

# SUMMARY OF BENEFITS

*Your CIGNA HealthCare Open Access Plus In-Network 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.

**For Employees of  
Salus Rehabilitation, LLC  
Open Access Plus In - Network - Value  
Plan**

BENEFIT INFORMATION	IN-NETWORK
<b>Calendar Year Plan Deductible</b> <i>Individual</i> <i>Family Maximum</i>	\$600 \$1,800
<b>Calendar Year Out-of-Pocket Maximum</b> <i>Individual</i> <i>Family Maximum</i>	<i>Excluding Plan Deductible</i> \$3,500 \$10,500
<b>Coinsurance</b>	CIGNA HealthCare pays 80% of eligible charges. You pay 20% of charges after plan deductible.
<b>Precertification -Inpatient – PHS+ (required for all inpatient admissions)</b>  <b>Precertification – Outpatient – PHS+ (required for selected outpatient procedures and diagnostic testing or outpatient services)</b>	Coordinated by your physician  Coordinated by your physician
<b>Annual Maximum</b>	\$100,000
<b>Lifetime Maximum</b>	\$500,000
<b>Pre-existing Condition Limitation</b>	Yes
<b>Physician Services</b> <b>Primary Care Physician (PCP) Office Visit</b>  <b>Specialty Care Physician Office Visit</b> <i>Consultant and Referral Physician Services</i>  <u>Note:</u> 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.  <i>Allergy Treatment/Injections - PCP or Specialist Physician</i>  <i>Allergy Serum (dispensed by physician in office)</i>  <i>Second Opinion Consultations (provided on voluntary basis)</i>  <i>Surgery Performed in the Physician’s Office- PCP or Specialist Physician</i>	\$30 copayment per office visit; No charge if only x-ray and/or lab services are performed and billed.  \$45 copayment per office visit; No charge if only x-ray and/or lab services are performed and billed.    \$30 or \$45 copayment per office visit or actual charge, whichever is less  No charge  \$30 or \$45 copayment per office visit  \$30 or \$45 copayment per office visit
<b>Preventive Care</b> <i>Routine Preventive Care for Children through age 2 (including routine immunizations)</i>  <i>Immunizations</i>  <i>Routine Preventive Care for Children and Adults from age 3 (including routine immunizations)</i> <b>One per calendar year</b>  <i>Immunizations</i>	\$20 copayment per office visit; No charge if only x-ray and/or lab services are performed and billed.  No charge, no plan deductible  \$20 copayment per office visit; No charge if only x-ray and/or lab services are performed and billed  No charge, no plan deductible
<b>Mammograms, PSA, Pap Test</b> (only one preventive test per calendar year)  <u>Note:</u> Preventive care related services and diagnostic related services are paid at the same level of benefits as other x-ray and lab service, based on place of service.	No charge if billed by independent diagnostic facility or outpatient hospital \$20 copayment per visit for associated wellness exam

BENEFIT HIGHLIGHTS	IN-NETWORK
<b>Inpatient Hospital Services including:</b> <i>Semi-Private Room and Board</i> <i>Diagnostic/Therapeutic Lab and X-ray</i> <i>Drugs and Medication</i> <i>Operating and Recovery Room</i> <i>Radiation Therapy and Chemotherapy</i> <i>Anesthesia and Inhalation Therapy</i>	\$300 copayment per day up to 5 days per admission, plus 20% of charges*
<b>Inpatient Hospital Doctor's Visits/Consultations</b> <i>Inpatient Hospital Professional Services</i>	No charge No charge
<b>Outpatient Facility Services includes:</b> <i>Operating Room, Recovery Room, Procedure Room and Treatment Room and Observation Room including:</i> <i>Diagnostic/Therapeutic Lab and X-rays</i> <i>Anesthesia and Inhalation Therapy</i> <i>Physician &amp; Outpatient Professional Services</i> <b>Note:</b> <i>Non-surgical treatment procedures are not subject to the facility copay.</i>	\$250 copayment per facility visit, plus 20% of charges  No charge
<b>Laboratory and Radiology Services (includes preadmission testing)</b> <i>Physician's Office</i> <i>Outpatient Hospital Facility</i> <i>Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit)</i>  <i>Independent X-Ray and/or Lab Facility</i> <i>Independent X-Ray and/or Lab Facility (in conjunction with an Emergency Room visit)</i>	No charge 20% of charges* No charge  No charge No charge
<b>Advanced Radiological Imaging (MRIs, MRAs, CAT Scans, PET Scans, etc.)</b> <i>Inpatient Facility</i>  <i>Outpatient Facility</i>  <i>Emergency Room (billed by facility as part of the Emergency Room visit)</i>  <i>Physician's Office</i>	20% of charges*  20% of charges*  No charge  No charge
<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> <i>therapy sessions provided as part of Home Health Care accumulate to the Short-Term Rehab Therapy maximum.</i>	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.
<b>Emergency and Urgent Care Services</b> <i>Physician's Office – PCP or Specialist Physician</i>  <i>Hospital Emergency Room</i>  <i>Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician)</i>  <i>Urgent Care Facility or Outpatient Facility</i>  <i>Ambulance</i>	\$30 or \$45 copayment per office visit; No charge if only x-ray and/or lab services are performed and billed.  \$300 copayment per visit, plus 20% of charges *( <i>copay waived if admitted</i> )  No charge  \$45 copayment per visit ( <i>copay waived if admitted</i> )  No charge

BENEFIT HIGHLIGHTS	IN-NETWORK
<p><b>Maternity Care Services</b>  <i>Initial Office Visit to Confirm Pregnancy</i>  <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 Specialist 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><b>Inpatient Services at Other Health Care Facilities Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities</b>  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><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><b>Family Planning Services</b>  <i>Office Visits (lab &amp; radiology tests, counseling)</i></p> <p><b>Vasectomy/Tubal Ligation (excludes reversals)</b>  Inpatient Facility</p> <p>Outpatient Facility  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><b>Infertility Services</b>  <i>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.</i></p>	<p>Not covered</p>
<p><b>TMJ – Surgical and Non-Surgical</b></p>	<p>Not covered</p>
<p><b>Mental Health and Substance Abuse</b>  <b>Inpatient</b> - 10 days combined maximum per calendar year for inpatient Mental Health and inpatient Substance Abuse</p> <p><b>Mental Health</b>  <b>Acute:</b> Based on a ratio of 1:1  <b>Partial:</b> Based on a ratio of 2:1  <b>Residential:</b> Based on a ratio of 2:1</p> <p><b>Substance Abuse</b>  <b>Acute Detox:</b> Based on a ratio of 1:1 (requires 24 hour nursing)  <b>Acute Inpatient Rehab:</b> Based on a ratio of 1:1 (requires 24 hour nursing)  <b>Partial:</b> Based on a ratio of 2:1  <b>Residential:</b> Based on a ratio of 2:1</p> <p><b>Outpatient-Individual</b> – 25 visits maximum per calendar year for outpatient Mental Health and outpatient Substance Abuse</p> <p><b>Group Therapy-Mental Health</b> – combined maximum with Outpatient Individual Mental Health services based on a ratio of 1:1</p> <p><b>Intensive Outpatient Mental Health &amp; Substance Abuse</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*</p> <p>\$45 copayment per office visit</p> <p>\$15 copayment per office session</p> <p>\$50 per program copayment*</p>



## Benefit Exclusions: (continued)

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.*