

SUMMARY OF BENEFITS

Your CIGNA HealthCare Indemnity plan



CIGNA HealthCare

Features that Add Value

- The CIGNA HealthCare 24-Hour Health Information LineSM connects you to **trained 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 programs and services designed to enhance your health and wellness. Just call 1.800.870.3470 or visit our web site at www.cigna.com.
- Prescription drug coverage is a **part of your plan**. With national and independent pharmacies participating across the country, you can have your prescription filled **wherever you go**. CIGNA Tel-Drug gives you quick, **convenient** delivery of your medications right to your home.

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 helpful easy-to-use tools with personalized benefits information to help you make the most of your plan.
- **We Speak Many Languages**SM. We offer Language Line Services so that you can **talk with us** in 150 different languages. Just call Customer Service and ask for an interpreter to assist you.

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 19 and any additional preventive care benefits described in the Benefits Highlights.
- **CIGNA Well Informed** provides members with customized medical and wellness information to help them make healthier choices, better understand a diagnosis or treatment, and manage their health. The program includes personalized letters and other educational information to help you improve your health. Only you, your doctor and CIGNA have access to this information.
- 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**.

Freedom of Choice

- You can choose any licensed doctor, specialist or hospital. However, you are required to pay a deductible each year and then a percentage of each bill after the deductible is paid.
- The provider may bill you for the difference between the billed charge and the allowed amount under your benefit plan, in addition to applicable deductibles and coinsurance amounts.
- Once the out-of-pocket as shown in the benefit summary is reached, the plan pays 100% of eligible charges for the remainder of the year.

*For Employees of
Equity League Health Trust Fund
Supplemental Plan*

BENEFIT HIGHLIGHTS

<p>Physician Services <i>Primary Care Physician (PCP) Office Visit</i></p> <p><i>Specialty Physician Office Visit</i> <i>Consultant and Referral Physician Services</i> Note: <i>OB/GYN physician is considered a Specialist Physician</i></p> <p><i>Allergy Treatment/Injections - PCP or Specialty Physician</i></p> <p><i>Allergy Serum (dispensed by physician in office)</i></p> <p><i>Second Opinion Consultations (provided on voluntary basis)</i></p> <p><i>Surgery Performed in the Physician's Office PCP or Specialty Physician</i></p>	<p>30% of charges*; 30% of charges* if only x-ray and/or lab services performed and billed</p> <p>30% of charges*; 30% of charges* if only x-ray and/or lab services performed and billed</p> <p>30% of charges*</p> <p>30% of charges*</p> <p>30% of charges*</p> <p>30% of charges*</p>
<p>Preventive Care <i>Routine Preventive Care for Children to age 19 (including routine immunizations)</i></p> <p><i>Immunizations</i></p> <p><i>Routine Preventive Care for Children and Adults from age 19 (including routine immunizations)</i> Unlimited maximum per calendar year</p> <p><i>Immunizations</i></p>	<p>30% of charges*; 30% of charges* if only x-ray and/or lab services performed and billed</p> <p>No charge, no plan deductible</p> <p>30% of charges*; 30% of charges* if only x-ray and/or lab services performed and billed</p> <p>No charge, no plan deductible</p>
<p>Mammograms, PSA, Pap Test Note: <i>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.</i></p>	<p>30% of charges* if billed by an independent diagnostic facility or outpatient hospital</p> <p>30% of charges* for the associated wellness exam</p>
<p>Inpatient Hospital Services includes: <i>Semi-Private Room and Board</i> <i>Diagnostic/Therapeutic Lab and X-ray</i> <i>Drugs and Medication</i> <i>Operating and Recovery Room</i> <i>Radiation Therapy and Chemotherapy</i> <i>Anesthesia and Inhalation Therapy</i> <i>MRIs, MRAs, CAT Scans, PET Scans, etc.</i></p>	<p>30% of charges*</p> <p>Precertification required</p>
<p>Inpatient Hospital Doctor's Visits/Consultations <i>Inpatient Hospital Professional Services</i></p>	<p>30% of charges*</p> <p>30% of charges*</p>
<p>Outpatient Facility Services <i>Operating Room, Recovery Room, Procedure Room and Treatment Room including:</i> <i>Diagnostic/Therapeutic Lab and X-rays</i> <i>Anesthesia and Inhalation Therapy</i> <i>Physician & Outpatient Professional Services</i></p>	<p>30% of charges*</p> <p>30% of charges*</p>
<p>Laboratory and Radiology Services (includes preadmission testing) <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></p> <p><i>Independent X-Ray and/or Lab Facility (in conjunction with an Emergency Room visit)</i></p>	<p>30% of charges*</p> <p>30% of charges*</p> <p>30% of charges*</p> <p>30% of charges*</p> <p>30% of charges*</p>

BENEFIT HIGHLIGHTS

<p>Advanced Radiological Imaging (MRIs, MRAs, CAT Scans, PET Scans, etc.)</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>30% of charges*</p> <p>30% of charges*</p> <p>30% of charges*</p>
<p>Short-Term Rehabilitative Therapy and Cardiac Rehabilitations-- (includes physical, speech, occupational, pulmonary rehab & cognitive therapy) 60 days maximum per calendar year for all therapies combined</p> <p><u>Note:</u> therapy sessions provided as part of Home Health Care accumulate to the Short-Term Rehab Therapy maximum.</p>	<p>30% of charges*; 30% of charges* if only x-ray and/or lab services performed and billed.</p>
<p>Chiropractic Services – Unlimited maximum per calendar year</p> <p><i>Note: Care may be subject to medical necessity</i></p>	<p>30% of charges*; 30% of charges* if only x-ray and/or lab services performed and billed.</p>
<p>Emergency and Urgent Care Services <i>Physician's Office-PCP or Specialty 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 or Outpatient Facility</i></p> <p><i>Ambulance</i></p>	<p>30% of charges*; 30% of charges* if only x-ray and/or lab services performed and billed.</p> <p>30% of charges*</p> <p>30% of charges*</p> <p>30% of charges*</p> <p>30% of charges*</p>
<p>Maternity Care Services <i>Initial Office Visit to Confirm Pregnancy</i> <u>Note:</u> OB/GYN physician is considered a Specialist Physician</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 Specialty Physician</i></p> <p><i>Delivery - Facility (Inpatient Hospital/Birthing Center Charges)</i></p>	<p>30% of charges*; 30% of charges* if only x-ray and/or lab services performed and billed.</p> <p>30% of charges*</p> <p>30% of charges*</p> <p>30% of charges*, Precertification required</p>
<p>Inpatient Services at Other Health Care Facilities <i>Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities</i> 60 days maximum per calendar year combined for all facilities listed</p>	<p>30% of charges*, Precertification required</p>
<p>Home Health Services - Includes outpatient private duty nursing when approved as medically necessary 200 days maximum per calendar year; 16 hour maximum per day</p>	<p>\$50 annual deductible per person, plus 25% of charges</p>
<p>Family Planning Services <i>Office Visits (tests, counseling)</i> (Subject to the preventive care dollar maximum)</p> <p>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></p>	<p>30% of charges*; 30% of charges* if only x-ray and/or lab services performed and billed.</p> <p>30% of charges*, Precertification required</p> <p>30% of charges*</p> <p>30% of charges*</p> <p>30% of charges*; 30% of charges* if only x-ray and/or lab services performed and billed.</p>

BENEFIT HIGHLIGHTS

<p>Infertility Services Office Visit (lab & radiology tests, counseling)-PCP or Specialist Physician</p> <p>Treatment/Surgery (includes artificial insemination) (excludes in-vitro fertilization, GIFT, ZIFT, etc.) Inpatient Facility Outpatient Facility Physician's Services - Inpatient or Outpatient</p>	<p>30% of charges*; 30% of charges* if only x-ray and/or lab services performed and billed.</p> <p>30% of charges*, Precertification required 30% of charges* 30% of charges*; 30% of charges* if only x-ray and/or lab services performed and billed.</p>
<p>TMJ - Surgical and Non-Surgical-case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity. Physician's Office</p> <p>Inpatient Facility Outpatient Facility Physician's Services</p>	<p>30% of charges*; 30% of charges* if only x-ray and/or lab services performed and billed. 30% of charges*, Precertification required 30% of charges* 30% of charges*</p>
<p>Mental Health Inpatient - 30 days maximum per calendar year# Acute: Based on a ratio of 1:1 Partial: Based on a ratio of 2:1 Residential: Based on a ratio of 2:1</p> <p>Outpatient Individual – 45 visits maximum per calendar year#; also covered 3 psychiatric emergency visits (these visits apply towards the 45 visits annual maximum).</p> <p>Group Therapy Mental Health – combined maximum with Outpatient Individual Mental Health services based on a ration of 2:1</p> <p>Intensive Outpatient Mental Health– 3 programs maximum per calendar year# based on a ratio of 1:1 with outpatient Mental Health 3 psychiatric emergency visits# (these visits apply towards the 45 visits annual maximum#)</p>	<p>30% of charges*, Precertification required</p> <p>30% of charges*</p> <p>30% of charges*</p>
<p>Substance Abuse Inpatient - 30 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</p> <p>Outpatient Individual – 60 visits maximum per calendar year# (these visits apply towards the 60 visits annual maximum#).</p> <p>Intensive Outpatient Substance Abuse– 3 programs maximum per calendar year# based on a ratio of 1:1 with outpatient Substance Abuse visits (these visits apply towards the 60 visits annual maximum#)</p>	<p>30% of charges*, Precertification required</p> <p>30% of charges*</p> <p>30% of charges*</p>
<p>Durable Medical Equipment Unlimited maximum per calendar year</p>	<p>30% of charges*</p>
<p>External Prosthetic Equipment Unlimited maximum per calendar year</p>	<p>30% of charges*</p>
<p>Wigs Limit: One wig per lifetime Covered for loss of hair due to medical condition</p>	<p>No charge, no plan deductible</p>
<p>Acupuncture – Subject to medical necessity review. Treatment will be approved if rendered by a trained acupuncturist for relief of pain, or producing anesthesia.</p>	<p>30% of charges*</p>

Calendar Year Deductible	
Individual	\$350
Family Maximum	\$700
Calendar Year Out-of-Pocket Maximum	Excludes Plan Deductible
Individual	\$5,000
Family Maximum	\$10,000
Coinsurance	CIGNA HealthCare pays 70% of eligible charges. You pay 30% of charges after plan deductible.
Precertification -Inpatient – PHS (required for all inpatient admissions)	Participant must obtain approval for inpatient admission ; subject to penalty/reduction or denial for non-compliance
Lifetime Maximum	Unlimited
Pre-existing Condition Limitation	No

**Services are subject to calendar year deductible and maximum reimbursable charge limitations. Providers may bill the member the difference between their billed charge and the maximum reimbursable charge as determined by the benefit plan.*

- *Once the out-of-pocket maximum is reached, the plan pays 100% of eligible charges for the remainder of the plan year, with the exception of certain benefits that are subject to calendar year limits.*

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, including clinically severe (morbid) obesity, including: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.
7. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
8. Court ordered treatment or hospitalizations.
9. Infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures. Cryopreservation of donor sperm and eggs are also excluded from coverage.
10. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction.
11. Medical and hospital care and costs for the child of a Dependent, unless this infant child is otherwise eligible under the plan.
12. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance.
13. Consumable medical supplies other than ostomy supplies and urinary catheters.
14. Private hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
15. 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.
16. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
17. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
18. All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in the plan.
19. Routine foot care, however, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.
20. Genetic screening or pre-implantation genetic screening.
21. Fees associated with the collection or donation of blood or blood products.
22. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
23. All nutritional supplements and formulae are excluded, except infant formula needed for the treatment of inborn errors of metabolism.
24. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
25. The following services are excluded from coverage regardless of clinical indications: Massage Therapy; Cosmetic Surgery and Therapies; Macromastia or Gynecomastia Surgeries; Surgical Treatment of Varicose Veins; Abdominoplasty/Panniculectomy; Rhinoplasty;

Blepharoplasty; Redundant Skin Surgery; Removal of Skin Tags; Acupressure; Craniosacral/cranial therapy; Dance Therapy, Movement Therapy; Applied Kinesiology; Rolfing; Prolotherapy; Transsexual Surgery; Non-medical counseling or ancillary services; Assistance in the activities of daily living; Cosmetics; Personal or Comfort Items; Dietary Supplements; Health and Beauty Aids; Aids or devices that assist with non-verbal communications; Dental implants for any condition; Telephone Consultations; E-mail & Internet Consultations; Telemedicine; Health Club Membership fees; Weight Loss Program fees; Smoking Cessation Program fees; Reversal of male and female voluntary sterilization procedures; and Extracorporeal Shock Wave Lithotripsy for musculoskeletal and orthopedic conditions.

These Are Only the Highlights

As you can see, the plan is designed to combine in-depth coverage with cost-effective prices. This summary contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations including legislated benefits are contained in the Summary Plan Description or Insurance Certificate. This plan is insured and/or administered by Connecticut General Life Insurance Company, a CIGNA Company.

“CIGNA HealthCare” refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.

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