

SUMMARY OF BENEFITS

Your CIGNA HealthCare Point-of-Service Open Access plan



CIGNA HealthCare

Features that Add Value

- The convenience of referral-free access to participating specialty physicians, and¼
- The option of selecting a personal Primary Care Physician (PCP) who is your source for routine care and for guidance when you need more than routine care.
- The CIGNA HealthCare 24-Hour Health Information LineSM connects you to registered nurses and a library of hundreds of recorded programs on important health topics 24 hours a day, seven days a week, from anywhere in the U.S.
- CIGNA Healthy Rewards® includes special offers on health and wellness programs and services often not covered by traditional benefit plans. To learn more, call 1.800.870.3470 or visit our Web site at www.cigna.com.
- Prescription drug coverage is a part of your plan. More than 50,000 pharmacies participate nationwide, so you can have your prescription filled wherever you go. Mail-order service means quick, convenient delivery of your medications right to your home.
- Our Guest Privileges program brings your CIGNA HealthCare benefits along when you temporarily relocate or send kids to schools away from home. Call Member Services to learn more.

Quality Service Is Part of Quality Care

- Service is at the heart of everything we do. Our goal is to give you:
- Fast, accurate answers
- Responsive, courteous and professional assistance
 - Ease and convenience in finding the information you need to manage your health
- www.cigna.com – Visit our interactive Web site to learn more about your plan and get health information, 24 hours a day.
- We Speak Many LanguagesSM. We offer the Language Line Services so that you can talk with us in 140 different languages. Just call Member Services, and ask for an interpreter to assist you.

It's Your Health

When you choose CIGNA HealthCare, you can take advantage of our health and wellness programs

- Preventive care services for every covered family member.
- Your PCP can serve as your first contact for care, advice and direction. He/she will recommend specialists and coordinate follow-up care. And, when you need to see a participating specialist – no referral is required. Just make the appointment and go!
- CIGNA Well Aware for Better HealthSM can help you manage chronic conditions like asthma, diabetes or cardiac care.
- The CIGNA HealthCare Healthy Babies® program provides you with education and support to help you have a healthy pregnancy and a healthy baby. And there's no copayment for prenatal care office visits after the first visit that confirms you're pregnant.

You Can Depend on CIGNA HealthCare

- Quality comes first. We select participating providers carefully. And we make sure you have a wide range of PCPs and specialists to choose from.
- We're highly rated by independent evaluators of quality, including the National Committee for Quality Assurance (NCQA).
- Emergency and urgent care are covered wherever you go, worldwide, 24 hours a day. Urgent care centers can take care of your urgent care needs, and you pay a lower copayment.

It's Your Choice

When your PCP coordinates your care and you visit network providers, you get access to quality care at the lowest out-of-pocket costs available under your plan. Your plan also offers the freedom to choose the providers you prefer — even if they aren't part of the network. Your benefits are highest when you see participating providers, but you're still covered for visits to other providers.

CITY OF CLEVELAND/CLEVELAND UTILITIES

CIGNA HealthCare of Tennessee, Inc.

This is a summary of benefits for Active and Pre-65 Retirees of City of Cleveland/Cleveland Utilities. Service specific maximums accumulate in one direction (in-network will accumulate to out-of-network). Lifetime maximums, out-of-pocket maximums and/or plan deductibles do not cross accumulate. All in-network services must be performed by the Primary Care Physician (PCP) or the in-network Specialist or approved by the local Healthplan. CIGNA Pharmacy plan copays do not integrate with the employer medical program.

CIGNA HealthCare Benefit Summary
City of Cleveland/Cleveland Utilities, Actives and Pre-65 Retirees
Open Access Point of Service (Employee Version)

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<i>Lifetime Maximum</i>	Unlimited	5 Million
<i>Coinsurance Levels</i>	80%	60% of Reasonable and Customary
<i>Contract Year Deductible</i>		
<i>Individual</i>	\$1,000 per person	\$2,000 per person
<i>Family Maximum</i>	\$2,000 per family	\$4,000 per family
<i>Annual Out-of-Pocket Maximum</i>		
<i>Individual</i>	\$500 per person	\$2,500 per person
<i>Family Maximum</i>	\$1,000 per family	\$4,500 per family
<i>Physician's Services</i>		
<i>Primary Care Physician's Office visit</i>	\$20 per office visit copay; No charge if only x-ray and/or lab services performed and billed.	60% after plan deductible
<i>Specialty Care Physician's Office Visit</i> Note: OB/GYN provider is considered a Specialist.	No charge after Specialist \$30 per office visit copay	60% after plan deductible
<i>Surgery Performed In the Physician's Office</i>	No charge after the PCP or Specialist per office visit copay	60% after plan deductible
<i>Allergy Treatment/Injections</i>	No charge after either the PCP or Specialist per office visit copay or the actual charge, whichever is less.	60% after plan deductible
<i>Allergy Serum (dispensed by the physician in the office)</i>	No charge	60% after plan deductible
<i>Preventive Care</i>		
<i>Routine Preventive Care: Well-Baby, Well-Child, Adult and Well-Woman (including immunizations)</i>	No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed.	In-network coverage only
<i>Immunizations</i>	No charge	

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Mammograms, PSA, PAP Smear</p> <p><i>Preventive Care Related Services (i.e. "routine" services)</i></p> <p><i>Diagnostic Related Services (i.e. "non-routine")</i></p>	<p>No charge</p> <p>Note: The associated wellness exam is subject to the PCP or Specialist per office visit copay</p> <p>Subject to the plan's x-ray & lab benefit; based on place of service</p>	<p>60% after plan deductible</p> <p>Note: The associated wellness exam is not covered</p> <p>Subject to the plan's x-ray & lab benefit; based on place of service</p>
<p>Inpatient Hospital –</p> <p>Facility Services</p>	<p>80% after plan deductible</p>	<p>60% after plan deductible</p>
<p>Outpatient Facility Service.</p>	<p>80% after plan deductible</p>	<p>60% after plan deductible</p>
<p>Emergency and Urgent Care Services</p> <p><i>Physician's Office</i></p> <p><i>Hospital Emergency Room</i></p> <p><i>Urgent Care Facility or Outpatient Facility</i></p> <p><i>Ambulance</i></p>	<p>No charge after \$20 per office visit copay; No charge if only x-ray and/or lab services performed and billed.</p> <p>No charge after \$100 per visit copay** (Copay waived if admitted)</p> <p>No charge after \$30 per visit copay** (Copay waived if admitted)</p> <p>80% after plan deductible**</p> <p>** If not a true emergency, services are not covered</p>	<p>No charge after \$20 per office visit copay **</p> <p>No charge after \$100 per visit copay**</p> <p>No charge after \$30 per visit copay**</p> <p>80% after plan deductible**</p> <p>**If not a true emergency, services are not covered.</p>
<p>Inpatient Services at Other Health Care Facilities</p> <p><i>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</i></p> <p>60 days maximum per calendar year</p>	<p>80% after plan deductible</p>	<p>60% after plan deductible</p>
<p>Laboratory and Radiology Services (including pre-admission testing)</p> <p>Advanced Radiological Imaging (i.e. MRIs, CAT Scans, PET Scans, etc.</p> <p><i>Other Laboratory and Radiology Services:</i></p> <p><i>Physician's Office</i></p>	<p>No charge</p> <p>No charge</p>	<p>No charge after plan deductible</p> <p>60% after plan deductible</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<i>Outpatient Hospital Facility</i>	No Charge	60% after plan deductible
<i>Independent X-ray and/or Lab Facility</i>	No charge	60% after plan deductible
<i>Outpatient Short-Term Rehabilitative Therapy</i> Includes: Cardiac rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy Chiropractic Services (Separate 30 visit Max)	No charge after the PCP or Specialist per visit copay, 90 visits combined maximum per contract year; No charge if only x-ray and/or lab services performed and billed.	60% after plan deductible 90 visits combined maximum per contract year
<i>Home Health Care</i> Maximum:	No charge 60 days per contract year	60% after plan deductible
<i>Maternity Care Services</i> <i>Initial Visit to Confirm Pregnancy</i> <i>All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)</i> <i>Delivery-Facility (Inpatient Hospital, Birthing Center)</i>	No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed 80% after plan deductible 80% after plan deductible	60% after plan deductible 60% after plan deductible 60% after plan deductible
<i>Organ Transplant</i> <i>Includes all medically appropriate, non-experimental transplants</i> <i>Office Visit</i> <i>Inpatient Facility</i> <i>Inpatient Physician's Services</i> <i>Travel Maximum</i>	No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed 80% after plan deductible 80% after plan deductible \$10,000 per transplant/per Lifetime maximum (only available when using a Lifesource Facility)	In-network coverage only Not covered
<i>Durable Medical Equipment</i> <i>Note: services do accumulate to the plan's Lifetime maximum</i>	No charge \$3,500 maximum per contract year	In-network coverage only
<i>External Prosthetic Appliances</i> <i>Note: services do accumulate to the plan's Lifetime maximum</i>	No charge after \$200 EPA deductible \$1,000 maximum per contract year	In-network coverage only



BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Vision Care <i>Eye Exam every 12 months.</i> <i>Eye Glasses/Contact Lenses not covered</i>	\$10 per office visit copay	In-network coverage only
Prescription Drugs <i>CIGNA PharmacyPlus Retail Drug Program</i> <i>Generic Push, Incentive Prescription Drug List</i> <i>Includes oral contraceptives and contraceptive devices</i> <i>Specialty Injectables Covered</i>	\$10 per 30-day supply for generic drugs \$20 per 30-day supply for preferred brand-name drugs \$50 per 30-day supply for non-preferred brand-name drugs	In-network coverage only
CIGNA Tel-Drug Mail Order Drug Program <i>Includes oral contraceptives and contraceptive devices</i>	\$20 per 90-day supply for generic drugs \$40 per 90-day supply for preferred brand-name drugs \$100 per 90-day supply for non-preferred brand-name drugs	In-network coverage only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<i>Mental Health and Substance Abuse Rehabilitative Services</i>		
Inpatient Mental Health Services	Same as Inpatient Hospital Services; 30 MH day maximum per contract year for TN and non-Mississippi residents. Mississippi residents: 30 MH days and 60 Partial Hospitalization	Same as Inpatient Hospital Services; 30 day maximum per contract year for TN and non-Mississippi residents. Mississippi residents: 30 MH days and 60 Partial Hospitalization Precertification applies
Outpatient Individual Mental Health Services	Same as Physician Office Visit Copayment; 25 visit maximum per contract year for TN and non-Mississippi residents. Mississippi residents: 52 visits maximum per contract year.	Same as Physician services; 25 visit maximum per contract year for TN and non-Mississippi residents. Mississippi residents: 52 visits maximum per contract year. Precertification applies
Outpatient Mental Health Group Therapy	Same as Physician Office Visit Copayment; 40 visit maximum per contract year combined with SA visits for all residents.	In-network coverage only
Inpatient Substance Abuse Rehabilitation Services	\$50 copayment per day; 30 day maximum per contract year	In-network coverage only
Outpatient Individual Substance Abuse Rehabilitation Services	\$15 copayment per visit for the first 2 visits and \$25 per visit thereafter, 20 visit maximum per contract year	In-network coverage only
Outpatient Group Substance Abuse Rehabilitation Services	\$15 copayment per visit; 40 visit maximum per contract year, combined with MH visits	In-network coverage only
Inpatient Substance Abuse Detoxification Services	Same as Inpatient Hospital Copay	Same as Inpatient Hospital Copay
Outpatient Substance Abuse Detoxification Services	Same as Specialty Physician Office Visit Copayment. Missouri residents: Biologically Based Mental Illness is covered as any other illness	Same as any other Illness



Your plan does not provide coverage for the following except as required by law:

1. Any service or supply not described as covered in the Covered Services section of the Agreement.
2. Any medical service or device that is not medically necessary.
3. Care for health conditions that are required by state or local law to be treated in a public facility or supplied by a public school system.
4. Treatment of an illness or injury which is due to war or care for military service disabilities treatable through governmental services.
5. Any services and supplies for or in connection with experimental, investigational or unproven services.
6. Dental treatment of the teeth, gums or structures directly supporting the teeth, however, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within 6 months of the accident.
7. Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, including clinically severe (morbid) obesity, including: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.
8. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
9. Court ordered treatment or hospitalizations.
10. Infertility services, infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
11. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction.
12. Medical and hospital care and costs for the child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
13. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance.
14. Consumable medical supplies other than ostomy supplies and urinary catheters.
15. Private hospital rooms and/or private duty nursing except as covered under the Home Health Care provision.
16. Artificial aids, including but not limited to hearing aids, semi-implantable hearing devices, audiant bone conductors, bone anchored hearing aids, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
17. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
18. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
19. Non-prescription drugs, and investigational and experimental drugs, except as provided in the member agreement.
20. Routine foot care, however, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
21. Genetic screening or pre-implantation genetic screening.
22. Fees associated with the collection or donation of blood or blood products.
23. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
24. All nutritional supplements and formulae are excluded, except infant formula needed for the treatment of inborn errors of metabolism.
25. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
26. The following services are excluded from coverage regardless of clinical indications: Massage Therapy; Cosmetic Surgery and Therapies; Macromastia or Gynecomastia Surgeries; Surgical Treatment of Varicose Veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Orthognathic Surgeries; Redundant Skin Surgery; Removal of Skin Tags; Acupressure; Craniosacral/cranial therapy; Dance Therapy, Movement Therapy; Applied Kinesiology; Rolwing; Prolotherapy; Transsexual Surgery; Non-medical counseling or ancillary services; Assistance in the activities of daily living; Cosmetics; Personal or Comfort Items; Dietary Supplements; Health and Beauty Aids; Aids or devices that assist with non-verbal communications; Treatment by Acupuncture; Dental implants for any condition; Telephone Consultations; E-mail & Internet Consultations; Telemedicine; Health Club Membership fees; Weight Loss Program fees; Smoking Cessation Program fees; Reversal of male and female voluntary sterilization procedures; and Extracorporeal Shock Wave Lithotripsy for musculoskeletal and orthopedic conditions.

This summary of benefits contains the highlights only. The specific benefits and exclusions are contained in your Group Service Agreement or certificate.

"CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp®, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.

Some Healthy Rewards are not available in all states. Additionally, not all Healthy Rewards programs are available to members of CIGNA HealthCare of California, Inc., CIGNA Dental Health of California, Inc. and CIGNA Behavioral Health of California, Inc. A discount program is NOT insurance, and the member must pay the entire discount charge. If your CIGNA HealthCare plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. Healthy Rewards programs are separate from your medical benefits.