
CIGNA Access Plus Copay Health Plan

Effective Date: July 1, 2009

BENEFIT HIGHLIGHTS

In-Network

Out-of-Network¹

(See "Outpatient Clinic Services" for "outpatient clinic" or "hospital-based" services.)

Physician Office Visit

Includes Office Surgery, allergy treatment, labs and if done in the physician's office. CT Scans, MRI's and PET Scans would be paid under Outpatient Services listed below.

Primary Care Provider	\$30 copay per visit	70% after deductible
Specialist	\$40 copay per visit	70% after deductible
Allergy treatments, labs and x-rays without an office visit charge	100% no deductible	70% after deductible

Preventive Care- routine examinatinns and well-baby care- all locations²

Please refer to the Preventive Health Benefits Quick Reference Guide

Primary Care Provider	100% no deductible	In-Network coverage only
Specialist	100% no deductible	In-Network coverage only
Pap Smears, Mammograms, and Prostate Specific Antigen Tests	100% no deductible	70% after deductible
Colonoscopy after age 50 one every ten years regardless of diagnosis	100% no deductible	70% after deductible

If anesthesia is billed separately, contact CIGNA for 100% payment for in-network services

Urgent Care Centers includes all services rendered at Urgent Care	\$40 copay per visit	\$40 copay per visit
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Emergency Room Visit

If admitted inpatient benefits would apply and ER copay waived (if ER copay is billed, contact CIGNA)

Emergency	\$150 copay per visit	\$150 copayment
Non-Emergency	70% after deductible	70% after deductible

Inpatient Services

Inpatient Hospital Facility & Hospital Based Services	80% after deductible	70% after deductible
Inpatient Medical Physician, Surgeon and Anesthesiologist	80% after deductible	70% after deductible
Inpatient Pathologist/Labs	80% after deductible	70% after deductible
Inpatient Mammograms	80% after deductible	70% after deductible
Inpatient X-rays, Ultrasounds and other low tech diagnostic tests	80% after deductible	70% after deductible
Inpatient CT Scans, MRI's, MRA's and PET Scans	80% after deductible	70% after deductible

	<u>In-Network</u>	<u>Out-of-Network¹</u>
Inpatient Chemotherapy and Dialysis	80% after deductible	70% after deductible
Outpatient Services- other than, Emergency Room & Urgent Care Centers		
Outpatient Hospital Facility & Hospital Based Services	80% after deductible	70% after deductible
Outpatient Clinical Services	80% after deductible	70% after deductible
Outpatient Medical Physician, Surgeon and Anesthesiologist	80% after deductible	70% after deductible
Outpatient Pathologist/Labs	100% no deductible	70% after deductible
Outpatient Mammograms	100% no deductible	70% after deductible
Outpatient X-rays, Ultrasounds and other low tech diagnostic tests	80% no deductible	70% after deductible
Outpatient CT Scans, MRI's, MRA's and PET Scans	80% no deductible	70% after deductible
<i>Including the physician's office visit, contrast dyes billed separately will be paid under the Outpatient X-Rays</i>		
Outpatient Chemotherapy and Dialysis	80% after deductible	70% after deductible
Ambulance		
Emergency	80% after deductible	80% after deductible
Non-Emergency	70% after deductible	70% after deductible
Maternity		
<i>Maternity Delivery includes Prenatal and Post-delivery care regardless of place of service</i>		
Hospital & Professional Services- Delivery	80% after deductible	70% after deductible
Diabetic Supplies		
Please refer to Diabetic Disease Management Outline		
Skilled Nursing Facility		
60 days per Contract Period	80% after deductible	70% after deductible
Rehabilitative Therapy- maximums apply to home, office and outpatient settings³		
Primary Care Provider	\$30 copayment per visit	70% after deductible
Specialist	\$40 copayment per visit	70% after deductible
Home Health Care, Durable Medical Equipment⁴ and Hospice Services		
	80% after deductible	70% after deductible
Transplants		
Performed at Lifesource Center (Hospital & Professional Services)	100% after deductible	70% after deductible
Performed at Non-Lifesource Center (Hospital & Professional Services)	80% after deductible	70% after deductible
Infertility & Sexual Dysfunction Services- maximum of \$4000 per lifetime⁵		
Primary Care Provider	\$30 copayment	70% after deductible
Specialist	\$40 copayment	70% after deductible
Inpatient & Outpatient Facilities & Professional Services	80% after deductible	70% after deductible

	In-Network	Out-of-Network
Mental Health Services		
Office	\$40 copayment	70% after deductible
Inpatient	80% after deductible	70% after deductible
Intensive Outpatient Mental Health (Maximum: up to 3 programs per contract year)	80% after \$50 per program copay & ded.	70% after \$50 per program copay & ded.
Substance Abuse Services		
Office	\$40 copayment	70% after deductible
Inpatient	80% after deductible	70% after deductible
Intensive Outpatient Substance Abuse Maximum: up to 3 programs per contract year)	80% after \$50 per program copay & ded.	70% after \$50 per program copay & ded.
Lifetime Benefit Maximum	Unlimited	Unlimited
Annual Maximum- In & Out-of-Network combined	\$10,000,000	\$10,000,000
Deductibles		
Individual (per Contract Year)	\$750	\$1,500
Family (per Contract Year)	\$1,500	\$3,000
Coinsurance Maximum		
Individual (per Contract Year)	\$3,000	\$6,000
Family (per Contract Year)	\$6,000	\$12,000

The Deductibles and Coinsurance Maximums noted above DO NOT apply to the services below:

Vision Care

Comprehensive Eye Exam (Eye exam every 12 months) \$30 deductible per exam- any vision provider
(No network applies to this benefit only)

Routine vision benefit includes one complete eye exam including basic vision screening and refraction. Expenses incurred for charges made for the purchase of eyeglasses, contact lenses (including fitting) and frames are excluded.

Administered by Caremark

Prescription Drugs- Retail (up to 30 day supply)

Infertility Drugs up to \$5,000 Lifetime Maximum

Tier 1 (Generic)	\$0 copayment	Copayment + charge over in-net work allowed amount
Tier 2 (Preferred Brand)	\$35 copayment	Copayment + charge over in-net work allowed amount
Tier 3 (Brand)	\$55 copayment	Copayment + charge over in-net work allowed amount
Tier 4 (Specialty Brand)	75 % coinsurance with a maximum of \$50 and a maximum of \$100	75 % coinsurance + with a minimum charge of \$50 + charge over in-network allowed amount

Prescription Drugs- Mail Order Drug (MOD) - 90 day supply

Tier 1 (Generic)	\$0 copayment	In-network coverage only
Tier 2 (Preferred Brand)	\$70 copayment	In-network coverage only
Tier 3 (Brand)	\$110 copayment	In-network coverage only
Tier 4 (Specialty Brand)	75% coinsurance with a minimum of \$100 and a maximum of \$300	In-network coverage only

Over the Counter (OTC) Smoking Cessation Products \$10 copayment

In order to receive coverage for these OTC products through your prescription benefit, obtain a written prescription from your physician. Provide your prescription information to the pharmacy and the pharmacist will be able to process the OTC product for coverage under the Tier 1 (Generic) benefit noted above. If the cost of the retail prescription is less than your generic copay, you will pay the full cost of the OTC product.

1. Coinsurance for Out-of-Network is based on Maximum Reimbursable Charge
2. Coverage for each member up to 24 months of age includes periodic assessments and immunizations. Benefits are limited to six well-baby visits for members through 12 months old and three well-child visits for members 13 months up to 24 months. For children and adults age 2 and older, coverage for one physician exam and related diagnosis services per contract year.
3. Maximum visits per contract period (in and out of network): 30 visits for speech therapy; 30 visits for combined physical, occupational, and chiropractic visits; cardiac/pulmonary rehab, unlimited visits.
4. For Durable Medical Equipment, please have your physician contact Apria (1-800-901-3566)/Unlimited visits.
5. Infertility and Sexual Dysfunction Services- Coverage will be provided for the following services: Testing and treatment services performed in connection with an underlying medical condition. Testing performed specifically to determine the cause of infertility. Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility)

EXCLUSIONS- What is not covered? (by way of example but not limited to):

Your plan provides coverage for medically necessary services. Your plan does not provide coverage for the following except as required by law:

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public school system or school district.
3. Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
4. Treatment of an illness or injury which is due to war, declared or undeclared.
5. Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
6. Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.

7. Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be: Not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or The subject of review or approval by an Institutional Review Board for the proposed use
8. Cosmetic Surgery and Therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
9. The following services are excluded from coverage regardless of clinical indications: Acupressure; Dance therapy, movement therapy; Applied kinesiology; Rolfing.
10. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. 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. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
11. 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.
12. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician
13. Infertility services, 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.
14. Reversal of male and female voluntary sterilization procedures.
15. Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
16. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
17. Non-medical counseling or ancillary services, including, but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
18. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
19. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, and skin preparations
20. Private hospital rooms and/or private duty nursing
21. Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
22. Artificial aids, including but not limited to corrective orthopedic shoes, arch supports,

- elastic stockings, garter belts, corsets, dentures and wigs.
23. Hearing aids, including, but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
 24. Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
 25. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
 26. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
 27. Treatment by acupuncture.
 28. All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
 29. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs. Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.
 30. Dental implants for any condition. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
 31. Blood administration for the purpose of general improvement in physical condition. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
 32. Cosmetics, dietary supplements and health and beauty aids. All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
 33. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
 34. Telephone, e-mail & Internet consultations and telemedicine.
 35. Massage Therapy
 36. Cognitive Therapy

Monthly Rates

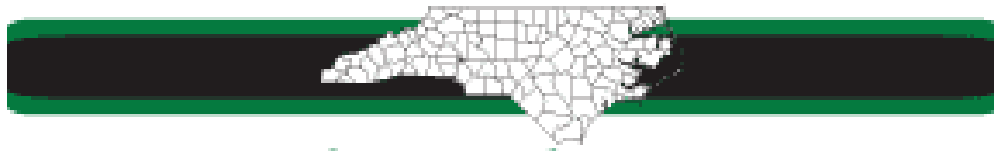
Employee	\$510.36	(County pays \$510.36)
Employee & Spouse	\$1,051.34	(County pays \$510.36)
Employee & Children	\$969.66	(County pays \$510.36)
Employee & Family	\$1,229.96	(County pays \$510.36)

FOR CLAIMS/CUSTOMER SERVICE, PLEASE CALL: 866.622.2288

website address: www.cigna.com



COUNTY HEALTH PLAN



Covering the counties that cover our state.

Preventive Health Benefits Wellness Exams & Immunizations

	Birth to 2 years	Ages 3 to 10	Ages 11 to 18	Ages 19 and older
Well-baby/Well-child/ Well-person exams	Birth, 1, 2, 4, 6, 9, 12, 15, 18, & 24 months. Additional visit at 2-4 days for infants discharged less than 48 hours after delivery	Once a year for children ages 3-5 & every 2 years for children ages 6-10	Once a year	Periodic visits, depending on your age
Diphtheria, tetanus, and acellular pertussis (DTaP)	2, 4, & 6 months & between 15 & 18 months	Between ages 4 & 6	Tetanus - diphtheria - acellular pertussis (Tdap) given once, ages 11-64	Tetanus - diphtheria (Td) every 10 years; Tdap given once, ages 11-64
Haemophilus influenzae b (Hib)	2, 4, & 6 months & between 12 & 15 months			
Hepatitis A	Between 12 & 23 months			May be required for persons at risk
Hepatitis B virus (HBV)	At birth, 1-4 months & 6-8 months	Between ages 3 & 10 if not previously immunized	Between ages 11 & 18 if not previously immunized	May be required for persons at risk
HPV (Gardasil)		Girls 9 -10, as your doctor advises	Girls and women ages 11 - 12, catch up ages 13 -26	Catch up, women through age 26
Influenza vaccine	Annually between 6 & 23 months			Ages 19 & 49, as your doctor advises; age 50 & older, annually
Measles-mumps-rubella (MMR)	Between 12 & 15 months	Between ages 4 & 6 or 11 & 12 if not given earlier	If not already immune	Rubella (German measles) women of childbearing age if not immune
Meningococcal (MCV4)			Between ages 11-12 or prior to high school (age 15); college freshman living in dorms	
Pneumococcal conjugate (PCV) pneumonia	2, 4 & 6 months & between 12 & 16 months			Age 65 & older, once (or younger than 65 for those with risk factors)
Poliovirus (IPV)	2 & 4 months & between 6 & 18 months	Between ages 4 & 6		
Rotavirus (RotaTeq)	2, 4 & 6 months			

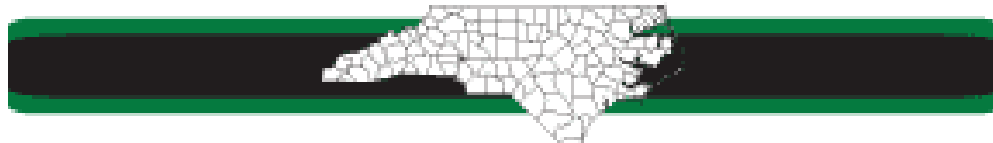
	Birth to 2 years	Ages 3 to 10	Ages 11 to 18	Ages 19 and older
Varicella (chickenpox)	Between 12 & 15 months	Between ages 4 & 6	Second dose catch up or if no evidence of prior immunization or chickenpox	Second dose catch up or if no evidence of prior immunization or chickenpox
Zoster				Age 60+
Screenings				
Blood pressure		At each visit	Once a year	Every 2 years or as your doctor advises
Cholesterol		Selective screening of children at risk due to family history		Complete lipoprotein profile, fasting non-fasting at ages 20 & older, every 5 years
Colon Cancer				Colorectal cancer screening at ages 50 and older: <ul style="list-style-type: none"> • Sigmoidoscopy once every 5 years • Colonoscopy once every 10 years • Fecal occult blood test annual • Barium enema once every 5 years
Diabetes				45 & older, or if history of risk factor, every 3 years
Fluoride	Evaluate for sufficient fluoride in drinking water			
Hearing	Newborn & as doctor advises	4, 5, 6, 8, & 10 or as doctor advises	12, 15 & 18 or as doctor advises	65 & older or as your doctor advises
Hemoglobin or hematocrit			Once a year for females after menarche	
PSA				Once a year for men 50+ or any age with risk factors
Size measurements	Weight, length & head circumference at each visit	Height and weight at each visit	Height and weight once a year	Height and weight periodically, include BMI
Ultrasound AAA				Men 65-75 who have ever smoked
Vision		3, 4, 5, 6, 8 & 10 or as doctor advises	12, 15 & 18 or as doctor advises	By Snellen chart ages 65 & older, as often as your doctor advises

WOMEN'S HEALTH	
	Ages 19 and older
Chlamydia	Sexually active females under age 25
Mammogram	Women ages 40 & older, annually
Osteoporosis	Age 65 or older (or at 60 for women at risk)
Pap Test	Women ages 19-64 at least every 3 years

For additional information on what is covered by your plan, please review your Summary of Benefits. This summary contains highlights only. The specific terms of coverage, exclusions and limitations, including legislated benefits, are included in the Summary Plan Description or Insurance certificate.

These preventive health benefits are based on recommendations from the Advisory Committee on Immunization Practices, U.S. and other nationally recognized authorities. This document is a general guide. Always discuss your preventive care needs with your doctor.

COUNTY HEALTH PLAN



Covering the counties that cover our state.

THE COUNTY HEALTH PLAN COVERAGE FOR DIABETES DISEASE MANAGEMENT

	CIGNA	CAREMARK
WHAT IS OFFERED	1-866-622-2288	1-866-209-6409
RN Guidance	RN: Access to a personal, experienced registered nurse to call for guidance and support	
Newsletter & Mailings	Newsletter & Mailings: Diabetes Outlook, a personal workbook to keep important medical dates; a record of symptoms and self-care guidelines; educational mailings; reminders of important screenings, test and exams, including Hemoglobin A1C tests, cholesterol screenings, retinal eye exams and foot exams.	
Diabetic Supplies		At IN-NETWORK RETAIL & MAIL ORDER: Testing strips, lancets, needles and syringes will be covered with no deductible and in-network co-insurance.
Glucose Meters		One touch and Accu-check version are no-charge if you fill a new RX for strips at a 90 days supply. The manufacturer will send you a "coupon" for a free meter.
Insulin Pumps	The insulin pumps are covered under the medical plan and subject to the deductible and coinsurance. Benefits are paid as Durable Medical Equipment.	
Insulin Pump Supplies	Insulin supplies like batteries, cannulas, and reservoirs are covered at 100%, no deductible. Benefits are paid as Consumable Medical Supplies.	
Insulin		Covered at the pharmacy for a co-pay, available for a 90 day supply by mail order