SUMMARY OF BENEFITS Connecticut General Life Insurance Co.

Purdue University
Purdue Copay Plan

Annual deductibles and maximums	In-network	Out-of-network
Lifetime maximum	Unlimited per individual	
Pre-existing condition limitation (PCL)	Does not apply	
Coinsurance	Inpatient and outpatient facility services You pay 20% Plan pays 80% after the plan deductible is met All other services You pay 0% Plan pays 100% after the applicable copay	You pay 30% Plan pays 70% after the plan deductible is met

Maximum reimbursable charge
• Determined based on the lesser of:
  • the health care professional's normal charge for a similar service; or
  • a percentile of the amount charged by health care professionals in the geographic area where the service is received.
• Out-of-network services are subject to a calendar year plan deductible and maximum reimbursable charge limitations.
	N/A	80th percentile

Calendar year plan deductible • The amount you pay for out -of-network services counts towards your in-network and out-of-network plan deductibles. • Applies to outpatient/inpatient facility charges only (does not apply to tier two and tier three lab charges). • After each family member meets his or her individual plan deductible, the plan will pay his or her claims, less any coinsurance amount. After the family plan deductible has been met, each individual's claims will be paid by the plan, less any coinsurance amount.	**Employee** $250 **Employee and family** $500	**Employee** $500 **Employee and family** $1,000
Calendar year out-of-pocket maximum • The amount you pay for out-of network services counts towards both your in-network and out-of-network out-of-pocket maximums. • Plan deductibles contribute towards your out-of-pocket maximum. • Copays and tier two and tier three lab charges do not contribute towards the out-of-pocket maximum. • Mental health and substance abuse services count towards your out-of-pocket maximum.	**Employee** $1,200 **Employee and family** $2,400	**Employee** $4,000 **Employee and family** $8,000

Annual deductibles and maximums	In-network	Out-of-network
• After each family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. After the family out-of-pocket maximum has been met, the plan will pay 100% of each individual's covered expenses.		

Benefits	In-network	Out-of-network
Physician services		
Office visit • OBGYN are considered under the primary care physician copay • Convenience care clinic considered under the primary care physician copay	**Primary care physician** You pay $15 per visit **Specialist** You pay $30 per visit	You pay 30% Plan pays 70% after the plan deductible is met
Office visits only related to tobacco cessation	**Primary care physician** You pay $0 per visit **Specialist** You pay $0 per visit	You pay 30% Plan pays 70% after the plan deductible is met
Physician services (hospital) • In hospital visits and consultations • Inpatient • Outpatient	**Inpatient and outpatient services** You pay 20% Plan pays 80% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Surgery (in a physician's office)	**Primary care physician** You pay $15 per visit **Specialist** You pay $30 per visit	You pay 30% Plan pays 70% after the plan deductible is met
Preventive care		
Preventive care • Includes well-baby, well-child, well-woman and adult preventive care • Includes immunizations • Includes lab and x-ray billed by the doctor's office	You pay 0% Plan pays 100%	Not covered
Preventive mammogram, PSA, pap smear • Coverage includes the associated preventive outpatient professional services	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
Preventive colonoscopy, sigmoidoscopy, similar routine surgical procedures • Coverage includes the associated preventive outpatient professional services	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met

Benefits	In-network	Out-of-network
Diagnostic care		
Diagnostic mammogram • Diagnostic PSA and pap smears will be covered under the tiered lab benefit (see lab benefit for details)	You pay 20% Plan pays 80% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Diagnostic colonoscopy, sigmoidoscopy, similar routine surgical procedures	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
Inpatient hospital facility services		
Semi-private room and board and other non-physician services • Inpatient room and board, pharmacy, x-ray, lab, operating room, surgery, etc. • Private room stays may result in extra charges for the patient	You pay 20% Plan pays 80% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Inpatient professional services • For services performed by surgeons, radiologists, pathologists and anesthesiologists	You pay 20% Plan pays 80% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Multiple surgical reduction • Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.	Included	Included
Outpatient services		
Outpatient surgery (facility charges)	You pay 20% Plan pays 80% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Outpatient professional services • For services performed by surgeons, radiologists, pathologists and anesthesiologists	You pay 20% Plan pays 80% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Physical, occupational, cognitive and speech therapy • 50 days per calendar year for all therapies combined • Includes physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation and cognitive therapy • Therapy days, provided as part of an approved home health care plan, accumulate to the outpatient short term rehab therapy maximum	**Primary care physician** You pay $15 per visit **Specialist** You pay $15 per visit	You pay 30% Plan pays 70% after the plan deductible is met

Benefits	In-network	Out-of-network
Cardiac rehabilitation • Limited to 36 days per calendar year	**Specialist** You pay $30 per visit	You pay 30% Plan pays 70% after the plan deductible is met
Chiropractic care • Limited to 26 days per calendar year	**Specialist** You pay $30 per visit	You pay 30% Plan pays 70% after the plan deductible is met
Nutritional counseling • Unlimited visit maximum per calendar year	Cost and reimbursement vary based on the facility in which the service is performed	Cost and reimbursement vary based on the facility in which the service is performed
Lab and x-ray		
Lab • Physician's office • Outpatient hospital facility • Independent lab & x-ray facility • Labs associated with a preventive care screening will be paid at 100% • Diagnostic PSA and pap smear test will be paid based on lab tier.	**Tier One Lab** You pay 0 Plan pays 100% **Tier Two Lab** You pay 30% Plan pays 70%	You pay 50% Plan pays 50%
X-ray • Physician's office • Ultra sound included	You Pay 0% Plan pays 100% after the office visit copay	You pay 30% Plan pays 70% after the plan deductible is met
X-ray • Outpatient hospital facility • Ultra sound included	You pay 20% Plan pays 80% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Lab and x-ray, emergency room and urgent care • Emergency room when billed by the facility as part of the emergency room visit • Urgent care when billed by the facility as part of the urgent care visit • Independent x-ray and/or lab facility in conjunction with a emergency room visit	You Pay 0% Plan pays 100%	
Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.) • Physician's office visit	You pay a per scan copay of $200	You pay 30% Plan pays 70% after the plan deductible is met
Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.) • Inpatient hospital facility	You pay 20% Plan pays 80% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met

Benefits	In-network	Out-of-network
Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.) • All outpatient facilities to include hospital and independent facility	You pay a per scan copay of $200	You pay 30% Plan pays 70% after the plan deductible is met
Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.) • Emergency room • Urgent care facility	You pay a per scan copay of $200	
Emergency and urgent care services		
Hospital emergency room • Includes radiology, pathology and physician charges • Copay waived if admitted, then inpatient hospital charges would apply • Out-of-network services are covered at the in-network rate	You pay a $200 copay	
Ambulance • Out-of-network services are covered the same as in-network services Note: Non-emergency transportation (e.g. from hospital back home) is generally not covered	You pay 0% Plan pays 100%	
Convenience care clinic	You pay $15 per visit	You pay 30% Plan pays 70% after the deductible is met
Urgent care services • Out-of-network services are covered at the in-network rate • Copay waived if admitted, then inpatient hospital charges would apply	You pay a $40 copay	
Other health care facilities		
Skilled nursing facility, rehabilitation hospital and other facilities • 60 days per calendar year	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
Home health care • Unlimited days per calendar year	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
Hospice • Inpatient services • Outpatient services	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met

Benefits	In-network	Out-of-network
Other health care services		
Durable medical equipment • Unlimited calendar year maximum	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
External prosthetic appliances (EPA) • Unlimited calendar year maximum	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
TMJ • Doctor's office • Inpatient facility • Outpatient facility • Physician's services • Always excludes appliances and orthodontic treatment • Subject to medical necessity • Services subject to $5,000 lifetime maximum	Cost and reimbursement vary based on the facility in which it is performed	Cost and reimbursement vary based on the facility in which it is performed.
Infertility treatment	Not covered	Not covered
Family planning • Inpatient hospital facility • Outpatient facility • Physician services • Surgical services such as tubal ligation or vasectomy are covered (excluding reversals) • Includes contraceptive devices	Cost and reimbursement vary based on the facility in which it is performed	Not covered
Wigs • $300 maximum per calendar year	You pay 0% Plan pays 100%	You pay 30% Plan pays 70% after the plan deductible is met
Oral Surgery • Physician's office • Outpatient hospital facility • Emergency room • Independent x-ray and/or lab facility • Independent x-ray and/or lab facility as part of an ER visit	Cost and reimbursement vary based on the facility in which it is performed	Cost and reimbursement vary based on the facility in which it is performed
Mental health and substance abuse services		
Please note the following regarding Mental Health (MH) and Substance Abuse (SA) benefit administration: • Substance Abuse includes alcohol and drug abuse services • Transition of Care benefits are provided for a 90-day time period		

Benefits	In-network	Out-of-network
Inpatient mental health services • Unlimited days per calendar year • Mental health services are paid at 100% after you reach your out-of-pocket maximum	You pay 20% Plan pays 80% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Outpatient mental health physician's office services • Unlimited visits per calendar year • Out-of-Network Mental health services are paid at 100% after you reach your out-of-pocket maximum • This includes individual, group therapy mental health and intensive outpatient mental health	You pay $10 per visit In doctor office only, all other places of service deductible/coinsurance apply.	You pay 30% Plan pays 70% after the plan deductible is met
Outpatient mental health facility services • Unlimited visits per calendar year • Mental health services are paid at 100% after you reach your out-of-pocket maximum • This includes individual, group therapy mental health and intensive outpatient mental health	You pay 20% Plan pays 80% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
Inpatient substance abuse services • Unlimited days per calendar year • Substance abuse services are paid at 100% after you reach your out-of-pocket maximum	You pay 20% Plan pays 80% after the plan deductible is met	You pay 30% Plan pays 70% after the plan deductible is met
Outpatient substance abuse physician's office services • Unlimited visits per calendar year • Out-of-Network Substance abuse services are paid at 100% after you reach your out-of-pocket maximum • This includes individual and intensive outpatient substance abuse services	You pay $10 per visit In doctor office only, all other places of service deductible/coinsurance apply.	You pay 30% Plan pays 70% after the plan deductible is met
Outpatient substance abuse facility services • Unlimited visits per calendar year • Substance abuse services are paid at 100% after you reach your out-of-pocket maximum • This includes individual and intensive outpatient substance abuse services	You pay 20% Plan pays 80% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
Prescription drugs – provided through *Medco*		
Pharmacy coverage • **Pharmacy benefits are NOT payable through Cigna**	**Pharmacy benefits are provided through *Medco*** **Retail Pharmacy (up to a 30-day supply)** **Generic** You pay 20% **Preferred** You pay 30% **Non preferred** You pay 50%	

Benefits	In-network	Out-of-network
	***Medco* Pharmacy Mail-order Service (up to a 90-day supply)** **Generic** You pay 15% **Preferred** You pay 25% **Non preferred** You pay 45%	
Pharmacy out-of-pocket maximum	Individual $1,300 Family $2,600	
Vision care • **Vision benefits are NOT payable through Cigna**	Coverage provided through VSP	

Cigna

Definitions

Coinsurance – After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called coinsurance.

Copay – A flat fee you pay for certain covered services such as doctor's visits or prescriptions.

Deductible – A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.

Direct access to obstetricians and gynecologists – You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.myCigna.com or contact customer service at the phone number listed on the back of your ID card.

Out-of-pocket m**aximum** – Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "maximum reimbursable charges" or negotiated fees for covered services.

Place of service – Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.

Selection of a primary care provider – Your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, CIGNA may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.myCigna.com or contact customer service at the phone number listed on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

Transition of care – Provides in-network health coverage to new customers when the customer's doctor is not part of the CIGNA network and there are approved clinical reasons why the customer should continue to see the same doctor.

Maximizing your health care dollars

Log on to myCIGNA.com for resources to help you choose a health care professional or compare the cost and quality of medical services, medications and hospital care.

When you need a medical service or procedure, CIGNA offers you opportunities to save on prescription medicine, routine medical care, laboratory services, radiology scans, and outpatient surgery. Details are below:

Lab – Save on lab services by using a free-standing laboratory instead of a hospital- or clinic-based lab.

Urgent care – For non-emergency conditions that need attention before you can see your doctor, you can save money by going to an urgent care center instead of an Emergency Room (ER).

Convenience care – For minor or routine conditions, go to a Convenience Care Clinic when your doctor is unavailable. Convenience Care Clinics are retail-based and often found in pharmacies or grocery stores.

Radiology – Costs for MRIs, PET, and CT scans can vary greatly. Non-hospital based outpatient radiology centers often cost much less than a hospital. CIGNA's network includes both hospitals and outpatient centers, so you can find a radiology center that's right for you.

Outpatient surgery – Costs for colonoscopies, arthroscopies, and other outpatient procedures can vary greatly. Using a free-standing outpatient surgery center can save hundreds of dollars.

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Exclusions

What's Not Covered (*not all-inclusive*):

Your plan provides coverage for most medically necessary services. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Services provided through government programs
- Services that aren't medically necessary
- Experimental, investigational or unproven services
- Services for an injury or illness that occurs while working for pay or profit including services covered by worker's compensation benefits
- Cosmetic services
- Dental care, unless due to accidental injury to sound natural teeth
- Infertility Services
- Reversal of sterilization procedures
- Genetic screenings
- Obesity surgery and services
- Non-prescription and anti-obesity drugs
- Custodial and other non-skilled services
- Weight loss programs
- Hearing aids
- Acupuncture
- Treatment of sexual dysfunction
- Telephone, email and internet consultations in the absence of a specific benefit
- Eyeglass lenses and frames, contact lenses and surgical vision correction

These are only the highlights

This summary outlines the highlights of your plan. For a complete list of both covered and not-covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.

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