

How The Plan Works

The CIGNA plan is a health maintenance organization (HMO) with a network of participating, private practice physicians, hospitals and other health care providers.

To access the CIGNA network of health care, select a Health Care Center from the Health Care Center and Physician Guide.

For CIGNA details or to obtain a copy of the Physician Guide call CIGNA at (800) 244-6224 or (800) CIGNA24. You can also visit the CIGNA website at www.cigna.com.

Annual Deductible

None.

Copayments

The copayments will range from \$10 to \$50, but can be higher for certain specialty services. Your copayment for a 30 day supply of prescription drugs is \$7 per fill for generic drugs and \$15 per fill for brand name drugs, closed formulary. Only prescriptions obtained from a CIGNA participating pharmacy are covered.

Your Out-Of-Pocket Limit

The out-of-pocket maximum you might have to pay for medical copayments are \$1,000 per person/\$2,000 per family per contract year (October 1 to September 30).

Covered Expense

Please refer to the Summary of Benefits (page 10) for services covered under the CIGNA Plan.

In An Emergency

Go to the nearest medical facility for treatment. You are covered at all times. The emergency room copayment is \$50 (copayments are waived if you are immediately admitted into the hospital) and there is no charge for an ambulance. An emergency is considered to be any life-threatening illness or injury.

Coverage Outside California

When traveling outside of your “service area”, you are covered for emergency or urgent care services only. Claims for emergency services should be submitted to:

CIGNA
P.O. Box 182228
Chattanooga, TN 37422-7223

CIGNA:**Summary of Benefits**

	<i>Current Benefits</i>
OUT-OF-POCKET MAXIMUMS	
Individual	\$1,000
Family (Aggregate)	\$2,000
LIFETIME MAXIMUM	
Lifetime Maximum	Unlimited
PROFESSIONAL SERVICES	
Primary Care Physician Copay	\$10
Specialist Copay	\$10
HOSPITAL SERVICES	
Inpatient Copay	\$0
Outpatient Copay	\$0
EMERGENCY COPAYMENTS	
Emergency Room Copay	\$50
Urgent Care Copay	\$25
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES	
Inpatient Mental Health/Substance Abuse (30 days)	\$50 per day
Outpatient Mental Health (20 visits)	\$25 per visit
Outpatient Substance Abuse (total of 20 visits per contract year)	\$15 per visit (first 2 visits); \$25 thereafter
Group Therapy (Includes telephonic consultations)	\$15
FAMILY PLANNING	
Family Planning Counseling	\$10
Tubal Ligation & Vasectomy Facility	\$0
Surgery in Physicians Office	\$10
Infertility (cover office visits, diagnosis and medical treatment to correct infertility)	30% Coinsurance. (No coverage for drugs, In-vitro, GIFT, ZIFT, etc.)
OTHER	
Home Health Care	No Charge
Skilled Nursing Facility Copay	No Charge, 60 days per contract year
Durable Medical Equipment	No Charge; \$3,500 Maximum per contract year
External Prosthetics	\$200 Deductible, \$1000 Maximum per contract year
Outpatient Short Term Rehab (60 visits per contract year)	\$20
MRI, CT, PET Scans	No Charge
Vision Riders	Not Included
Pre-Existing Condition Limitation	None
Well Aware (Asthma & Diabetes)	Included
24 Hour Health Information Line	Included
Working Wonders	Included
PRESCRIPTION DRUGS RIDERS	
Closed formulary (including Oral Contraceptives and mandatory generic.)	\$7 generic/\$15 brand

The following is a summary of some of the services that are not covered by CIGNA HealthCare. Please consult the CIGNA HealthCare Group Service Agreement for a description of your benefits and a complete list of exclusions and coverage limitations. If you have any questions about a specific service or treatment, contact Member Services.

Your CIGNA HealthCare program does not provide coverage for the following, except where required by law:

1. Any services, except emergency services and obstetrical and gynecological services, which are provided without the prior written approval of CIGNA HealthCare or your primary care physician and any services, except emergency services, which are not provided by a participating provider.
2. Services that are not medically necessary.
3. Charges that the person is not legally required to pay.
4. Charges for care and services for sickness or injury connected to military service.
5. Custodial care, education or training.
6. Experimental or investigational procedures and treatments.
7. Organ transplants, except as provided in the Group Services Agreement, and unless approved by CIGNA HealthCare.
8. Cosmetic Surgery.
9. Reports, evaluations, examinations, or hospitalizations not required for health reasons, such as employment or insurance examinations.
10. Any dental services or services for related conditions. (Medically Necessary treatment of orthographic problems, which may include TMJ disorder, shall not be excluded.)
11. Reversal of voluntary sterilization procedures, and certain infertility services.
12. Transsexual surgery and related services.
13. Personal or comfort items such as personal care kits, television and telephones.
14. Artificial aids such as splints, wigs, and most consumable medical supplies.
15. Certain internal prostheses.
16. Surgical treatment for correction of refractive errors, including radial keratotomy.
17. Non-prescription drugs and "brand name" prescription drugs when a "generic" equivalent exists. (In the event a Member insists on a more expensive "brand name" drug, the member shall be financially responsible for the amount which the cost of the "brand name" drug exceeds the "generic" drug, plus the brand name copayment. Coverage will be provided for "brand name" prescription drugs at the same copayment level as "generic" drugs, if they are determined as Medically Necessary by the HEALTHPLAN Medical Director or his/her designee and not otherwise excluded under the Prescription Drug Rider.)
18. All drugs that do not appear on the HEALTHPLAN Formulary. (Coverage will be provided for non-Formulary Prescription Drugs at the same Copayment level as "generic" drugs, if they are determined as Medically Necessary by the HEALTHPLAN Medical Director or his/her designee and not otherwise excluded the Prescription Drug Rider.)
19. Routine foot care.
20. Amniocentesis, ultrasound and similar procedures solely to determine gender, unless medically necessary to determine the existence of a sex-related genetic disorder.
21. Vision services, eyeglasses, and contact lenses.