CIGNA HealthCare of Arizona Individual Plan

Definition of terms:

Copayment (copay) – A predetermined fee for office visits, prescriptions, hospital or other services that the member pays at the time of service.

Coinsurance – The portion of a covered claim that the member pays.

Deductible – A dollar amount that a member pays before the plan begins to pay toward the cost of covered medical expenses.

Summary of Benefits

What's Covered	What You Pay
Primary Care Physician Services ▪ Preventive Care ▪ Adult Medical Care ▪ Periodic Physical Evaluation for Adults ▪ Well Child Care ▪ Routine Immunizations and Injections	$25 Copay per office visit
Specialty Care Physician Services ▪ Office Visit ▪ Consultation and Referral Physician Services ▪ Allergy Testing & Treatment ▪ Obstetrical/Gynecological Visit	$50 Copay per office visit
Other Medical Services ▪ Laboratory & X-ray ▪ Blood Pressure Checks ▪ Casting & Dressing	No Charge
Prescription Drugs ▪ Prescription medications and diabetic supplies including insulin, syringes, test strips (30 day supply) ▪ Subject to Plan Formulary ▪ Limited to generic drugs unless one does not exist or substitution is not permitted by law. Individuals purchasing brand-name drugs when a generic equivalent is available are responsible for the difference in cost and the copayment.	$15 Copay for generic drugs $40 Copay for brand-name drugs $60 Copay for non-preferred and brand-name drugs
Emergency Services ▪ Hospital Emergency Room, Outpatient Facility, or Other Non-Contracted Facilities ▪ Ambulance	$150 Copay per visit 80%/20% Coinsurance* You pay 20% Plan Year deductible applies**
Urgent Care Services ▪ CIGNA Medical Group Urgent Care Facility or Other Contracted Facilities	$75 Copay per visit

What's Covered	What You Pay
Inpatient Hospital Services ▪ Semi-private Room & Board ▪ Physician & Surgeon Charges ▪ Diagnostic & Therapeutic Laboratory and X-ray Services ▪ Drugs, Medications, & Biologicals ▪ Special Care Units ▪ Operating Room, Recovery Room, Oxygen, Anesthesia, Respiratory & Inhalation Therapy ▪ Hemodialysis ▪ Radiation Therapy & Chemotherapy	80%/20% Coinsurance* You pay 20% Plan Year deductible applies** $1,000 Individual deductible per Plan Year $3,000 Family deductible per Plan Year
Outpatient Hospital Services ▪ Physician Services ▪ Operating Room & Recovery Room ▪ Anesthesia, Respiratory Inhalation Therapy, Hemodialysis, Radiation Therapy, Chemotherapy, Mammography Screening, Therapeutic Laboratory	80%/20% Coinsurance* You pay 20% Plan Year deductible applies** $1,000 Individual deductible per Plan Year $3,000 Family deductible per Plan Year
▪ Diagnostic Laboratory and X-ray (CT, MRI, MRA, PET)	$100 Copay per test
Chiropractic Care Services ▪ 20 self-referral chiropractic days for medically necessary treatment of neck and back pain within the scope of chiropractic practice.	$50 Copay per office visit
Maternity Care Services ▪ Prenatal & Postpartum Exams	No Charge
▪ Delivery Coverage provided if delivery occurs after the contract has been in force for 21 consecutive months. Pregnancy complications are covered.	80%/20% Coinsurance* You pay 20% Plan Year deductible applies**

What's Covered	What You Pay
Family Planning Services Voluntary Surgical Sterilization ▪ Inpatient & Outpatient You pay 20% Plan Year deductible applies**	80%/20% Coinsurance*
▪ Primary Care Physician Office Visit/ Specialty Care Physician Office Visit	$25 Copay/$50 Copay
▪ Infertility Service	Not Covered
Inpatient Services at Other Participating Health Care Facilities ▪ Skilled Nursing Facility ▪ Extended Care & Rehabilitation	80%/20% Coinsurance* You pay 20% Plan Year deductible applies**
Short-Term Rehabilitative Therapy ▪ Outpatient	**$50 Copay** per office visit; limit of 60 combined days per Plan Year.
▪ Inpatient You pay 20% Plan Year deductible applies**	80%/20% Coinsurance*
Mental Health Services ▪ Outpatient office visit*** **$15 Copay** per group therapy visit	**$40 Copay** per one-on-one
▪ Inpatient	Not Covered

What's Covered	What You Pay
Substance Abuse & Detoxification Services ▪ Outpatient	**$15 Copay** per office visit for the first two (2) visits; **$40** per visit for each visit thereafter up to twenty (20) visits***
▪ Inpatient	**$100 Copay** per day up to eight (8) days
Home Health Services ▪ See Service Agreement for Benefits, Exclusions and Limitations	No Charge
Durable Medical Equipment ▪ See Service Agreement for Benefits, Exclusions and Limitations	No Charge $3500 Maximum benefit per member per Plan Year
External Prosthetics ▪ See Service Agreement for Benefits, Exclusions and Limitations	**$200 Copay** per member per Plan Year **$1000 maximum** benefit per member per Plan Year
Out-of-Pocket Limits	**$3,000 Individual** per Plan Year* **$9,000 Family** per Plan Year*
Plan Year Deductibles	**$1,000 Individual** per Plan Year** **$3,000 Family** per Plan Year**
Lifetime Maximum Benefit	Unlimited

* Out-of-Pocket Limits apply to Coinsurance paid by you. Notify Member Services when you have reached the Out-of-Pocket Limit for the Plan Year. Copayments and deductibles do not apply towards Out-of-Pocket Limits.

** Deductibles for the various services listed in this Summary of Benefits are combined to meet the Plan Year deductible requirement. Coinsurance amounts will apply after the deductible is met.

*** Services for Outpatient Substance Abuse Detoxification and Outpatient Mental Health are limited to a combined benefit of 20 visits per Plan Year.

This limited Summary of Benefits contains the benefit highlights only. Members must refer to their Service Agreement and Supplemental Riders for complete benefit information.

EXCLUSIONS:

Your plan provides coverage for medically necessary services pre-authorized by your Primary Care Physician and performed by participating providers. Your plan does not provide coverage for the following except as required by law.

GENERAL EXCLUSIONS AND LIMITATIONS:

Services that are unauthorized and non-emergent, not medically necessary, not a covered benefit, experimental or investigational; certain services for assistance in the activities of daily living, dental and other conditions related to the teeth and surrounding structures, and non-medical ancillary care, certain organ transplants, cosmetic services, therapies, consumable medical supplies, certain spinal adjustment and manipulation services, private hospital rooms and nursing, personal and comfort items, artificial aids, routine refractions, eye exercises and surgery for refractive error, acupuncture, routine foot care, health and beauty aids, dietary supplements, penile implants, infertility, obesity and transsexual surgery.

This exclusions summary contains highlights only and is subject to change. The specific terms of coverage, exclusions, and limitations are contained in the Individual Service Agreement and Supplemental Riders you will receive. **If you have questions about a specific service or treatment, contact CIGNA HealthCare.**

PREMIUM PAYMENT

Your monthly plan premium is due on the first day of each month. In the event of disenrollment based on premium non-payment, reinstatement of coverage is not guaranteed. CIGNA HealthCare of Arizona, Inc. will only reinstate a policy two times within a twelve (12) month period, and only when back premiums are paid in full. A reinstatement fee of $25.00 per reinstatement will be charged.