SUMMARY OF BENEFITS

CIGNA SELECT GROUP PLANS

TEXAS OPEN ACCESS PLUS PREMIER PLAN 5

Core Plan (Option 1)

BENEFIT	IN NETWORK	OUT OF NETWORK
Annual Individual Deductible	$1,500	$3,000
Annual Family Deductible	$3,000	$6,000
Coinsurance	CIGNA pays 80% of eligible charges	CIGNA pays 60% of eligible charges
Individual Out of Pocket Maximum	$3,000	$9,000
Family Out of Pocket Maximum	$6,000	$18,000
Copays and pharmacy charges do not apply to the out of pocket maximum		
Lifetime Maximum	$5,000,000 per member	
PHYSICIAN SERVICES		
Office Visit (including surgery) Primary Care Physician Specialist Physician	You pay $25 copay You pay $50 copay	You pay 40%*
Inpatient Physician Services and all In-Hospital Care Specialist Physician	You pay 20%*	You pay 40%*
Surgery (performed in an inpatient/outpatient setting) Specialist Physician	You pay 20%*	You pay 40%*
PREVENTIVE CARE CONDUCTED IN A PHYSICIAN'S OFFICE		
Children (through age 2) Lab Work, Preventive Screenings Immunizations (through age 6)	PCP or Specialist copay You pay 0%, deductible waived	You pay 40%* You pay 0%, deductible waived
Children and adults from age3; $500 calendar max Lab Work, Preventive Screenings Immunizations (over age 7)	PCP or Specialist copay You pay 0%, deductible waived	You pay 40%* You pay 40%*
Mammogram, PSA, Pap Smear Mammogram, Pap, and PSA Cancer Screenings The associated wellness exam will be covered at no charge after the PCP or Specialist copay	You pay 0%, Deductible waived	You pay 40%*
INPATIENT HOSPITAL FACILITY SERVICES		
Semi Private Room and Board and all In-Hospital Services *(inpatient room and board, pharmacy, x-ray and laboratory, operating room, etc.)*	You pay 20%*	You pay 40%*
OUTPATIENT SERVICES		
Lab, X-Ray, Ultrasound – Independent Facility	You pay 20%	You pay 40%*
Lab, X-Ray, Ultrasound – Outpatient Facility	You pay 20%	You pay 40%*
Advanced Radiological Imaging (i.e. MRI's, MRAs, CAT Scans and PET Scans, etc.)	You pay 20%*	You pay 40%*
Short Term Rehabilitation including physical, speech, and occupational therapy *60 maximum of days per calendar year, combined in and out of network*	PCP or Specialist copay	You pay 40%*
Outpatient Surgery Facility charge	You pay 20%*	You pay 40%*

CIGNA SELECT GROUP PLANS

TEXAS OPEN ACCESS PLUS PREMIER PLAN 5

Core Plan

BENEFIT	IN NETWORK	OUT OF NETWORK
EMERGENCY & URGENT CARE SERVICES		
Urgent Care Services	You pay $35 Copay	You pay $35 for true emergency; otherwise, You pay 40%*
Hospital Emergency Room *(including radiology, pathology and ER physician and ancillary charges)* *Copay waived if admitted to hospital*	You pay $250 Copay	You pay $250 Copay for true emergency; otherwise, You pay 40%*
Ambulance	You pay 20%*	You pay 20%* for true emergency; otherwise, You pay 40%*
OTHER HEALTH CARE FACILITIES		
Skilled Nursing Facility, Rehabilitation Hospital and Sub Acute Facilities *Maximum of 60 days per calendar year, combined in and out of network*	You pay 20%*	You pay 40%*
Home Health *Maximum of 60 days per calendar year, combined in and out of network combined*	You pay 20%*	You pay 40%*
DURABLE MEDICAL EQUIPMENT (DME)		
Maximum of $2,000 per calendar year, combined in and out of network combined	You pay 20%*	You pay 40%*
MENTAL HEALTH and SUBSTANCE ABUSE		
Mental Health and Substance Abuse *(Combined)* *Inpatient*	You pay 20%*	You pay 40%*
Outpatient Mental Health and Substance Abuse *(Includes Individual, (Group Therapy-Mental Health only) and Intensive Outpatient)*		
Physician's Office	PCP or Specialist copay	You pay 40%*
Outpatient Facility	You pay 20%*	You pay 40%*
PRESCRIPTION DRUGS		
Generic	You pay $20 per 30-day supply	You pay 40%
Brand Name	You pay $40 per 30-day supply	You pay 40%
Non Preferred Brand Name	You pay $60 per 30-day supply	You pay 40%
MAIL ORDER DRUGS		
Generic	You pay $40 per 90-day supply	You pay 40%
Brand Name	You pay $80 per 90-day supply	You pay 40%
Non-Preferred Brand Name	You pay $120 per 90-day supply	You pay 40%

***After plan deductible**

Highlights of Plan Exclusions:

What's Not Covered (*not all-inclusive*):

Your plan provides coverage for most medically necessary services. Examples of things your plan does not cover, unless required by law, include (but aren't limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an illness or injury which is due to war, declared or undeclared.
- Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be: Not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or The subject of review or approval by an Institutional Review Board for the proposed use, except as provided in the "Clinical Trials" section of "Covered Services and Supplies;" or The subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of "Covered Services and Supplies."
- Cosmetic Surgery and Therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- The following services are excluded from coverage regardless of clinical indications: 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; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. 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. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- 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.
- 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.
- Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under "Covered Services and Supplies."
- Infertility services, 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.
- Reversal of male and female voluntary sterilization procedures.

- Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
- Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
- Non-medical counseling or ancillary services, including, but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Inpatient Hospital Services," "Outpatient Facility Services," "Home Health Services" or “Breast Reconstruction and Breast Prostheses” sections of "Covered Services and Supplies."
- Private hospital rooms and/or private duty nursing except as provided in the Home Health Services section of “Covered Services and Supplies”.
- Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
- Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- Hearing aids, including, but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
- Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- 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 "Covered Services and Supplies.”
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director’s opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.

- All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
- Expenses incurred for medical treatment by a person age 65 or older, who is covered under this Agreement as a retiree, or his Dependents, when payment is denied by the Medicare plan because treatment was not received from a Participating Provider of the Medicare plan.
- Expenses incurred for medical treatment when payment is denied by the Primary Plan because treatment was not received from a Participating Provider of the Primary Plan.
- Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
- Telephone, e-mail & Internet consultations and telemedicine.
- Massage Therapy

These Are Only the Highlights

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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