Summary of Benefits

Service	Cost
PRIMARY CARE PHYSICIAN SERVICES ◆ Preventive Care ◆ Adult Medical Care ◆ Periodic Physical Evaluation for Adults ◆ Well Child Care ◆ Routine Immunizations and Injections	**$15 copay** per office visit
SPECIALTY CARE PHYSICIAN SERVICES ◆ Office Visit ◆ Consultation and Referral Physician Services ◆ Allergy Testing & Treatment ◆ Obstetrical/Gynecological Visit	**$30 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, and test strips (30 day supply) ◆ Subject to Healthplan 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** generic drugs **$30 copay** brand-name drugs **$60 copay** non-preferred brand-name drugs
CHIROPRACTIC CARE SERVICES ◆ 12 self-referral chiropractic visits for medically necessary treatment of neck and back pain within the scope of chiropractic practice.	**$30 copay** per office visit A total of 12 visits per Plan Year
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%**
OUTPATIENT HOSPITAL SERVICES	
◆ Physician Services	**No Charge**
◆ Operating Room & Recovery Room	**$100 copay** for outpatient surgery
◆ Diagnostic & Therapeutic Laboratory and X-ray ◆ Anesthesia, Respiratory Inhalation Therapy, Hemodialysis, Radiation Therapy, Chemotherapy, Mammography Screening	**No Charge**
EMERGENCY SERVICES ◆ Hospital Emergency Room, Outpatient Facility, or Other Non-Contracted Facilities	**$100 copay** per visit
URGENT CARE SERVICES ◆ CIGNA Health Care Center After Hours Care Facility or Other Contracted Facilities	**$50 copay** per visit

CIGNA HealthCare of Arizona

Rev. 12/02 54431

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MATERNITY CARE SERVICES	
◆ Prenatal & Postpartum Exams	**No Charge**
◆ Delivery (Maternity care is provided only if the member becomes pregnant AFTER 3 months from the effective date of coverage.)	**80%/20% coinsurance*** **You pay 20%**
FAMILY PLANNING SERVICES Voluntary Surgical Sterilization	
◆ Inpatient	**80%/20% coinsurance*** **You pay 20%**
◆ Outpatient	**$100 copay**
◆ Primary Care Physician Office Visit/Specialty Care Physician Office Visit	**$15 copay/$30 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%** Limit of 60 days per Plan Year
SHORT-TERM REHABILITATIVE THERAPY	
◆ Outpatient	**$15 copay** per office visit Limit of 60 consecutive days per condition per Plan Year.
◆ Inpatient	**80%/20% coinsurance*** **You pay 20%**
SUBSTANCE ABUSE & DETOXIFICATION SERVICES	
◆ Outpatient	**$30 copay** per visit**
◆ Inpatient	**80%/20% coinsurance*** **You pay 20%** Limit of 20 days per Plan Year
MENTAL HEALTH SERVICES	
◆ Outpatient	**$30 copay** per office visit**
◆ Inpatient	**Not covered**
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**
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	**$2500 Individual** per Plan Year* **$5000 Family** per Plan Year*
LIFETIME MAXIMUM BENEFIT	**Unlimited**

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

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

This Summary of Benefits is a supplement to the Individual & Family Plan Service Agreement (Health Screened) and Supplemental Riders provided to members and is not intended as a complete summary of the services and benefits covered or excluded. Members must review their Individual & Family Plan Service Agreement (Health Screened) and Supplemental Riders for a complete description of covered services and benefits, exclusions and limitations, and other terms and conditions of coverage.

General Exclusions and Limitations include, but are not limited to, the following types of services:
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.

Rev. 12/02 54431