

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)
<p>DEDUCTIBLES, MAXIMUMS</p> <p>Plan Year Deductible (Medical Only)</p> <p>Coinsurance (Medical Only)</p> <p>Out-of-Pocket Maximum/Plan Year (Medical Only)</p> <p>Maximum Lifetime Benefit</p>	<p>YOU PAY</p> <p>Individual: \$250; Family: \$500</p> <p>20%</p> <p>Individual: \$1,000; Family: \$2,000</p> <p>Unlimited</p>
<p>PREVENTIVE CARE*</p> <p>Routine Physical Examination (Primary Care Physician)</p> <p>Routine Childhood and Adult Immunizations</p> <p>Hearing Tests</p> <p>Well Child Care</p> <p>Routine Gynecological Exam (one per plan year)</p> <p>Mammograms</p> <p>Prostrate Cancer Screening</p> <p>Routine Eye Exam (one per calendar year for all ages) (Discounts Available for Eyewear)</p> <p>* Includes Routine Laboratory and Testing</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p>
<p>OTHER PHYSICIAN SERVICES</p> <p>Office Visits and/or Office Surgery</p> <p>Maternity Care</p>	<p>Deductible, then 20% to the Out of Pocket Maximum</p> <p>Deductible, then 20% to the Out of Pocket Maximum</p>
<p>OUTPATIENT DIAGNOSTIC TESTING</p> <p>Radiology and Laboratory Services</p>	<p>Deductible, then 20% to the Out of Pocket Maximum</p>
<p>HOSPITAL CARE</p> <p>Inpatient Services</p> <p>Same Day or Outpatient Surgery</p> <p>Radiation and Chemotherapy</p> <p>Physician Visits and Services</p> <p>Anesthesiologist Services</p> <p>Operating Room</p> <p>X-ray and Laboratory Services</p> <p>Medications and Supplies</p> <p>Newborn Care</p>	<p>Deductible, then 20% to the Out of Pocket Maximum (Inpatient admissions and some outpatient procedures require prior authorization)</p>

OPEN ACCESS +

BENEFITS	OPEN ACCESS + (In-Network Benefits Only; No referrals Necessary)
<p>EMERGENCY & URGENT CARE Hospital Emergency Room Urgent Care Facility <i>(Medically Necessary and Worldwide)</i></p>	<p>YOU PAY</p> <p>\$50 per visit (waived if admitted) \$25 per visit</p>
<p>MENTAL HEALTH/SUBSTANCE ABUSE</p> <p>OUTPATIENT INPATIENT DRUG/ALCOHOL ABUSE <i>(diagnosis, detox, rehab, and medical treatment)</i></p>	<p>\$0 \$0 (prior authorization required) \$0 (prior authorization required)</p>
<p>PRESCRIPTION DRUGS Through participating pharmacies</p>	<p>Retail: \$5 generic/\$15 preferred brand name/\$35 non-preferred brand name drugs. Maintenance drugs (90 day supply) available only through mail order (Tel-Drug) \$0 generic/\$15 preferred brand name/\$35 non-preferred brand name drugs. (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). INPATIENT</p>	<p>Deductible, then 20% to the Out of Pocket Maximum Deductible, then 20% to the Out of Pocket Maximum</p>
<p>CHIROPRACTIC CARE 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 *Coverage based on CIGNA medical guidelines.</p>	<p>Deductible, then 20% to the Out of Pocket Maximum</p>
<p>DURABLE MEDICAL EQUIPMENT</p>	<p>Deductible, then 20% to the Out of Pocket Maximum</p>
<p>EXTERNAL PROSTHETIC APPLIANCES</p>	<p>Deductible, then 20% to the Out of Pocket Maximum</p>
<p>OTHER BENEFITS ORAL SURGERY <i>(accidents only)</i> REMOVAL OF BONEY IMPACTED WISDOM TEETH SKILLED NURSING CARE <i>(100 days per person/per plan year maximum)</i> AMBULANCE <i>(if medically necessary)</i> BLOOD TRANSFUSIONS HOME HEALTH SERVICES 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>GOOD FOR YOU! BY SCHOOLCARE Health and Wellness Incentives, Employee Assistance Program</p>	<p>Covered</p>