Your Preferred Provider Plan (PPO) provides convenient, low-cost coverage in our network . . . plus the option to go out of network when you wish.

In-Network

CHOICE OF DOCTORS
You can use any “preferred provider” in our network without a referral. Or, when you wish, you can go out of network.

LOW COST
When you receive care from a preferred provider, you’ll enjoy considerable savings. See the listing of preferred providers in your “CIGNA HealthCare Directory.”

PERSONALIZED CARE
In the private office of your physician.

HOSPITALIZATION
Your costs will be lower when you use a hospital in our network and your stay has been pre-approved.

CIGNA’S TOLL-FREE CARE LINE
Call for steps to take before admittance to a hospital, or for assistance in finding a preferred provider when you’re at home or out of town. Call CIGNA CareLine at the toll-free number on your ID Card for further information.

EMERGENCY CARE
No matter where you travel in the U.S. or worldwide, you’re covered for emergency care. See your “CIGNA HealthCare Directory” for details.

NO CLAIMS OR OTHER PAPERWORK
In the network, just show your CIGNA ID card to receive care.

Out-of-Network

OUT-OF-NETWORK COVERAGE
You’re still covered when you go out of network, though your cost will be higher. No referrals are needed. Out-of-network, you must pay for services received and file a claim for reimbursement . . . after meeting your deductible. See the out-of-network costs in the Summary of Benefits inside.

DEDUCTIBLES AND OUT-OF-POCKET MAXIMUMS
Your out-of-pocket costs and plan deductibles apply to the Stop Loss Limit. Once the Stop Loss Limit is reached, the plan pays 100% of eligible charges for the rest of the plan year, except for Mental Health, while not confined to a hospital, which continue to be paid at the levels specified.

THESE ARE ONLY THE HIGHLIGHTS
If you have any questions about a specific service or treatment, contact Customer Service.
# Summary of Benefits

*Your Coverage and the Out-of-Pocket Costs to You*

<table>
<thead>
<tr>
<th>AT A GLANCE</th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible (excluding copay)</td>
<td>$150</td>
<td>$150</td>
</tr>
<tr>
<td>Individual</td>
<td>$450</td>
<td>$450</td>
</tr>
<tr>
<td>Annual Stop Loss Limit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$5,000 of covered charges</td>
<td>$5,000 of covered charges</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

## SPECIFIC BENEFITS

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Preventive Care for Children incl. Immunizations <em>birth to age 19</em></td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>Routine Preventive Care</td>
<td>$10 per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td>Well Woman Exam incl. pap test</td>
<td>$10 per visit</td>
<td>20% of charges*</td>
</tr>
<tr>
<td>Illness or Injury</td>
<td>$10 per visit</td>
<td>20% of charges*</td>
</tr>
<tr>
<td>Allergy Treatment</td>
<td>$10 per visit or actual charge, whichever is less</td>
<td>20% of charges*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic - 30-day supply</td>
<td>$3 per prescription/refill</td>
<td>20% of charges*</td>
</tr>
<tr>
<td>Brand Name- 30-day supply</td>
<td>$7 per prescription/refill</td>
<td>20% of charges*</td>
</tr>
<tr>
<td>Tel-Drug Mail Order Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic - 90-day supply</td>
<td>$6 per prescription/refill</td>
<td>Not covered</td>
</tr>
<tr>
<td>Brand Name - 90-day supply</td>
<td>$14 per prescription/refill</td>
<td>Not covered</td>
</tr>
<tr>
<td>Maternity Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>$10 for first visit to confirm pregnancy, then covered under delivery</td>
<td>20% of charges*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Charges</td>
<td>10% of charges*</td>
<td>20% of charges*</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infertility Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit incl. tests &amp; counseling</td>
<td>$10 per visit</td>
<td>20% of charges*</td>
</tr>
<tr>
<td>Vasectomy/Tubal Ligation (excl. reversals)</td>
<td></td>
<td>20% of charges*</td>
</tr>
<tr>
<td>Physician Charges</td>
<td>10% of charges*</td>
<td>20% of charges*</td>
</tr>
<tr>
<td>Emergency Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor's Office</td>
<td>$10 per visit</td>
<td>20% of charges*</td>
</tr>
<tr>
<td>Ambulance</td>
<td>10% of charges*</td>
<td>Care will be covered at in-network benefit level if it meets CIGNA HealthCare's definition of emergency</td>
</tr>
<tr>
<td>Specific Benefits</td>
<td>In-Network</td>
<td>Out-Of-Network</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Surgeon's Fees</td>
<td>10% of charges*</td>
<td>20% of charges*</td>
</tr>
<tr>
<td>Inpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>10% of charges*</td>
<td>20% of charges*</td>
</tr>
<tr>
<td>Outpatient Short-Term Rehabilitation</td>
<td>$10 per visit</td>
<td>20% of charges*</td>
</tr>
<tr>
<td>incl. Physical, Speech, Occupational and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Second Surgical Opinion</td>
<td>$10 per visit</td>
<td>20% of charges*</td>
</tr>
<tr>
<td>X-ray and Lab</td>
<td>No charge</td>
<td>Covered at 100% for first $150, then 20% of</td>
</tr>
<tr>
<td>Inpatient and Outpatient Facility -</td>
<td></td>
<td>charges*</td>
</tr>
<tr>
<td>Billed by Physician's office</td>
<td></td>
<td>Covered at 100% for first $150, then 20% of</td>
</tr>
<tr>
<td>Billed by other than Physician's office</td>
<td></td>
<td>charges*</td>
</tr>
<tr>
<td>Special Services</td>
<td>10% of charges*</td>
<td>20% of charges*</td>
</tr>
<tr>
<td>Home Health Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(includes home visits for Diabetes Self Management</td>
<td>40 visits max./calendar year**</td>
<td>40 visits max./calendar year**</td>
</tr>
<tr>
<td>courses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Care – Outpatient Only</td>
<td>10% of charges*</td>
<td>20% of charges*</td>
</tr>
<tr>
<td>210 days max./calendar year; includes 5 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>for family bereavement counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>10% of charges*</td>
<td>20% of charges*</td>
</tr>
<tr>
<td>External Prosthetic Appliances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>10% of charges*</td>
<td>20% of charges*</td>
</tr>
<tr>
<td>Outpatient Facility / Office Visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 days max./calendar year**#</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Facility / Office Visit</td>
<td>10% of charges*</td>
<td>20% of charges*</td>
</tr>
<tr>
<td>60 visits max./calendar year**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Subject to calendar year deductible and reasonable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and customary charge limitations for out-of-network</td>
<td></td>
<td></td>
</tr>
<tr>
<td>services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>** Treatment maximums cross-accumulate.</td>
<td></td>
<td></td>
</tr>
<tr>
<td># Includes up to 3 psychiatric emergency visits</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Regarding In-Network and Out-of-Network services:
- Once the Stop Loss Limit 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.

Regarding Out-of-Network services:
- All services must be provided by one of the preferred providers on our list.
- Except for well child care, only treatments of illness or injury are covered.
- Your out-of-pocket costs will be higher than with a preferred provider.
CASE MANAGEMENT
Coordinated by Intracorp. 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 balance between quality and cost effective care while maximizing the patient's quality of life.

EXCLUSIONS
Your plan provides coverage for medically necessary services. Your plan does not provide coverage for the following except as required by law:

1. Services that are not medically necessary, except specifically outlined preventive care;
2. Charges which the person is not legally required to pay;
3. Charges made by a hospital owned by or performing services for the U.S. government if the charges are directly related to a sickness or injury connected to military service;
4. Custodial services not intended primarily to treat a specific injury or sickness, or any education or training;
5. Experimental or investigational procedures and treatments;
6. Cosmetic surgery;
7. Reports, evaluations, examinations, or hospitalizations not required for health reasons, such as employment or insurance examinations;
8. Treatment of the teeth or periodontium, except charges for dental work due to an injury to sound natural teeth sustained while insured for these benefits;
9. Reversal of voluntary sterilization procedures, and certain infertility services;
10. Transsexual surgery and related services;
11. Therapy to improve general physical condition;
12. Personal or comfort items such as personal care kits, television, and telephone rental in hospitals;
13. Eyeglasses, hearing aids or examinations and prescription fitting, except as provided in the Certificate;
14. Certain internal or external prostheses;
15. Surgical treatment for correction of refractive errors, including radial keratotomy;
16. Prescription and non-prescription drugs, except as provided in the benefits section of the Certificate;
17. Routine foot care;
18. Amniocentesis, ultrasound, or any other procedures requested solely for sex determination of a fetus, unless medically necessary to determine the existence of a sex-linked genetic disorder;
19. Any injury resulting from, or in the course of, any employment for wage or profit;
20. Any sickness which is covered under any workers' compensation or similar law.
21. Charges for over the counter disposable or consumable supplies, including orthotic devices.
22. Charges in excess of reasonable and customary limitations.

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 Plan Description or insurance certificate.

This Plan is insured and/or administered by Connecticut General Life Insurance Company, a CIGNA Company.

If you have any questions about a specific service or treatment, contact Customer Service.
Important Notices
Special Enrollment Requirements from CIGNA HealthCare

This flyer contains important information you should read before you enroll. If you have any questions about this information, please contact your benefits manager.

IF YOU ARE DECLINING COVERAGE NOW
If you have decided to decline coverage for yourself or your dependents (including your spouse), you may be able to enroll yourself and/or your dependents in this plan later, under some circumstances, without waiting for an open enrollment period.

SPECIAL ENROLLMENT ALLOWED
You can enroll yourself and your dependents in this plan without waiting for an open enrollment period if:

1. You decline coverage under this plan because you have other health care coverage, then you lose the other coverage because you are no longer eligible, or because the employer failed to pay the required premium.
   In such cases, you must enroll in this plan within 30 days after losing the other coverage.

2. You decline coverage under this plan because you have COBRA coverage, then you complete your COBRA coverage period.
   In such cases, you must complete your entire COBRA coverage period and you must enroll in this plan within 30 days after completing your COBRA coverage period.

3. You decline coverage under this plan, and then a new dependent is added to your family due to marriage, birth, adoption, or placement for adoption.
   In such cases, you must enroll in this plan within 30 days after the marriage, birth, adoption, or placement for adoption.

OTHER LATE ENTRANTS
If you decide not to enroll in this plan now, then want to enroll later, you must qualify for special enrollment. If you do not qualify for special enrollment, you may have to wait until an open enrollment period, or you may not be able to enroll, depending on the terms and conditions of your benefit plan. Please contact your benefit plan administrator for more information.

Protecting Your Confidentiality

PROTECTION OF YOUR CONFIDENTIAL INFORMATION
At CIGNA HealthCare, we are committed to maintaining the confidentiality of our members' health information. We have established policies and safeguards to protect oral, written and electronic information across our organization.

INFORMATION ABOUT CIGNA HEALTHCARE PRIVACY PRACTICES
Our Notice of Privacy Practices is distributed at enrollment to all members covered under a medical insurance policy. Customers covered under self insured medical plans will receive notices from their employers and can obtain a copy of CIGNA HealthCare's notice by calling Member Services.

RELEASE OF CONFIDENTIAL INFORMATION
We will not use or disclose your confidential information for any purpose other than the purposes permitted by the HIPAA Privacy Rule without your written authorization. For example, we will not supply confidential information to another company for its marketing purposes or to a potential employer with whom you are seeking employment unless you authorize it.

ACCESS TO YOUR MEDICAL RECORDS
You may ask to inspect or to obtain a copy of your confidential information that is included in certain records we maintain. We may charge you copying and mailing costs. Under limited circumstances, we may deny you access to a portion of your records. Instructions on how to obtain a copy of your records will be included in the privacy notice you receive from CIGNA HealthCare or your employer after you enroll.

INFORMATION TO EMPLOYERS
We may disclose your confidential information to your employer or to a company acting on your employer's behalf so that it can monitor, audit and otherwise administer the health benefit plan in which you participate. Your employer is not permitted to use the confidential information we disclose for any purpose other than administering your health benefit plan.
BENEFIT LIMITATIONS FOR
PRE-EXISTING CONDITIONS

It is important for you to know that this plan limits coverage for certain pre-existing conditions. Federal law allows plans to limit benefits for pre-existing conditions for up to 12 months, or for up to 18 months for late enrollees who do not qualify for Special Enrollment. You should consult your benefit plan administrator or your benefit plan documents to learn how the pre-existing condition limitation is applied under this plan.

The pre-existing condition limitation cannot apply to pregnancy. A newborn child who is enrolled in a plan within 30 days after the date of birth cannot be subject to pre-existing condition limitations. In addition, a child who is adopted or placed for adoption before reaching age 18, and who is enrolled in a plan within 30 days after adoption or placement, cannot be subject to pre-existing condition limitations. (A newborn or adopted child would be subject to pre-existing condition limitations if the child later changes health care plans and has a break in coverage of 63 days or more between plans.)

PRE-EXISTING CONDITIONS

If you or your covered dependent(s) have received medical advice, diagnosis, care or treatment for an injury or sickness before beginning coverage (or a waiting period for coverage) under this plan, that injury or sickness may be considered a pre-existing condition.

Under federal law, medical advice, diagnosis, care or treatment received in the 6 months before coverage (or a waiting period for coverage) begins may be considered a pre-existing condition. You should consult your benefit plan administrator or your benefit plan documents to learn how pre-existing conditions are defined under this plan.

Genetic information which does not result in a specific diagnosis cannot be considered a pre-existing condition.

CREDIT FOR PRIOR COVERAGE

This plan will give you credit for the number of days you were covered under prior plans. This credit for prior coverage may be used to reduce or eliminate the amount of time you must wait before pre-existing conditions are covered by this plan.

The following types of plans are considered creditable:
- a self-insured group health plan;
- an individual or group health insurance plan or HMO plan;
- Part A or Part B of Medicare;
- Medicaid, except coverage solely for pediatric vaccines;
- a health plan for current and former members of the armed forces and their dependents;
- a plan provided through the Indian Health Service;
- a State health benefits risk pool;
- the Federal Employees Health Benefits Program;
- a plan provided under the Peace Corps Act;
- a state, county or municipal public health plan;
- coverage provided under state or federal health continuation mandates (such as COBRA); and
- an individual or group health conversion plan.

If you have not been covered under any health care plan for 63 days or more, your coverage under prior plans will not be creditable. Eligibility waiting periods will not count toward the 63 days.

For example, you change jobs, and your coverage with employer "A" ends on January 1:

- If you are hired by a new employer "B" on March 1 and begin your waiting period for new coverage on that day, your previous coverage will be creditable, because fewer than 63 days have gone by between plans.
- If you are hired by employer "B" on April 1, your previous coverage will not be creditable, because the lapse period between plans is 63 days or longer.
- If you are hired by employer "B" on May 1, but continued COBRA coverage from your previous plan until May 1, your previous coverage (including the COBRA coverage) will be creditable because the coverage was continuous with no 63-day or longer break in coverage.

The credit you receive may eliminate the entire pre-existing condition limitation period under this plan, or reduce a portion of the limitation period.

For example:

- If you had 12 months of creditable coverage under a previous plan, and then become covered for this plan, the pre-existing condition limitation under this plan will not apply to you, because you 12 months of prior creditable coverage satisfies the entire limitation period under this plan.
- If you had 5 months of creditable coverage under a previous plan and then you switch to this plan, 5 months would be subtracted from your 12-month limitation period under this plan, and your remaining limitation period would be 7 months.

CERTIFICATION OF PRIOR CREDIBLE COVERAGE

To receive credit, you must provide proof of your prior coverage. You have the right to request a Certificate of Health Coverage from your previous employer or carrier. If necessary, your CIGNA Customer Service Representative may be able to help you obtain this documentation.

If you already have a Certificate of Health coverage for your prior plan, please attach a copy (do not send the original) to your enrollment form. If you do not have a Certificate at this time, you should still complete and submit your enrollment materials.

If, for any reason, you need to submit your Certificate after you enroll, please send it to the following address:

Eligibility Services
CIGNA HealthCare
P.O. Box 9077
Melville, NY 11747-9077
OR via fax to
(631) 845-3464

Once your prior coverage records are reviewed and cross is calculated, you will receive a notice of your available credit and your remaining pre-existing condition limitation period.

Please Note: Pre-existing condition limitations may vary because of state law. Please consult your benefit plan administrator or benefit plan documents for more details.

"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, CIGNA Vision Care, Inc., Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intercorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.

In Arizona, HMO plans are offered by CIGNA HealthCare of Arizona, Inc. In California, HMO plans are offered by CIGNA HealthCare of California, Inc. In Virginia, HMO plans are offered by CIGNA HealthCare of Virginia, Inc. and CIGNA HealthCare Mid-Atlantic, Inc. In North Carolina, HMO plans are offered by CIGNA HealthCare of North Carolina, Inc. All other medical plans in these states are insured or administered by Connecticut General Life Insurance Company.

558997f 7/03 PCL ©2003 CIGNA Health Corporation
New enrollees often ask questions like these about their new health plans. We’re happy to answer all questions—in detail.

What is the difference between in-network and out-of-network?
Your in-network coverage gives you the highest level of coverage at the lowest cost. You have the option of visiting one of the local participating physicians in our network of “preferred providers.” You can select any of the doctors in this network, at any time. By doing so, you have cost saving advantages. With out-of-network benefits, you can see any doctor you wish, and you’ll still be covered for treatment of illness or injury. Keep in mind, however, that your out-of-pocket expenses will be higher than with in-network benefits.

Do I have to choose between in-network and out-of-network now?
No. Each time you seek medical care, you choose the doctor you’d like to see, whether he or she is a preferred provider or an out-of-network physician.

What if I go to an out-of-network doctor, and he or she sends me to a participating hospital? Will I pay in-network or out-of-network charges for the hospitalization?
You may be admitted to a participating hospital by either an in-network or out-of-network doctor. In either case, CIGNA will cover the medical services provided by the participating hospital at the in-network level.

Do I need a referral to see a specialist?
Though you may want your doctor’s advice and assistance in arranging treatment with a specialist in the network, you do not need a referral to see a participating specialist. If you choose to see an out-of-network specialist, the health care services you receive will be covered at the out-of-network benefit level.

What is CIGNA’s toll-free care line?
The toll-free care line is staffed by registered nurses who can help you find a participating physician, specialist or medical facility, or pre-certify a hospital stay. You’ll find the 800 number on the back of your ID card.

When scheduling an appointment please be certain to confirm that the provider is still participating in the SelectSourceSM PPO program.

What is utilization review? What is Intracorp?
Utilization review is a part of CIGNA’s managed care program. It is a process used to review the delivery of health care services to make sure they are medically necessary and appropriate to your care. Intracorp is a CIGNA subsidiary that performs utilization review, including hospital pre-admission certification, continued stay review and case management.
What is pre-admission certification and continued stay review?

Pre-admission certification/continued stay review is a program designed to help you and your dependents avoid unnecessary or excessively long hospital stays. You must have any request for a non-emergency hospital stay other than a maternity stay approved before you are admitted, or your costs could be substantially higher. As a part of the precertification process, CIGNA will determine an appropriate length of your hospital stay. If you choose to stay beyond this approved length of stay, you must obtain an approval.

Precertification is not required for a maternity stay of 48 hours for vaginal deliveries or 96 hours for cesarean sections. Depending on your benefit plan, you may be eligible for additional benefits. Any hospital stay beyond the initial 48 or 96 hours must be approved. Please contact your benefit plan administrator or Customer Service for details.

What if my doctor keeps me hospitalized longer than my pre-admission certification allows?

Intracorp will contact your hospital the day before you are to be discharged to see if you are still scheduled to be discharged. If you are not, due to complications or some other medical necessity, then the additional days will be certified. Intracorp will continue calling and following up on your case until you are discharged.

If you remain in the hospital beyond the number of days that are certified, and no medical reason is given for your continued stay, your costs may be higher.

Who is responsible for obtaining pre-admission certification?

You must obtain a pre-admission certification/continued stay review by calling the toll-free number shown on the back of your ID card. If you don’t get your stay pre-approved, your reimbursement will be decreased as a penalty and you will pay more.

How do I file a claim? How long does it take to be reimbursed?

To be reimbursed for eligible medical expenses, you will have to submit a claim form every time you use out-of-network services. You should send your completed claim form to the address indicated on the form. Once you file your completed claim form, claims are generally paid within 10 to 15 working days. However, if questions about your claim arise, payment may be delayed.

What is the CIGNA HealthCare Healthy Babies Program?

Your plan offers some very important and helpful benefits for mothers-to-be called the CIGNA HealthCare Healthy Babies Program. This program is designed for expectant mothers to promote good health and a healthy baby at delivery time. All you have to do to participate is call CIGNA’s toll-free care line before the end of the third month of your pregnancy (or as soon as your doctor confirms you’re pregnant). In exchange for your participation you will receive a free, comprehensive prenatal book.

Am I covered for emergency and urgent care away from home?

All emergency care for life-threatening or severe medical conditions is reimbursed at the in-network level. However, going to a participating hospital emergency room will keep your out-of-pocket costs as low as possible.

You also are covered for treatment of any life-threatening emergencies and any serious illness or injury when you are away from home and not within the preferred provider network area.

If you have to be admitted to the hospital for further care after your emergency room treatment, your hospital stay must be certified. Within 24 hours of being admitted, you or someone in your family must call the toll-free number shown on your ID card. If you neglect to call and get certified, your reimbursement will be decreased.

In urgent medical situations, we have away-from-home care. CIGNA has provider networks all over the country. So if you’re traveling or you have a child away at school, you’ll be able to take advantage of the plan in any of our networks nationwide. All you have to do is call CIGNA’s toll-free care line and they’ll give you the names of participating doctors in the immediate area. And just like at home, it’s all covered at the in-network level with no claim forms and only a small cost.
What if my doctor isn't on your list?
To receive your maximum benefit, you should select a physician from CIGNA's list of preferred providers. Our participating physicians meet CIGNA’s credentialing standards to become a part of our network, and are selected based on a review of their professional qualifications, including educational background, medical training and experience. You can continue seeing your current physician, even if he or she is not a preferred provider. However, your health care services will only be covered at the out-of-network benefit.

Can my current doctor be added to your network?
If your current doctor meets our credentialing standards, and is interested in becoming a CIGNA Preferred Provider, he or she can call our Provider Relations Department to get more information on joining the CIGNA SelectSourceSM Preferred Provider network.

What if I'm in the middle of treatment, and my doctor isn't in your network?
To take full advantage of your in-network coverage, you should select a participating physician who will review your medical history and work with you to complete your treatment. Or, you may complete your treatment with the doctor you are currently seeing, but your services will be covered only at the out-of-network benefit.

What if my doctor is on the list, but his/her office is shown as “accepting current patients only”? Can I still choose my doctor?
If you are an existing patient of a participating physician, you may elect him or her to provide your care.

What is the incentive for doctors to join the CIGNA network? How are they compensated?
Some doctors join the CIGNA network to build a patient base or to increase their patient base in a given location.
CIGNA has negotiation with participating providers to charge you less than their normal fees for their services.

Whom do I call with questions? Whom do I call if I feel I'm not getting the appropriate care?
If you have any questions about your benefits, the quality of service, or believe you are not getting the appropriate care, you should call CIGNA HealthCare at the toll-free number listed on the back of your ID card. The Customer Services representative will try to resolve any problems right away. If, after this, you’re still not satisfied, you can request more action through a formal grievance procedure.
Your CIGNA HealthCare prescription benefits plan has a two-tier structure to help you control your medical expenses. Please check your Summary of Benefits or the front of your CIGNA HealthCare ID card for your exact prescription copayment or coinsurance amounts.*

The CIGNA HealthCare Prescription Drug List divides medications into two categories or tiers:

- **Generic**
- **Brand**

Your copayment or coinsurance amount depends on the category in which your prescription medication is listed.

* Please check your insurance certificate and/or applicable pharmacy rider to determine your specific prescription drug coverage and exclusions.

**The Two Tiers:**

**Generic (First Tier)**

Generic drugs are covered at the generic copayment or coinsurance under this benefit. A generic drug is labeled with the medication’s basic chemical name and usually has a brand-name equivalent. The U.S. Food and Drug Administration (FDA) requires that generic drugs have the same active chemical composition, same potency and be offered in the same form as their brand-name equivalents. Generic drugs must meet the same FDA standards as brand-name drugs and are tested and certified by the FDA to be as effective as their brand-name counterparts.

**Brand (Second Tier)**

These are the brand-name drugs that may or may not have an equally effective generic equivalent. You’re covered for these medications at the brand copayment or coinsurance.

Additionally, your prescription drug coverage may require that you pay the brand copayment or coinsurance plus the difference in cost between the brand-name drug and the generic drug (up to the cost of the brand-name drug) if you or your doctor chooses a brand-name drug when a generic drug is available. Because drug coverage varies by employer plan, please refer to your plan’s benefit booklet for more specific information or call CIGNA HealthCare at the number on your CIGNA HealthCare ID card.

**Frequently Asked Questions:**

**Q:** What is the CIGNA HealthCare Prescription Drug List?

**A:** Our Prescription Drug List – known as a “formulary” by medical professionals – is an extensive list of brand-name and generic prescription drugs. The majority of the prescriptions you get from your doctor will be for drugs already on the list. Your benefit plan covers the cost of Prescription Drug List medications, less any applicable copayments, coinsurance and/or deductibles.

Our Prescription Drug List is developed and updated on a regular basis in accordance with clinical recommendations of the CIGNA HealthCare Pharmacy and Therapeutics Committee, a panel of participating physicians and pharmacists. Only those medications that have successfully passed federally required clinical testing and evaluation and have been proven effective are included in the list.
Q: What is my out-of-pocket cost? How do I know what to pay for my prescription drugs?

A: Your out-of-pocket cost depends on:

- Whether your pharmacy plan covers the drug. Please check your insurance certificate and/or applicable pharmacy rider to determine your specific prescription drug coverage and exclusions.

- Whether the medication or dose requiring prior authorization for coverage under your pharmacy plan has been approved. Refer to the Prior Authorization section for more information.

- The category in which your prescription medication is listed.

Please check your Summary of Benefits or the front of your CIGNA HealthCare ID card for your exact prescription copayment, coinsurance and/or deductible amounts. Copayment, coinsurance and/or deductible amounts are set by the pharmacy plan offered by your employer.

Additionally, some prescription drug plans provide a financial incentive to use generic drugs. Some plans require that you pay the brand copayment or coinsurance plus the difference in cost between the brand-name drug and the generic drug (up to the cost of the brand-name drug) if you or your doctor chooses a brand-name drug when a generic drug is available. Because drug coverage varies by employer plan, please refer to your plan’s benefit booklet for more specific information or call CIGNA HealthCare at the number on your CIGNA HealthCare ID card.

Q: What is a pharmacy deductible?

A: A deductible is a fixed dollar amount that you pay out-of-pocket each year for covered prescription drugs before pharmacy benefits are payable by the pharmacy plan.

Please check your Summary of Benefits or the front of your ID card to determine if there is a deductible for your pharmacy benefit plan and the amount of the deductible. The deductible amount is set by the pharmacy plan offered by your employer.

If your pharmacy benefit plan has a pharmacy deductible, you will need to satisfy the deductible before your pharmacy plan copayments or coinsurance apply.

You will need to pay any applicable copayment, coinsurance and/or deductible amounts at the time of service (when your prescription is filled) at a participating pharmacy.

Q: Why do I have different copayments or coinsurance for different drugs?

A: The cost of drugs varies widely, even though several different medications may be used to treat the same condition.

Generic drugs are generally lower in cost than brand-name drugs. You’re covered for these medications at the generic copayment or coinsurance under this benefit.

Brand-name drugs generally cost more than generic drugs, and therefore a higher copayment or coinsurance level will apply.
Q: What if my doctor prescribes a medication that isn’t on the prescription drug list?

A: If your doctor believes that you must have a medication that is not on the prescription drug list, you must pay the full amount of the cost of the drug unless you are granted an exception by CIGNA HealthCare. Your doctor can request an exception. Your doctor has been provided information about how to request an exception by calling CIGNA HealthCare. CIGNA HealthCare will evaluate each request and work with your doctor and pharmacy to provide coverage for the medication if the exception is approved. If you’d like to learn more about the exception process, you can call CIGNA HealthCare at the toll-free number on your CIGNA HealthCare ID card.

Q: What drugs are covered?

A: Because drug coverage varies by employer plan, please refer to your plan’s Summary of Benefits for complete information.

In the two-tier plan, prescription drugs — including prenatal vitamins, insulin and related diabetes care supplies — are covered unless specifically excluded.

Q: How do I receive a copy of the CIGNA HealthCare Prescription Drug List?

A: For a complete version of the CIGNA HealthCare Prescription Drug List, visit our Web site at www.cigna.com or call the toll-free number on your CIGNA HealthCare ID card.

Q: How do I fill a prescription?

A: Take your prescription to any CIGNA HealthCare participating pharmacy. Our participating pharmacies include major chain pharmacies as well as local drug stores. Check your CIGNA HealthCare directory or our Web site at www.cigna.com for participating pharmacies in your area.

When you go to a participating pharmacy, present your CIGNA HealthCare ID card, prescription and the out-of-pocket amount required under the pharmacy plan.

And if you have questions about your prescription drug benefits, just call CIGNA HealthCare. The toll-free number is on your CIGNA HealthCare ID card.

Q: What happens if I’m away from home and need prescription medication?

A: Whether you’re traveling for business or on vacation, call Member Services to locate nearby CIGNA HealthCare participating pharmacies. When you use a participating pharmacy, you generally receive a higher level of benefit coverage and pay the appropriate copayment, coinsurance and/or deductible amounts for your medication.

Q: What happens if I use a non-participating pharmacy?

A: If you decide to use a non-participating pharmacy, you pay the full cost of the prescription.

For a medical emergency situation, have your prescription filled at the nearest pharmacy. If it’s not a participating pharmacy, keep your receipt and contact CIGNA HealthCare for instructions for reimbursement of your emergency prescription.
Please check your Summary of Benefits to see if your pharmacy plan has an out-of-network pharmacy benefit. If this option is available to you, you will still have to pay for the full cost of the prescription. You will need to mail a completed Prescription Drug Claim Form with the original receipts (not cash register receipts) to CIGNA HealthCare for reimbursement.

For a Prescription Drug Claim Form, visit our Web site at www.cigna.com (select “Important Forms”) – or call the toll-free number on your CIGNA HealthCare ID card.

**Q:** How do I get my prescriptions filled by mail?

**A:** CIGNA HealthCare offers home delivery of prescription medications through CIGNA Tel-Drug. Please check the details of your employer’s health benefit plan to see if this option is available to you. CIGNA Tel-Drug offers a convenient way to receive up to a 90-day supply of any prescription medication covered by your benefit plan.

Have your doctor write a prescription for a 90-day supply; fill out the CIGNA Tel-Drug patient profile/order form enclosed in your pre-enrollment kit (or available online at www.cigna.com; select “Important Forms”); include your doctor’s original prescription, your mail order copayment, coinsurance and/or deductible; and mail everything to CIGNA Tel-Drug in the postage-paid envelope provided.

To protect your privacy, CIGNA Tel-Drug mails your filled prescription to you by first-class mail in a package that doesn’t reveal its contents or the CIGNA Tel-Drug name.

You can learn more by calling 1.800.835.3784, or visit us on the Web at www.cigna.com or www.teldrug.com.

**Q:** I’m going to be away from home for an extended period of time. What do I do about the medications I take on a continuing basis?

**A:** If your prescription drug supply will run out while you’re away, contact CIGNA HealthCare at the number listed on your CIGNA HealthCare ID card. A customer service representative may override the day-supply limit, allowing you to fill a prescription for an extended period of time.

**Prior Authorization**

**Q:** What is prior authorization?

**A:** For certain medications or doses, your doctor may need to contact CIGNA HealthCare to request prior authorization for coverage of your prescription under the pharmacy plan.

To determine if prior authorization is required for your prescription, ask your doctor to check the CIGNA HealthCare Prescription Drug List or our Web site at www.cigna.com for the complete prescription drug list.

**Q:** Why do certain drugs require prior authorization?

**A:** The CIGNA HealthCare Pharmacy and Therapeutics Committee determines which drugs will require prior authorization for coverage. Prior authorization guidelines are determined on a drug-by-drug basis and may be based on FDA and manufacturer guidelines, medical literature, safety, appropriate use and benefit design.
Please refer to your Summary of Benefits and/or the CIGNA HealthCare Prescription Drug List for information about which drugs require prior authorization under your pharmacy plan.

Q: **What if my doctor prescribes a medication that requires prior authorization?**

A: If your doctor prescribes a drug that requires prior authorization for coverage, ask your doctor to call the number listed on your CIGNA HealthCare ID card to begin the authorization process. Your doctor’s office must complete the appropriate prior authorization form and fax or call CIGNA HealthCare at the number on your CIGNA HealthCare ID card and provide the necessary information.

If the request is approved, the doctor will receive a fax confirmation. The authorization will be processed in our claim system to allow you to have coverage for this drug. The length of the authorization will depend on the diagnosis and drug. When your doctor advises you that the drug has been approved, you should contact the participating pharmacy to fill the prescription(s). If the request is denied, you and your doctor will be notified that coverage for the drug is not authorized.

If you have questions about a specific prior authorization request, call Member Services at the toll-free number on your CIGNA HealthCare ID card.

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**Exclusions and Limitations**

By way of example, but not of limitation, the following are specifically excluded services and benefits:

- Any drugs or medications available over-the-counter that do not require a prescription by Federal or State Law, and any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin.

- Any drugs that are experimental or investigational, within the meaning set forth in the Plan Documents.

- Food and Drug Administration (FDA) approved prescription drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal.

- All newly FDA-approved drugs, prior to review by the Pharmacy and Therapeutics Committee.

- Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions, and medications used for travel prophylaxis.

- Replacement of Prescription Drugs and Related Supplies due to loss or theft.

- Drugs used to enhance athletic performance.
Drugs which are to be taken by or administered to a Member while the Member is a patient in a licensed hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals.

Prescriptions more than one year from the original date of issue.

If you have questions
We're here to help. Just call Member Services at the toll-free number on your CIGNA HealthCare ID card if you have a question about your CIGNA HealthCare prescription drug benefits. Or visit our Web site, www.cigna.com.

“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.

In Arizona, HMO plans are offered by CIGNA HealthCare of Arizona, Inc. In California, HMO plans are offered by CIGNA HealthCare of California, Inc. In Virginia, HMO plans are offered by CIGNA HealthCare of Virginia, Inc. and CIGNA HealthCare Mid-Atlantic, Inc. In North Carolina, HMO plans are offered by CIGNA HealthCare of North Carolina, Inc. All other medical plans in these states are insured or administered by Connecticut General Life Insurance Company.
With the CIGNA HealthCare Online Provider Directory, you can:
- Locate independent participating providers, specialists, dentists, pharmacies, hospitals and facilities closest to home, work or other locations you specify.
- Create, download and print your own personal directory to have on hand anytime you need it.

Searching is quick and easy. Here’s how it works:


2. Enter your search criteria. You can search by name for a specific provider, or search by location and distance to see matching providers in your area.

3. Indicate your plan, and the type of physician. This helps ensure that you see just what you’re looking for.

4. Review your providers. Get a complete profile including education, languages spoken, hospital affiliations, and a detailed map with directions.*

* Driving directions not available in Puerto Rico.
Your Online Provider Directory:

- Convenient, instant, anytime access.
- Our most up-to-date list of providers.
- Search by distance, zip code, language spoken, name, hospital affiliation and specialty.

And there’s much more – at www.cigna.com:

- myCIGNA.com – Once you enroll, you have access to your own personalized Web site, where you can see specific information about your health plan including covered services and the status of your most recent claims.
- See what we offer where you are – learn about wellness programs in your area.
- See what’s new – www.cigna.com is the first place you’ll see updates about your benefits and our services!
- Change your primary care physician (PCP) easily online (if choosing a PCP is part of your plan).
- Search for prescription medications covered by our pharmacy programs.
- CIGNA Tel-Drug Online Prescription Center – fill your prescription medications, check the status of your order, or look at your prescription order history with a few clicks – anytime!

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