the office.</p> <p>80% of charges* after \$200 copayment per admission</p> <p>80% of charges*</p>	<p>70% of charges**</p> <p>60% of charges**</p> <p>70% of charges**</p> <p>60% of charges* after \$200 deductible per admission, precertification required</p> <p>60% of charges**</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Services at Other Health Care Facilities <i>Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities</i> 120 days maximum per calendar year# combined for all facilities listed	80% of charges*	60% of charges**
Home Health Services – Includes outpatient private duty nursing when approved as medically necessary 40 days maximum per calendar year#; 16 hour maximum per day#	80% of charges*	60% of charges**
Family Planning Services <i>Office Visits (lab & radiology tests, counseling)</i> Vasectomy/Tubal Ligation (excludes reversals) <i>Inpatient Facility</i> <i>Outpatient Facility</i> <i>Physician's Services – Inpatient or Outpatient</i> <i>Physician's Office</i>	100% of charges after \$25 or \$35 copayment per office visit; 100% of charges after office visit copay if only x-ray and/or lab services performed and billed within the office. 80% of charges* after \$200 copayment per admission 80% of charges* after \$100 copayment per facility visit 80% of charges* 100% of charges after \$25 or \$35 copayment per office visit; 100% of charges after office visit copay if only x-ray and/or lab services performed and billed within the office.	70% of charges** 60% of charges* after \$200 deductible per admission, precertification required 60% of charges* after \$150 deductible per facility visit 60% of charges** 70% of charges**
Infertility Services <i>Office Visit (lab & radiology tests, counseling)-PCP or Specialist Physician</i> Treatment/Surgery (excludes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.) <i>Inpatient Facility</i> <i>Outpatient Facility</i> <i>Physician's Services</i>	100% of charges after \$25 or \$35 copayment per office visit; 100% of charges after office visit copay if only x-ray and/or lab services performed and billed within the office. 80% of charges* after \$200 copayment per admission 80% of charges* after \$100 copayment per facility visit 80% of charges*	70% of charges** 60% of charges* after \$200 deductible per admission, precertification required 60% of charges* after \$150 deductible per facility visit 60% of charges**
TMJ - Surgical and Non-Surgical-case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity. <i>Physician's Office</i> <i>Inpatient Facility</i> <i>Outpatient Facility</i> <i>Physician's Services - Inpatient or Outpatient</i>	100% of charges after \$25 or \$35 copayment per office visit; 100% of charges after office visit copay if only x-ray and/or lab services performed and billed within the office. 80% of charges* after \$200 copayment per admission 80% of charges* after \$100 copayment per facility visit 80% of charges*	70% of charges** 60% of charges* after \$200 deductible per admission, precertification required 60% of charges* after \$150 deductible per facility visit 60% of charges**
Mental Health Inpatient - 30 days combined maximum per calendar year# Outpatient Individual – 30 visits combined maximum per calendar year# Group Therapy Mental Health – combined maximum with Outpatient Individual Mental Health services based on a ratio of 2:1	80% of charges* 80% of charges* 80% of charges*	50% of charges*, precertification required 50% of charges** 50% of charges**

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Substance Abuse Inpatient - Unlimited days maximum per calendar 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 – Alcohol & Drug Abuse Treatments limited to 3 series of treatments per Lifetime# Group Therapy Substance Abuse – combined maximum with Outpatient Individual Substance Abuse services based on a ratio of 2:1	80% of charges* 100% of charges after \$35 copayment per office visit 100% of charges after \$35 copayment per session	60% of charges*, precertification required 50% of charges** 50% of charges**
Durable Medical Equipment Unlimited maximum per calendar year	80% of charges*	60% of charges**
External Prosthetic Appliances Unlimited maximum per calendar year	80% of charges*	60% of charges**
Prescription Drugs	Carved Out	Carved Out
OTHER BENEFIT INFORMATION	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Plan Deductible <i>Individual / Family Maximum</i>	\$500 / \$1,000	\$1,000 / \$2,000
Calendar Year Out-of-Pocket Maximum <i>Individual / Family Maximum</i>	<i>Including Plan Deductible</i> \$3,000 / \$6,000	<i>Including Plan Deductible</i> \$6,000 / \$12,000
Coinsurance	CIGNA HealthCare pays 80% of eligible charges. You pay 20% of charges after plan deductible.	CIGNA HealthCare pays 60% or 70% of eligible charges. You pay 40% or 30% 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

*Services are subject to calendar year deductible

** Services are subject to calendar year deductible and reasonable and customary charge/maximum reimbursable charge limitations.

In-network and out-of-network services apply to the same treatment or dollar maximum.

Footnotes:

Regarding In-Network and Out-of-Network Services:

- Once the out-of-pocket maximum is reached, 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.
- All inpatient hospital admissions require Preadmission Certification and Continued Stay Review. Failure to obtain Preadmission Certification and/or Continued Stay Review may result in non-compliance penalties and/or reduction of benefits. Call the toll-free number on your CIGNA HealthCare ID Card.

Regarding In-Network Services:

- All services must be provided by one of the preferred providers on our list in order to be covered.

Regarding Out-of-Network Services:

- Your out-of-pocket costs will be higher than with a preferred 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

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. 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.
9. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction.
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. 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; Surgical Treatment of Varicose Veins; Abdominoplasty/Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant Skin Surgery; Removal of Skin Tags; Acupuncture; 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.

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