

SCHOOLCARE SUMMARY OF BENEFITS

Benefits outlined below are intended only as a general summary and are covered when provided or coordinated by your CIGNA HealthCare Primary Care Physician and you use the CIGNA network. All benefits are subject to the terms and conditions of your Health Benefits Booklet. In the event of any inconsistency between this Summary and the Health Benefits Booklet, the provisions as defined in the Health Benefits Booklet and Endorsements will govern. Covered benefits are subject to review for medical necessity. Plan year is defined from July 1 through June 30.

BENEFITS	HMO
DEDUCTIBLES, MAXIMUMS Annual Deductible Out-of-Pocket Maximum/ per plan year Maximum Lifetime benefit	AN HMO MEMBER PAYS N/A N/A Unlimited
PREVENTIVE CARE Routine Physical Examination Routine Childhood Immunizations Well Child Care Routine Gynecological Exam (one per plan year, no referral necessary) Mammograms Prostate Cancer Screening	\$10 per visit \$0 \$10 per visit \$10 per visit \$0 \$0
ROUTINE VISION CARE Routine Exam (one per plan year for all ages, no referral necessary) Discounts Available for Eyewear	\$10 per visit
HEARING TESTS (covered under PCP to age 19)	\$10 per visit
OTHER PHYSICIAN SERVICES Office Visits and/or Office Surgery Maternity Care	\$10 per visit \$10 per visit (initial visit only)
OUTPATIENT DIAGNOSTIC TESTING Radiology and Laboratory Services	\$0 (Some tests require prior authorization.)
HOSPITAL CARE Inpatient Services Same Day or Outpatient Surgery Radiation and Chemotherapy Physician Visits and Services Anesthesiologist Services Operating Room X-ray and Laboratory Services Medications and Supplies Newborn Care	\$0 (Inpatient admissions and some outpatient procedures require prior authorization.)
EMERGENCY ROOM CARE (Medically Necessary and Worldwide)	\$50 per visit (waived if admitted)

BENEFITS	HMO
<p>MENTAL HEALTH/SUBSTANCE ABUSE</p> <p>OUTPATIENT</p> <p>INPATIENT</p> <p>DRUG/ALCOHOL ABUSE <i>(diagnosis, detox, rehab, and medical treatment)</i></p>	<p>AN HMO MEMBER PAYS</p> <p>\$10 copay per visit</p> <p>\$0 (prior authorization required)</p> <p>\$0 (prior authorization required)</p>
<p>PRESCRIPTION DRUGS</p> <p>Through participating pharmacies</p>	<p>\$5 generic/\$15 preferred brand name/\$35 non-preferred brand name drugs</p> <p>Maintenance (90 day supply) available only through mail order for one copay. (prior authorization required for some drugs)</p>
<p>PHYSICAL, OCCUPATIONAL AND SPEECH THERAPIES</p> <p>OUTPATIENT: short-term rehab, up to 60 visits per person/per plan year; includes PT, OT, ST and cardiac rehab (combined maximum)</p> <p>INPATIENT</p>	<p>\$10 per visit</p> <p>\$0 (prior authorization required)</p>
<p>CHIROPRACTIC CARE</p> <p>20 visits per person/per plan year (no referral necessary)</p>	<p>\$10 per visit</p>
<p>ACUPUNCTURE*</p> <p>12 visits per person/per plan year (no referral necessary)</p> <p><i>*Coverage based on CIGNA's medical guidelines.</i></p>	<p>\$10 per visit (reimbursement limited to \$75 per visit)</p>
<p>DURABLE MEDICAL EQUIPMENT</p> <p>\$5,000 maximum/per person/per plan year</p>	<p>20%</p>
<p>EXTERNAL PROSTHETIC APPLIANCES</p> <p>\$10,000 maximum/per person/per plan year</p>	<p>20%</p>
<p>OTHER BENEFITS</p> <p>ORAL SURGERY <i>(accidents only)</i></p> <p>REMOVAL OF BONEY IMPACTED WISDOM TEETH</p> <p>SKILLED NURSING CARE <i>(100 days maximum per person/per plan year)</i></p> <p>AMBULANCE <i>(if medically necessary)</i></p> <p>BLOOD TRANSFUSIONS</p> <p>HOME HEALTH SERVICES</p> <p>HOSPICE</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p>
<p>GOOD FOR YOU! BY SCHOOLCARE</p> <p>Health and Wellness Incentives, Employee Assistance Program</p>	<p>Covered</p>