

SUMMARY OF BENEFITS

Your CIGNA HealthCare Point of Service plan



CIGNA HealthCare

Features that Add Value

- Your plan offers the reassurance of having a **Primary Care Physician (PCP)**, a valuable resource for advice and guidance and your personal health advocate. As your needs change, so may your choice of doctors. That's why you can change your PCP for any reason.
- 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.
- Our Guest Privileges program **brings** your CIGNA HealthCare **benefits along** when you temporarily relocate or send kids to schools away from home. Call CIGNA HealthCare Member Services to learn more.
- CIGNA Behavioral Health offers you access to **professional consultation** over the phone to help you with problems that affect you, your family, or your work.

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 LanguagesSM**. We offer Language Line Services so that you can **talk with us** in 150 different languages. Just call Customer Services, 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 every covered family member.
- See participating OB/GYN – **no referral required**.
- **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.
- The CIGNA HealthCare Well-Aware Program for Better Health® can **help you manage** chronic conditions.
- The CIGNA HealthCare Healthy Babies® program provides you with information to help you have a **healthy pregnancy and a healthy baby**. And there's no copayment for prenatal care office visits after the first visit that confirms you're pregnant.

You Can Depend on CIGNA HealthCare

- **Quality comes first**. We select participating providers carefully. And we make sure you have a **wide range** of doctors and specialists to choose from.
- **Emergency and urgent care are covered** wherever you go, worldwide, **24 hours a day**. Urgent care centers can take care of your urgent care needs, and you pay a lower copayment.

It's Your Choice

- When your PCP coordinates your care and you visit network providers, you get access to quality care and lower out-of-pocket costs. Your plan also offers the **freedom to choose** the providers you prefer — even if they aren't part of the network. Your benefits are higher when you see participating providers, but you're still covered for visits to other providers. Participating providers charge a discounted rate for CIGNA members. If you use a non-network provider, the provider may bill you for the difference between the billed charge and the allowed amount under your benefit plan, in addition to applicable (higher than in-network) deductibles and coinsurance amounts.

For Employees of Montgomery College

Network Point of Service - ASO

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Physician Services Primary Care Physician (PCP) Office Visit</p> <p>Specialty Physician Office Visit <i>Consultant and Referral Physician Services</i> <u>Note:</u> OB/GYN physician is considered a Specialist Physician</p> <p>Allergy Treatment/Injections – PCP or Specialty Physician Allergy Serum (dispensed by physician in office) Second Opinion Consultations (provided on voluntary basis) Surgery Performed in the Physician's Office – PCP or Specialty Physician</p>	<p>\$15 copayment per office visit; No charge if only x-ray and/or lab services are performed and billed</p> <p>\$20 copayment per office visit; No charge if only x-ray and/or lab services are performed and billed</p> <p>\$15 or \$20 copayment per office visit or actual charge, whichever is less</p> <p>No charge</p> <p>\$15 or \$20 copayment per office visit</p> <p>\$15 or \$20 copayment per office visit</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>
<p>Preventive Care <i>Routine Preventive Care – Well Baby, Well Child Care, Adult Care and Well Woman (including Immunizations)</i> <u>Note:</u> Well Woman OB/GYN visits are subject to the specialty physician's office visit copay.</p>	<p>\$15 or \$20 copayment per office visit; No charge if only x-ray and/or lab services are performed and billed</p>	<p>Covered in-network only</p>
<p>Mammograms, PSA, Pap Test (Preventive Care Related Routine Services) <u>Note:</u> Diagnostic Related Services are subject to the plan's laboratory & radiology benefit; based on place of service)</p>	<p>No charge; for the procedure itself. Note: \$15 or \$20 copayment per office visit for the associated wellness exam</p>	<p>30% of charges**; Note: the associated wellness exam is not covered</p>
<p>Inpatient Hospital Services including: Semi-Private Room and Board Diagnostic/Therapeutic Lab and X-ray Drugs and Medication Operating and Recovery Room Radiation Therapy and Chemotherapy Anesthesia and Inhalation Therapy</p>	<p>\$250 copayment per admission</p>	<p>30% of charges**, Precertification required</p>
<p>Inpatient Hospital Doctor's Visits/Consultations Inpatient Hospital Professional Services</p>	<p>No charge No charge</p>	<p>30% of charges** 30% of charges**</p>
<p>Outpatient Facility Services Operating Room, Recovery Room, Procedure Room and Treatment Room including: Diagnostic/Therapeutic Lab and X-rays Anesthesia and Inhalation Therapy Physician and Outpatient Professional Services</p>	<p>No charge No charge</p>	<p>30% of charges** 30% of charges**</p>
<p>Laboratory and Radiology Services (includes preadmission testing) Physician's Office Outpatient Hospital Facility</p> <p><i>Emergency Room Facility (billed by facility as part of the Emergency Room visit)</i> Independent X-Ray and/or Lab Facility Independent X-Ray and/or Lab Facility (in conjunction with an Emergency Room visit)</p>	<p>No charge No charge for facility charges; No charge for outpatient professional charges No charge</p> <p>No charge No charge; (If Emergency Room visit is considered to be a true emergency)</p>	<p>30% of charges** 30% of charges**</p> <p>30% of charges**</p> <p>30% of charges** No charge; (If Emergency Room visit is considered to be a true emergency)</p>
<p>Advanced Radiological Imaging (MRIs, MRAs, CAT Scans, PET Scans, etc.) Inpatient Facility Outpatient Facility Emergency Room</p> <p>Physician's Office</p>	<p>No charge No charge No charge</p> <p>No charge</p>	<p>30% of charges** 30% of charges** No charge; except if not a true emergency, then not covered 30% of charges**</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Short-Term Rehabilitative Therapy Cardiac Rehabilitation and Chiropractic Services – (includes cardiac rehab, physical, speech, occupational, chiropractic, pulmonary rehab & cognitive therapy) – 60 days maximum per calendar year# for all therapies combined</p> <p><i>Note: therapy sessions provided as part of Home Health Care accumulate to the Short-Term Rehab Therapy maximum.</i></p>	<p>\$15 or \$20 copayment per office visit; No charge if only x-ray and/or lab services are performed and billed.</p>	<p>30% of charges**</p>
<p>Emergency and Urgent Care Services Physician's Office – PCP or Specialty Physician</p> <p><i>Hospital Emergency Room</i></p> <p><i>Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician)</i> <i>Urgent Care Facility or Outpatient Facility</i></p> <p><i>Ambulance</i></p>	<p>\$15 or \$20 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.</p> <p>\$100 copayment per visit, <i>waived if admitted</i></p> <p>No charge</p> <p>\$50 copayment per visit, <i>waived if admitted</i></p> <p>No charge</p> <p><i>Note: if not a true emergency, services are not covered</i></p>	<p>\$15 or \$20 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.</p> <p>\$100 copayment per visit, <i>waived if admitted</i></p> <p>No charge</p> <p>\$50 copayment per visit, <i>waived if admitted</i></p> <p>No charge</p> <p><i>Note: if not a true emergency, services are not covered</i></p>
<p>Maternity Care Services Initial Office Visit to Confirm Pregnancy</p> <p><i>All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (total maternity fee)</i> <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>\$15 or \$20 copayment for initial office visit</p> <p>No charge</p> <p>\$20 copayment per office visit; No charge if only x-ray and/or lab services performed and billed</p> <p>\$250 copayment per admission</p>	<p>30% of charges**</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 Skilled Nursing, Rehabilitation and Sub-Acute Facilities 60 days maximum per calendar year for all facilities listed#</p>	<p>\$250 copayment per admission</p>	<p>30% of charges**, Precertification required</p>
<p>Home Health Services - Includes outpatient private duty nursing when approved as medically necessary, 16 hour maximum per day#</p>	<p>No charge</p> <p>Unlimited maximum per calendar year</p>	<p>30% of charges**</p> <p>40 days maximum per calendar year reduced by any in-network days</p>
<p>Family Planning Services Office Visits (tests, counseling) – PCP or Specialty Physician</p> <p>Vasectomy/Tubal Ligation (excludes reversals) Inpatient Facility</p> <p><i>Outpatient Facility</i> Physician's Services – Inpatient or Outpatient Physician's Office</p>	<p>\$15 or \$20 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.</p> <p>\$250 copayment per admission</p> <p>No charge</p> <p>No charge</p> <p>\$15 or \$20 copayment per office visit</p>	<p>30% of charges**</p> <p>30% of charges**, Precertification required</p> <p>30% of charges**</p> <p>30% of charges**</p> <p>30% of charges**</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Infertility Services Office Visits (lab & radiology tests, counseling) – PCP or Specialty Physician</p> <p>Treatment/Surgery (includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.) Inpatient Facility Outpatient Facility Physician's Services</p>	<p>\$15 or \$20 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.</p> <p>\$250 copayment per admission No charge No charge</p>	<p>30% of charges**</p> <p>30% of charges** 30% of charges** 30% of charges**</p>
<p>TMJ – Surgical and Non-surgical: case-by-case basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity. Office visits</p> <p>Inpatient Facility Outpatient Facility Physician's Services</p>	<p>\$15 or \$20 copayment per office visit; No charge if only x-ray and/or lab services performed and billed</p> <p>\$250 copayment per admission No charge No charge</p>	<p>Covered in network only</p> <p>Covered in network only Covered in network only Covered in-network only</p>
<p>Mental Health and Substance Abuse Inpatient</p> <p>Mental Health 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>Substance Abuse 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 – In Network - Unlimited visits maximum per calendar year / Out of Network =20 visits maximum per calendar year for outpatient Mental Health and outpatient Substance Abuse.</p> <p>Group Therapy-Mental Health - combined maximum with Outpatient Individual Mental Health services based on a ration of 1:1</p> <p>Intensive Outpatient Mental Health & Substance Abuse 3 programs maximum per calendar year based on a ratio of 1:1 with outpatient Mental Health/ Substance Abuse visits.</p>	<p>\$250 copayment per admission, precertification required Unlimited maximum per calendar year</p> <p>\$20 copayment for visits 1-5; \$30 copayment for visits 6-30; \$50 copayment for visits 31+</p> <p>\$20 copayment for visits 1-5; \$30 copayment for visits 6-30; \$50 copayment for visits 31+</p> <p>50% of charges, no plan deductible</p>	<p>30% of charges*, precertification required 30 days maximum per calendar year</p> <p>50% of charges**</p> <p>50% of charges**</p> <p>50% of charges, no plan deductible</p>
<p>Durable Medical Equipment</p>	<p>No charge Unlimited maximum per calendar year</p>	<p>\$200 DME deductible \$700 maximum per calendar year</p>
<p>External Prosthetic Appliances</p>	<p>\$200 EPA deductible \$1,000 maximum per calendar year</p>	<p>\$200 EPA deductible \$1,000 maximum per calendar year</p>
<p>Vision Care Eye Exam – one exam every 12 months Reimbursement toward purchase of a pair of lenses or contact lenses every 12 months and frames every 12 months:</p>	<p>\$5 copayment per exam Maximum Reimbursement Allowance: Single Vision Lenses \$20 Bifocal Lenses \$30 Trifocal Lenses \$40 Lenticular Lenses \$75 Contact Lenses \$75 Frames \$30</p>	<p>Not Covered Maximum Reimbursement Allowance: Single Vision Lenses \$20 Bifocal Lenses \$30 Trifocal Lenses \$40 Lenticular Lenses \$75 Contact Lenses \$75 Frames \$30</p>

BENEFIT HIGHLIGHTS**IN-NETWORK****OUT-OF-NETWORK****OTHER BENEFIT INFORMATION**

Calendar Year Deductible <i>Individual</i> <i>Family</i>	None None	\$300 \$900
Calendar Year Out-of-Pocket (OOP) Maximum <i>Individual</i> <i>Family</i>	None None	Includes member paid coinsurance \$3,000 excludes deductible \$6,000 excludes deductible
Coinsurance	CIGNA HealthCare pays 100% of eligible charges. You pay 0% of charges	CIGNA HealthCare pays 70% of eligible charges. You pay 30% of charges after the plan deductible.
Precertification – Inpatient – PHS+ (required for all inpatient admissions) Precertification – Outpatient- PHS+ (required for selected outpatient services and diagnostic testing or outpatient services)	Coordinated by your physician Coordinated by your physician	Participant must obtain approval for inpatient admission; subject to penalty/reduction or denial for non-compliance Participant must obtain approval for selected outpatient procedures and diagnostic testing; subject to penalty/reduction or denial for non-compliance
Lifetime Maximum	\$2,000,000#	\$2,000,000#
Pre-existing Condition Limitation	No	Yes

** *Out-of-network services are subject to the 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.*

Day, visit or dollar maximums apply to In-Network and Out-of-Network services combined.

Regarding In-Network Services:

- *All services, except for emergency services, routine care provided by a participating OB/ GYN, and inpatient Mental Health and Substance Abuse services authorized by CIGNA Behavioral Health, Inc. must be provided by or authorized by your Primary Care Physician (PCP) in order to be covered.*

Regarding Out-of-Network Services:

- *All out-of-network hospital admissions and certain outpatient surgical and diagnostic procedures must be precertified and are subject to Continued Stay Review (CSR). A penalty applies to admissions which are not precertified. Non-approved admissions/days result in denial of benefits. The precertification penalty or cost of denied benefits does not apply to deductible or out-of-pocket maximum.*
- *Once the out-of-pocket maximum for Out-of-Network is reached, the plan pays 100% of eligible charges for the remainder of the plan year except for Mental Health and Substance Abuse services which remain at the levels specified.*
- *Coverage for pre-existing conditions will not be covered under this plan unless continuously insured for one year.*

Mental Health

All inpatient Mental Health and Substance Abuse benefits are authorized by CIGNA Behavioral Health, Inc., or its affiliates.

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 donor services and charges.
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. Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.

Benefit Exclusions (continued)

17. 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.
18. Routine foot care, however, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.
19. Genetic screening or pre-implantation genetic screening.
20. Fees associated with the collection or donation of blood or blood products.
21. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
22. All nutritional supplements and formulae are excluded, except infant formula needed for the treatment of inborn errors of metabolism.
23. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
24. Expenses incurred for medical treatment by a person age 65 or older, who is covered under the plan as a retiree, or his dependent, when payment is denied by the Medicare plan because treatment was not received from a participating provider of the Medicare plan.
25. 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.
26. The following services are excluded from coverage regardless of clinical indications: Massage Therapy; Macromastia or Gynecomastia Surgeries; Cosmetic Surgery and Therapies; Surgical Treatment of Varicose Veins; Rhinoplasty; Abdominoplasty/Panniculectomy; 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; Treatment by Acupuncture; 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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