

# SUMMARY OF BENEFITS

*Your CIGNA HealthCare Open Access Plus plan*



**CIGNA HealthCare**

## Features that Add Value

- The convenience of **referral-free access** to physicians, and the option to select a **personal Primary Care Physician (PCP)** as your source for routine care and guidance when you need specialized care. As your needs change, so may your choice of doctors. That's why you can change your PCP for any reason.
- The CIGNA HealthCare 24-Hour Health Information Line<sup>SM</sup> 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<sup>®</sup>** includes special offers on health and wellness programs and services often not covered by many traditional benefits plans. Just call 1.800.870.3470 or visit our web site at [www.cigna.com](http://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.

## 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; and 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. Once you enroll, register for myCIGNA.com, our convenient, secure web site that combines WebMD<sup>®</sup> tools with personalized benefits information to help you make the most of your plan.
- **We Speak Many Languages<sup>SM</sup>**. We offer Language Line Services so that you can **talk with us** in 150 different languages. Just call Customer Service and ask for an interpreter to assist you.
- Our interactive voice response system helps you find what you need faster over the phone. Use the speech recognition feature for information on your benefits, level of coverage, claims status, and more.

## It's Your Health

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

- **Preventive care services** for your children through age 2 and any additional preventive care benefits described in the Benefits Highlights.
- CIGNA Well Aware for Better Health<sup>®</sup> can **help you manage** certain chronic conditions.
- The CIGNA HealthCare Healthy Babies<sup>®</sup> program provides you with information to help you have a **healthy pregnancy and a healthy baby**

## You Can Depend on CIGNA HealthCare

- **Quality comes first**. We select “preferred providers” carefully. And we make sure you have a **wide range** of doctors to choose from.
- **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 your cost is lower.

## It's Your Choice

When 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 the highest when you see “preferred providers,” but you're still covered for visits to other providers.

**For Employees of  
Salus Rehabilitation, LLC  
Open Access Plus – Copay Plan (Basic)**

BENEFIT INFORMATION	IN-NETWORK	OUT-OF-NETWORK
<b>Calendar Year Plan Deductible</b> <i>Individual</i> <i>Family Maximum</i>	\$750 \$2,250	\$1,000 \$3,000
<b>Calendar Year Out-of-Pocket Maximum</b> <i>Individual</i> <i>Family Maximum</i>	Excluding Plan Deductible \$4,000 \$12,000	Excluding Plan Deductible \$6,000 \$18,000
<b>Coinsurance</b>	CIGNA HealthCare pays 80% of eligible charges. You pay 20% of charges after plan deductible.	CIGNA HealthCare pays 50% of eligible charges. You pay 50% of charges after plan deductible.
<b>Precertification -Inpatient – PHS+ (required for all inpatient admissions)</b>	Coordinated by your physician	Participant must obtain approval for inpatient admission; subject to penalty/reduction or denial for non-compliance
<b>Precertification – Outpatient – PHS+ (required for selected outpatient procedures and diagnostic testing or outpatient services)</b>	Coordinated by your physician	Participant must obtain approval for selected outpatient procedures and diagnostic testing; subject to penalty/reduction or denial for non-compliance.
<b>Annual Maximum</b>	\$300,000#	\$300,000#
<b>Lifetime Maximum</b>	\$1,000,000#	\$1,000,000#
<b>Pre-existing Condition Limitation</b>	Yes	Yes
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Physician Services</b> <b>Primary Care Physician (PCP) Office Visit</b>	\$30 copayment per office visit; No charge if only x-ray and/or lab services are performed and billed.	50% of charges**
<b>Specialty Physician Office Visit</b> <i>Consultant and Referral Physician Services</i>	\$45 copayment per office visit; No charge if only x-ray and/or lab services are performed and billed.	50% of charges**
<b>Note:</b> A copayment applies for OB/GYN visits. If your doctor is listed as a PCP in the provider directory, you will pay a PCP copayment. If your doctor is listed as a specialist, you will pay the specialist copayment.		
<b>Allergy Treatment/Injections - PCP or Specialty Physician</b>	\$30 or \$45 copayment per office visit or actual charge, whichever is less	50% of charges**
<b>Allergy Serum (dispensed by physician in office)</b>		
<b>Second Opinion Consultations (provided on voluntary basis)</b>	No charge	50% of charges**
<b>Surgery Performed in the Physician's Office- PCP or Specialty Physician</b>	\$30 or \$45 copayment per office visit	50% of charges**
<b>Preventive Care</b> <b>Routine Preventive Care for Children through age 2 (including routine immunizations)</b>	\$20 copayment per office visit; No charge if only x-ray and/or lab services are performed and billed.	Covered in-network only
<b>Immunizations</b>	No charge, no plan deductible	Covered in-network only
<b>Routine Preventive Care for Children and Adults from age 3 (including routine immunizations)</b> One per calendar year	\$20 copayment per office visit; No charge if only x-ray and/or lab services are performed and billed	Covered in-network only
<b>Immunizations</b>	No charge, no plan deductible	Covered in-network only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><b>Mammograms, PSA, Pap Test</b> (Only one preventive test per calendar year)</p> <p><b>Note:</b> Preventive care related services and diagnostic related services are paid at the same level of benefits as other x-ray and lab services, based on place of service.</p>	<p>No charge if billed by independent diagnostic facility or outpatient hospital; \$20 copayment per visit for associated wellness exam</p>	<p>50% of charges**</p>
<p><b>Inpatient Hospital Services including:</b> Semi-Private Room and Board Diagnostic/Therapeutic Lab and X-ray Drugs and Medication Operating and Recovery Room Radiation Therapy and Chemotherapy Anesthesia and Inhalation Therapy</p>	<p>\$300 copayment per day up to 5 days per admission, plus 20% of charges*</p>	<p>\$500 deductible per day up to 5 days per admission, plus 50% of charges*  Precertification required</p>
<p><b>Inpatient Hospital Doctor's Visits/Consultations</b> Inpatient Hospital Professional Services</p>	<p>No charge No charge</p>	<p>50% of charges** 50% of charges**</p>
<p><b>Outpatient Facility Services includes:</b> Operating Room, Recovery Room, Procedure Room and Treatment Room and Observation Room including: Diagnostic/Therapeutic Lab and X-rays Anesthesia and Inhalation Therapy Physician &amp; Outpatient Professional Services <b>Note:</b> Non-surgical treatment procedures are not subject to the facility copay.</p>	<p>\$250 copayment per facility visit, plus 20% of charges  No charge</p>	<p>\$500 deductible per facility visit, plus 50% of charges**  50% of charges**</p>
<p><b>Laboratory and Radiology Services (includes preadmission testing)</b> Physician's Office Outpatient Hospital Facility Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit)  Independent X-Ray and/or Lab Facility Independent X-Ray and/or Lab Facility (in conjunction with an Emergency Room visit)</p>	<p>No charge 20% of charges* No charge  No charge No charge</p>	<p>50% of charges** 50% of charges** No charge; if not a true emergency, then 50% of charges**  50% of charges** No charge; if not a true emergency, then 50% of charges**</p>
<p><b>Advanced Radiological Imaging (MRIs, MRAs, CAT Scans, PET Scans, etc.)</b> Inpatient Facility  Outpatient Facility  Emergency Room (billed by facility as part of the Emergency Room visit)  Physician's Office</p>	<p>20% of charges*  20% of charges*  No charge  No charge</p>	<p>50% of charges**  50% of charges**  No charge; except if not a true emergency, then 50% of charges**  50% of charges**</p>
<p><b>Short-Term Rehabilitative Therapy, Cardiac Rehabilitation and Chiropractic Services--(includes cardiac rehab, physical, speech, occupational, chiropractic, pulmonary rehab &amp; cognitive therapy)</b> 75 days maximum per calendar year# for all therapies combined <b>Note:</b> therapy sessions provided as part of Home Health Care accumulate to the Short-Term Rehab Therapy maximum.</p>	<p>No charge at FHCP/CHCP (CSN); Otherwise \$45 copayment per office visit; No charge if only x-ray and/or lab services are performed and billed.</p>	<p>50% of charges**</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><b>Emergency and Urgent Care Services</b> Physician's Office – PCP or Specialty Physician</p> <p>Hospital Emergency Room</p> <p>Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician)</p> <p>Urgent Care Facility or Outpatient Facility</p> <p>Ambulance</p>	<p>\$30 or \$45 copayment per office visit; No charge if only x-ray and/or lab services are performed and billed.</p> <p>\$300 copayment per visit, plus 20% of charges* (copay waived if admitted)</p> <p>No charge</p> <p>\$45 copayment per visit (copay waived if admitted)</p> <p>No charge</p>	<p>Care will be provided at in-network levels if it meets the "prudent layperson" definition of an emergency. Otherwise 50% of charges**</p>
<p><b>Maternity Care Services</b> Initial Office Visit to Confirm Pregnancy <b>Note:</b> A copayment applies for OB/GYN visits. If your doctor is listed as a PCP in the provider directory, you will pay a PCP copayment. If your doctor is listed as a specialist, you will pay the specialist copayment.</p> <p>All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (total maternity fee)</p> <p>Office Visits not included in the total maternity fee performed by OB or Specialty Physician</p> <p>Delivery - Facility (Inpatient Hospital/Birthing Center Charges)</p>	<p>\$30 or \$45 copayment for initial office visit; No charge if only x-ray and/or lab services are performed and billed.</p> <p>No charge</p> <p>\$30 or \$45 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.</p> <p>\$300 copayment per day up to 5 days per admission, plus 20% of charges*</p>	<p>50% of charges**</p> <p>50% of charges**</p> <p>50% of charges**</p> <p>\$500 deductible per day up to 5 days per admission, plus 50% of charges* Precertification required</p>
<p><b>Inpatient Services at Other Health Care Facilities</b> Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities 60 days maximum per calendar year# combined for all facilities listed</p>	<p>No charge at FHCP/CHCP (CSN); Otherwise 20% of charges*</p>	<p>50% of charges**</p>
<p><b>Home Health Services</b> – Includes outpatient private duty nursing when approved as medically necessary 100 days maximum per calendar year#; 16 hour maximum per day#</p>	<p>No charge</p>	<p>50% of charges**</p>
<p><b>Family Planning Services</b> Office Visits (lab &amp; radiology tests, counseling)</p> <p><b>Vasectomy/Tubal Ligation (excludes reversals)</b> Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services – Inpatient or Outpatient Physician's Office</p>	<p>\$30 or \$45 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.</p> <p>\$300 copayment per day up to 5 days per admission, plus 20% of charges*</p> <p>\$250 copayment per facility visit, plus 20% of charges</p> <p>No charge</p> <p>\$30 or \$45 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.</p>	<p>50% of charges**</p> <p>\$500 deductible per day up to 5 days per admission, plus 50% of charges* Precertification required</p> <p>\$500 deductible per facility visit, plus 50% of charges**</p> <p>50% of charges**</p> <p>50% of charges**</p>
<p><b>Infertility Services</b> Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.</p>	<p>Not covered</p>	<p>Not covered</p>
<p><b>TMJ - Surgical and Non-Surgical</b></p>	<p>Not covered</p>	<p>Not covered</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><b><i>Mental Health and Substance Abuse</i></b>  <b><i>Inpatient</i></b></p> <p><b><u>Mental Health</u></b>  <b><i>Acute:</i></b> Based on a ratio of 1:1  <b><i>Partial:</i></b> Based on a ratio of 2:1  <b><i>Residential:</i></b> Based on a ratio of 2:1</p> <p><b><u>Substance Abuse</u></b>  <b><i>Acute Detox:</i></b> Based on a ratio of 1:1 (requires 24 hour nursing)  <b><i>Acute Inpatient Rehab:</i></b> Based on a ratio of 1:1 (requires 24 hour nursing)  <b><i>Partial:</i></b> Based on a ratio of 2:1  <b><i>Residential:</i></b> Based on a ratio of 2:1</p> <p><b><i>Outpatient-Individual</i></b> – 25 visits maximum per calendar year# for outpatient Mental Health and outpatient Substance Abuse</p> <p><b><i>Group Therapy-Mental Health</i></b> – combined maximum with Outpatient Individual Mental Health services based on a ratio of 1:1</p> <p><b><i>Intensive Outpatient Mental Health &amp; Substance Abuse</i></b> – 3 programs maximum per calendar year based on a ratio of 1:1 with outpatient Mental Health/Substance Abuse visits</p>	<p>\$300 copayment per day up to 5 days per admission, plus 20% of charges*  20 days combined maximum per calendar year for inpatient Mental Health and inpatient Substance Abuse</p> <p>\$45 copayment per office visit</p> <p>\$15 copayment per session</p> <p>\$50 per program copayment*</p>	<p>\$500 deductible per day up to 5 days per admission, plus 50% of charges**  Precertification required</p> <p>10 days combined maximum per calendar year for inpatient Mental Health and inpatient Substance Abuse</p> <p>50% of charges**</p> <p>50% of charges**</p> <p>\$50 per program deductible, plus 50% of charges**</p>
<p><b><i>Durable Medical Equipment</i></b>  \$3,500 maximum per calendar year#</p>	<p>No charge</p>	<p>Covered in-network only</p>
<p><b><i>External Prosthetic Appliances</i></b>  \$200 EPA deductible per calendar year  \$1,000 maximum per calendar year#</p>	<p>No charge</p>	<p>Covered in-network only</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><b>Prescription Drugs</b> Diabetic Supplies includes: insulin needles &amp; syringes, diabetic test strips/lancets.</p>	No charge	Covered in-network only
<p><b><u>CIGNA Pharmacy Retail Drug Program</u></b> Includes: insulin, prenatal vitamins and certain prescription vitamins, oral contraceptives and contraceptive devices.</p>		
<p>Generic*** drugs on the Prescription Drug List for a 30-day supply</p>	\$12 copayment per prescription/refill	50% of charges***
<p>Brand Name*** drugs designated as preferred on the Prescription Drug List with no Generic equivalent for a 30-day supply</p>	35% of charges per prescription/refill	50% of charges***
<p style="text-align: right;">Maximum Copay</p>	\$75 maximum per prescription/refill	
<p>Brand Name*** drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List for a 30-day supply</p>	55% of charges per prescription/refill	50% of charges***
<p style="text-align: right;">Maximum Copay</p>	\$100 maximum per prescription/refill	
<p><b><u>CIGNA Tel-Drug Mail Order Drug Program</u></b> Includes: insulin, prenatal vitamins and certain prescription vitamins, oral contraceptives and contraceptive devices.</p>		
<p>Generic*** drugs on the Prescription Drug List for a 90-day supply</p>	\$25 copayment per prescription/refill	Covered in-network only
<p>Brand Name*** drugs designated as preferred on the Prescription Drug List with no Generic equivalent for a 90-day supply</p>	35% of charges per prescription/refill	Covered in-network only
<p style="text-align: right;">Maximum Copay</p>	\$150 maximum per prescription/refill	Covered in-network only
<p>Brand Name*** drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List for a 90-day supply</p>	55% of charges per prescription/refill	Covered in-network only
<p style="text-align: right;">Maximum Copay</p>	\$200 maximum per prescription/refill	Covered in-network only
<p><b>Pharmacy Deductible Individual/Family (Mail Order excluded)</b></p>	<b>\$50 per individual / None per family</b>	<b>\$50 per individual / None per family</b>
<p>***Designated as per generally-accepted industry sources and adopted by CG</p>		

\*Services are subject to calendar year deductible

\*\* Services are subject to calendar year deductible and reasonable and customary charge/maximum reimbursable charge limitations.

\*\*\*Services are subject to reasonable and customary charge/maximum reimbursable charge limitations.

# In-network and out-of-network services apply to the same treatment or dollar maximum.

**Footnotes:**

**Regarding In-Network and Out-of-Network Services:**

- Once the out-of-pocket maximum is reached, the plan pays 100% of eligible charges for the remainder of the plan year, except for Mental Health and Substance Abuse which continue to be paid at the levels specified.
- Coverage for pre-existing conditions will not be covered under this plan unless continuously insured for one year.

**Regarding In-Network Services:**

- All services must be provided by one of the preferred providers on our list in order to be covered.

**Regarding Out-of-Network Services:**

- Your out-of-pocket costs will be higher than with a preferred provider.
- All out-of-network hospital admissions and certain outpatient surgical and diagnostic procedures must be precertified and are subject to Continued Stay Review (CSR). A penalty applies to admissions which are not precertified. Non-approved admissions/days result in denial of benefits. The precertification penalty or cost of denied benefits does not apply to deductible or out-of-pocket maximum.

## Case Management

Coordinated by CIGNA HealthCare. This is a service designed to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

## Benefit Exclusions.

These are examples of the exclusions in your plan. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control.

1. Any service or supply not described as covered in the Covered Expenses section of the plan.
2. Any medical service or device that is not medically necessary.
3. Treatment of an illness or injury which is due to war or care for military service disabilities treatable through governmental services.
4. Any services and supplies for or in connection with experimental, investigational or unproven services.
5. Treatment of TMJ disorder.
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 plan.
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 provided under the Home Health Services 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 plan.
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. Expenses incurred for medical treatment by a person age 65 or older, who is covered under the plan as a retiree, or his dependent, when payment is denied by the Medicare plan because treatment was not received from a participating provider of the Medicare plan.
27. Expenses incurred for medical treatment when payment is denied by the primary plan because treatment was not received from a participating provider of the primary plan.
28. 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; Redundant Skin Surgery; Removal of Skin Tags; Acupressure; Craniosacral/cranial therapy; Dance Therapy, Movement Therapy; Applied Kinesiology; Rolfing; 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.

**These Are Only the Highlights**

*As you can see, the plan is designed to combine in-depth coverage with cost-effective prices. This summary contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations including legislated benefits are contained in the Summary Plan Description or Insurance Certificate. This plan is insured and/or administered by Connecticut General Life Insurance Company, a CIGNA Company.*

*“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.*