

## SCHOOLCARE SUMMARY OF BENEFITS

Benefits outlined below are intended as a general summary and are covered only when using a CIGNA participating provider. 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	OPEN ACCESS + (In-Network Benefits Only; No Referrals Necessary)
<b>DEDUCTIBLES, MAXIMUMS</b> Plan Year Deductible (Medical Only) Coinsurance (Medical Only) Out-of-Pocket Maximum/Plan Year (Medical Only) Maximum Lifetime Benefit	<b>YOU PAY</b> Individual: \$250; Family: \$500 20% Individual: \$1,000; Family: \$2,000 Unlimited
<b>PREVENTIVE CARE*</b> Routine Physical Examination (Primary Care Physician) Routine Childhood and Adult Immunizations Hearing Tests (covered under PCP to age 19) Well Child Care Routine Gynecological Exam Mammograms Prostate Cancer Screening Routine Eye Exam (one per plan year for all ages) ( Discounts Available for Eyewear) * Includes Routine Laboratory and Testing	\$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0
<b>OTHER PHYSICIAN SERVICES</b> Office Visits and/or Office Surgery Maternity Care	Deductible, then 20% to the Out of Pocket Maximum Deductible, then 20% to the Out of Pocket Maximum
<b>OUTPATIENT DIAGNOSTIC TESTING</b> Radiology and Laboratory Services	Deductible, then 20% to the Out of Pocket Maximum
<b>HOSPITAL CARE</b> 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	Deductible, then 20% to the Out of Pocket Maximum (Inpatient admissions and some outpatient procedures require prior authorization.)
<b>EMERGENCY ROOM CARE</b> (Medically Necessary and Worldwide)	\$50 per visit (waived if admitted)

# OPEN ACCESS +

BENEFITS	OPEN ACCESS + (In-Network Benefits Only; No referrals Necessary)
<p>MENTAL HEALTH*/SUBSTANCE ABUSE</p> <p>OUTPATIENT: 20 visits per plan year</p> <p>INPATIENT: 30 days plan year maximum (Prior Authorization Required)</p> <p>DRUG/ALCOHOL ABUSE <i>(diagnosis, detox, rehab, and medical treatment)</i></p> <p><i>*Certain biologically based mental health illnesses are not subject to the limits noted above.</i></p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>
<p>PRESCRIPTION DRUGS</p> <p>Through participating pharmacies</p>	<p>Retail: \$5 generic/\$15 preferred brand name/\$35 non-preferred brand name drugs</p> <p>Maintenance drugs (90 day supply) available only through mail order (Tel-Drug) \$0 generic/\$15 preferred brand name/\$35 non-preferred brand name drugs.</p> <p>(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>Deductible, then 20% to the Out of Pocket Maximum</p> <p>Deductible, then 20% to the Out of Pocket Maximum</p>
<p>CHIROPRACTIC CARE</p> <p>20 visits per person/per plan year</p>	<p>Deductible, then 20% to the Out of Pocket Maximum</p>
<p>ACUPUNCTURE*</p> <p>12 visits per person/per plan year</p> <p><i>*Coverage based on CIGNA medical guidelines.</i></p>	<p>Deductible, then 20% to the Out of Pocket Maximum (reimbursement subject to reasonable and customary charges)</p>
<p>DURABLE MEDICAL EQUIPMENT</p> <p>\$5,000 maximum/per person/per plan year</p>	<p>Deductible, then 20% to the Out of Pocket Maximum</p>
<p>EXTERNAL PROSTHETIC APPLIANCES</p> <p>\$10,000 maximum/per person/per plan year</p>	<p>Deductible, then 20% to the Out of Pocket Maximum</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 per person/per plan year maximum)</i></p> <p>AMBULANCE <i>(if medically necessary)</i></p> <p>BLOOD TRANSFUSIONS</p> <p>HOME HEALTH SERVICES</p> <p>HOSPICE</p>	<p>All other covered services subject to plan year deductible and 20% coinsurance to the out-of-pocket maximum for the plan year.</p>
<p>KEEPING FIT BY SCHOOLCARE</p> <p>Health and Wellness Incentives, Employee Assistance Program</p>	<p>\$0</p>