



CIGNA HealthCare

Your CIGNA Benefit Plan

For Employees of Equity-League Health Trust Fund

These are only the highlights.

This Benefit Summary highlights only some of the many benefits available under your plan

Complete description regarding the terms of coverage, including legislated benefits and exclusions and limitations will be provided in your insurance certificate or plan description.

Benefits are insured and/or administered by Connecticut General Life Insurance Company.

PREVENTIVE CARE

Our goal is to keep you healthy. Our preventive care benefits help uncover potential problems before they affect your health. See *the Summary of Benefits* inside for specific preventive care coverages.

EMERGENCY CARE

Don't worry. No matter where you travel in the U.S. or worldwide, you are covered for emergency care.

CHOICE OF DOCTORS

You can use any "preferred provider" in our network without a referral. See the CIGNA HealthCare Directory, visit our Web Site (www.cigna.com) or call customer service for assistance in locating participating providers. If you wish, you can go out of network.

OUT OF NETWORK COVERAGE

You're still covered when you go out of network, but your costs will be higher. No referrals are needed; however, you'll have to pay for services and file a claim for reimbursement.

HOSPITALIZATION

Pre-authorization is needed for hospital stays. If you use an in-network hospital, your cost will be even lower.

CIGNA's TOLL FREE CARE LINE

For assistance in finding a preferred provider or for steps to take before admittance to a hospital, call CIGNA's Careline at: 1-800-251-0669.

NO CLAIMS OR OTHER PAPERWORK

In the network, just show your CIGNA ID card and pay the small fee for the visit. There's no paperwork hassle.

Summary of Benefits

Preferred Provider Access (PPA)

| Benefits | In-Network | Out-of-Network |
|---|-------------------|--|
| Annual Deductible* Individual Family *Out-of-Network deductible waived when there are not two participating doctors available within 15 miles of your home address | None None | \$350 \$700 |
| Annual Out-of-Pocket Maximum¹ Individual Family | None None | \$ 5,000 excluding deductible \$10,000 excluding deductible |
| Pre-Existing Condition Limitation | Not Applicable | Not Applicable |
| Lifetime Maximum | Unlimited | |

Your Plan Pays

| | | |
|---|---|--|
| Office Visit Illness \ Injury Allergy Treatment | 100% after \$25 per visit 100% after \$25 per visit | 70%* 70%* |
| Preventive Care Routine Preventive Care for Children (including immunizations)* Adult Routine Preventive Care (including immunizations) Well Woman Care (including Pap Test) Mammograms * Note: New York Residents Only - No copay | 100% after \$25 per visit, birth to age 19 100% after \$25 per visit 100% after \$25 per visit 100% after \$25 per visit | 70%* 70%* 70%* 70%* |
| Independent X-Ray and Lab | 100% | 70%* |
| Prescription Drugs | Available under Prescription Drug Benefit Schedule | |
| Mail Order Drugs | Available under Prescription Drug Benefit Schedule | |
| Emergency Care Doctor's Office Emergency Room \ Urgent Care Facility Ambulance | 100% after \$25 per visit 100% 100% | 100% after \$25 per visit 100%* 100%* *Except if not a true emergency then 70%* |
| Maternity (Employee & Dependents) Initial Visit to Confirm Pregnancy Delivery \ Prenatal \ Postnatal Visits Hospital | 100% after \$25 100% 100% | 70%* 70%* 70%* |
| Hospital Inpatient Doctor Visits Preadmission Testing Preadmission Certification \ Continued stay Review ² | 100% 100% 100% Patient must get approval | 70%* 70%* 70%* Patient must get approval |
| Outpatient Surgical Facility | 100% | 70%* |
| Surgery Surgeon's Fees Second Opinion Consultation | 100% 100% after \$25 per visit | 70%* 100% after \$25 per visit |

Summary of Benefits

Preferred Provider Access (PPA)

| Benefits | In-Network | Out-of-Network |
|---|---|---|
| Infertility⁵ (Employee & Dependents) Office Visit Surgery | 100% after \$25 per visit 100% | 70%* 70%* |
| Outpatient Rehabilitation Includes Physical, Speech, Occupational ⁴ | 100% after \$25 per visit, up to 60 visits per year | 70%*, up to 60 visits per year |
| Chiropractic Therapy <i>Unlimited visits; Based on medical necessity and review after 15th visit</i> | No charge after \$25 per visit copay | 70%* |
| Special Services Skilled Nursing Facility Home Health Care Hospice - Inpatient Hospice - Outpatient | 100% up to 60 days per year 100% up to 200 visits per year 100% 100% | 70%* up to 60 days per year 70%* up to 200 visits per year 70%* 70%* |
| Durable Medical Equipment | 100% | 70%* |
| External Prosthetic Appliances | 100% | 70%* |
| Mental Health Inpatient Outpatient | 100%, up to 30 days per year 100% after \$25 per visit, up to 45 visits per year | 70%*, up to 30 days per year 70%*, up to 45 visits per year |
| Alcohol and Drug Abuse Rehabilitation Inpatient Outpatient | 100%, up to 30 days per year 100% after \$25 per visit, up to 60 visits per year | 70%*, up to 30 days per year 70%*, up to 60 visits per year |
| Group Therapy | Subject to Mental Health, Alcohol or Drug Abuse outpatient maximums and limitations | Subject to Mental Health, Alcohol or Drug Abuse outpatient maximums and limitations |

* Subject to Deductible (Refer to the next page for Service Specific Notes and Exclusions)

Service Specific Notes:

All plan deductibles, plan out-of-pocket maximums, and service specific maximums (dollar and occurrence) cross-accumulate between in-network and out-of-network unless otherwise noted.

Refer to numbered notations in Benefit Summary for cross-reference to the following notes.

1. Once the out-of-pocket maximum is reached the plan pays 100% of eligible charges for the remainder of the plan year.
2. All inpatient hospital admissions require Pre-Admission Certification and Continued Stay Review.
If your admission/stay is not authorized there may be a reduction or denial of coverage.
3. Infertility benefits are limited to services for testing, diagnosis, and corrective procedures only.
Charges for, or in connection with in-vitro fertilization, artificial insemination, or any other similar procedure are not covered.
4. Speech therapy which is not restorative in nature will not be covered.

Exclusions (by way of example but not limited to):

- Services not medically necessary, except specifically outlined preventive care.
- Charges which the person is not legally required to pay.
- Charges made by a hospital owned or operated by the U.S. government if the charges are directly related to a sickness or injury connected to military service.
- Custodial services not intended primarily to treat a specific injury or sickness, or any education or training.
- Experimental or investigational procedures and treatments.
- Cosmetic Surgery.
- Reports, evaluations, examinations or hospitalizations not required for health reasons such as employment or insurance examinations.
- Routine hearing exams or hearing aids.
- Routine eye exams and eyeglasses or lenses with the exception of the first pair of lenses or glasses following cataract surgery, unless vision care is specifically included in the plan(s).
- Treatment of teeth/periodontium under the medical plan except for emergency dental work to stabilize teeth due to injury to sound natural teeth.
- Reversal of voluntary sterilization procedures.
- Transsexual surgery and related services.
- Therapy to improve general physical condition.
- Personal or comfort items such as personal care kits, television, and telephone rental in hospitals.
- Surgical treatment for correction of refractive errors, including radial keratotomy.
- Routine foot care.
- 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.
- Any injury resulting from, or in the course of, any employment for wage or profit.
- Any sickness covered under any workers' compensation or similar law.
- Over the counter disposable or consumable supplies.
- Charges in excess of the Reasonable and Customary allowance.

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