

# CIGNA Health Benefit Plans

Open Access Plus

CALLIFORNIA  
Small Group Business



# Open Access Plan

# CALIFORNIA

## for Your Small Businesses

### 50 or fewer employees

Your employees and their families deserve the same kind of protection available to large employer groups. CIGNA HealthCare offers an Open Access Plan to small businesses, combining comprehensive coverage with quality care and cost-saving advantages.

CIGNA HealthCare's simple solutions for a healthy partnership meet your needs for quality, cost and convenience, while providing value-added benefits and services:

Employers can take advantage of accessibility, choice and cost control. Wellness features, internet self-service through myCIGNA.com, and 24-hour worldwide emergency coverage are available to members. Open Access Plus includes such features as:

- Optional PCP selection – member's choice. No referrals required.
- Quality medical management.
- The Open Access benefit plan allows for an array of member cost-share options – copayments, deductibles and coinsurance.
- Seamless administration with a single point of contact for member services, including claims and inquiry.
- Take advantage of preventive care, health education and wellness programs regularly offered to members.

### CIGNA HealthCare of California, Inc. Eligibility

<b>GROUP SIZE:</b>	2 – 50 eligible employees.*
<b>EMPLOYEE ELIGIBILITY:</b>	A minimum work week of 20 hours.
<b>PROPOSAL REQUESTS:</b>	Please submit the request for proposal, medical history and census form for a quote to be generated.
<b>EFFECTIVE DATES:</b>	The first of the month.
<b>RATE RENEWALS:</b>	Rates are guaranteed for one year from the effective date to the renewal date.
<b>CONTRIBUTION/PARTICIPATION REQUIREMENTS</b>	An employer who contributes a minimum of 50% of the eligible employees' health premiums must have a minimum of 70% of full-time, eligible employees enroll. If an employer contributes 100% of the eligible employees' premiums, 100% of the full-time, eligible employees must enroll.



**THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.**

BENEFIT	OPEN ACCESS PLUS	
	OAP PLAN*	
	IN-NETWORK	OUT-OF-NETWORK
<b>Deductible (Annual)</b>	\$1,000/\$2,000	\$3,000/\$6,000
<b>Lifetime Maximum</b>	\$5,000,000	\$5,000,000
<b>Professional Services</b> – Office PCP/Specialist Visits, Preventive Care, Well Child Care – Prenatal Exams (after initial diagnosis) – Routine Immunizations – Laboratory and X-Ray – Advanced Imaging (MRI, MRA, CAT and PET Scans)	\$25/\$50 copay per visit 80% after deductible No charge \$25/\$50 copay per visit 80% after deductible and \$150 per procedure copay	50% after deductible 50% after deductible 50% after deductible 50% after deductible 50% after deductible and \$300 per procedure copay
<b>Outpatient Services</b> – Physician or Surgeon – Operating and Recovery Room	80% after deductible 80% after deductible	50% after deductible 50% after deductible
<b>Hospitalization Services</b>	80% after deductible	50% after deductible
<b>Emergency Health Coverage</b> – Participating or Non-Participating Physician's Office – Hospital Emergency Room – Outpatient Facility or Urgent Care Facility	\$25/\$50 copay per visit \$150 copay per visit after deductible \$75 copay per visit after deductible	\$25/\$50 copay per visit \$150 copay per visit after deductible \$75 copay per visit after deductible
<b>Ambulance Services</b>	80% after deductible	80% after deductible
<b>Prescription Drug Coverage (Limited to 30-day supply)</b> – Generic Drugs** – Brand Name Drugs** – Non-Formulary Drugs**	\$15 \$30 \$45	Network coverage only Network coverage only Network coverage only
<b>Durable Medical Equipment (\$700 combined max.)</b>	80% after deductible	50% after deductible
<b>Mental Health and Substance Abuse</b> – Inpatient Mental Health Services (25 combined days with SA) – Outpatient Mental Health Services – Outpatient Therapy (20 combined visits with SA) – Group Therapy (20 combined visits with outpatient therapy)	80% after deductible and \$250 copay \$50 copay \$25 copay	50% after deductible and \$250 copay 50% after deductible 50% after deductible
<b>Severe Mental Illness of a Member of Any Age and Serious Emotional Disturbances of a Child</b> – Professional Services – Hospital Services	\$25/\$50 copay per visit 80% after deductible	50% after deductible 50% after deductible
<b>Substance Abuse Services</b> – Inpatient Substance Abuse Services (25 combined days with MH) – Outpatient Substance Abuse Therapy (20 combined visits with MH)	80% after deductible and \$250 copay \$50 copay	50% after deductible and \$250 copay 50% after deductible
<b>Home Health Services<sup>1</sup></b>	80% after \$50 deductible	80% after \$50 deductible
<b>Other Health Care Facilities<sup>2</sup></b> – Skilled Nursing and Rehabilitation	80% after deductible	50% after deductible
<b>Outpatient Rehabilitation Therapy<sup>3</sup></b>	\$25/\$50 copay per visit	50% after deductible
<b>Family Planning – Limited Benefit</b>	80% after deductible	50% after deductible
<b>Out-of-Pocket Maximum – Individual/Family (Annual)</b>	\$5,000/\$10,000	\$10,000/\$20,000
<b>Infertility Treatment Option</b>	Benefit is available by purchasing additional rider.	

\* Infertility benefits are not included.

\*\* Contraceptives included.

<sup>1</sup> Home Health Services has a 100-visit combined maximum.

<sup>2</sup> Other Health Care Facilities has a combined 60-day maximum.

<sup>3</sup> Outpatient Rehabilitation Therapy has a combined 20-day maximum.

## DISCLOSURE

Premiums charged to the group and its employees may vary by as much as 10% above or below standard rates, depending upon the existence of certain factors that would be expected to result in a group deviating from the standard cost of services. The factors, together called "the risk adjustment factor," include, but are not limited to, the medical history of the group, type of industry, and employee turnover.

**RATE CHANGE PROVISIONS** – CIGNA HealthCare's medical insurance policy allows CIGNA HealthCare to change your premium rates every 12 months. These rate adjustments may occur as the result of changes CIGNA HealthCare may make to its standard employee risk rates or changes CIGNA HealthCare may make to your group-specific risk adjustment factor. However, CIGNA HealthCare may adjust rates earlier if CIGNA HealthCare determines its liability is altered by any change relating to benefits provided under the policy due to state or federal law or by a revision in the insurance coverage under the policy. Any such change in rates will take effect on the effective date of the change in law or change in the insurance coverage. CIGNA HealthCare will notify you of any annual rate change 31 days prior to the effective date of the new premium rates. If a state-mandated benefit is added to your policy, CIGNA HealthCare will alert you and provide you with as much advance notice as possible.

**RENEWABILITY** – CIGNA HealthCare's policy is renewable at your option. Coverage will not be denied to a group because of the health status or claims experience of the group or any member of the group. However, during the term of the group policy, CIGNA HealthCare may terminate your group coverage if you do not pay the required premiums within 31 days of the premium due date or for non-compliance with other plan provisions. Also, at your renewal date, if your group fails to qualify as a small employer as defined under state law, CIGNA HealthCare may refuse to renew your policy. CIGNA HealthCare, following state notification requirements, can choose to change or eliminate plan options. Should that occur, additional plan options will be available to you only if specified requirements of the existing plans are met; i.e., residing within the service area.

**PRE-EXISTING CONDITION LIMITATION PROVISIONS** – Pre-existing Conditions, as determined by CIGNA HealthCare until the Member has been covered under the Group Service Agreement for six months (including the Member's eligibility waiting period).

A pre-existing condition is any condition for which medical advice, diagnosis, care or treatment was recommended or received for that condition during the six-month period immediately preceding the effective date of the Member's coverage.

■ If a Member was previously covered under another substantially similar group or individual plan or self-insured plan, including any state or federally required continuation of coverage, the following will apply, provided: (a) Member notified CIGNA HealthCare of such prior coverage; (b) no more than 63 days have elapsed between coverage under the prior plan and eligibility for coverage under this plan, exclusive of any waiting periods; and (c) Member applies for coverage under this plan within the applicable enrollment period:

■ If the Member has satisfied a waiting period for any Pre-existing Condition under the prior plan, the Pre-existing Condition limitation under this Agreement will be waived.

■ If the Member has partially satisfied a waiting period for any Pre-existing Condition under the prior plan, Member will be given credit under this Agreement's Pre-existing condition limitation for that period of time under this Agreement.

The elapsed time between the prior coverage and this coverage for the purpose of applying for credit for a Pre-existing Condition will be extended to one-hundred and eighty (180) days, if one of the following applies: (a) a Member's employment has ended; (b) the employer-sponsored health benefit plan is terminated; or (c) the employer's contributions cease.

**PLAN AVAILABILITY** – Each plan offered by CIGNA HealthCare to the small employer market in California is available to all small employers. A listing of CIGNA HealthCare's small employer plans and rates is provided in the summary brochure. Standard Filed Rates are included with all requests for proposal.

## General Exclusions and Limitations

■ Any services that are not Medically Necessary.

■ Care for military service disabilities treatable through governmental services if the Member is legally entitled to such treatment and facilities are reasonably available.

■ Services or articles for custodial or self-care activities, homemaker services and services designed primarily to assist in activities of daily living, except for such services that are required to be provided under Hospice Care Services.

■ Cosmetic therapy or surgical procedures primarily for the purpose of altering or reshaping normal structures in order to improve appearance.

■ All medical and surgical services for the treatment or control of obesity, unless Medically Necessary.

■ Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalizations not required for health reasons.

■ Court-ordered treatment or hospitalization, unless such order is being sought by a Participating Physician or unless otherwise covered under this plan.

■ Treatment for mandibular or maxillary prognathism, micrognathism or malocclusion, or surgical augmentation for orthodontics, or maxillary constriction. Medically Necessary treatment of orthognathic problems, which may include TMJ disorder, shall not be excluded.

■ Dental treatment of the teeth or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion.

■ Reversal of voluntary sterilization procedures.

■ Infertility services, Infertility drugs (oral and injectable), in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and variations of these procedures. Infertility rider is excluded.

■ Transsexual surgery (including medical or psychological counseling except as provided under Severe Mental Illness of a Member of any Age and Serious Emotional Disturbances of a Child, and hormonal therapy in preparation for, or subsequent to, any such surgery).

■ Penile implants unless Medically Necessary.

■ Medical and hospital care and costs for the infant child of a dependent, unless this infant child is otherwise eligible under the Group Benefits Certificate.

■ Non-medical ancillary services such as vocational rehabilitation, behavioral training, sleep therapy, employment counseling, psychological counseling and training or educational therapy for learning disabilities, development delays or mental retardation, except as provided under Severe Mental Illness of a Member of any Age and Serious Emotional Disturbances of a Child.

■ Therapy to improve general physical condition, including, but not limited to, cardiac rehabilitation and pulmonary rehabilitation programs, and any rehabilitative therapy. Medically Necessary rehabilitative therapy, including physical, speech and occupational therapy, is provided on an inpatient or outpatient basis.

■ Private hospital rooms and/or private duty nursing unless determined to be Medically Necessary.

■ Personal or comfort items.

■ Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.

■ Adjustment or manipulation of the spine except as provided under "Rehabilitation Therapy."

■ All non-prescription investigational and experimental drugs and devices.

■ Routine foot care unless Medically Necessary.

■ Membership costs or fees associated with health clubs and weight loss clinics.

■ Amniocentesis, ultrasound, or any other procedures requested solely for sex determination of a fetus.

■ Cost of immunizations or medications for the purpose of travel, or for protection against occupational hazards and risks.

■ Cosmetics, health and beauty aids, dietary supplements, and nutritional formulas except Medically Necessary formulas and special food products for the treatment of phenylketonuria (PKU).

**LIMITATIONS** – Circumstances beyond CIGNA HealthCare's control. To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within the control of CIGNA HealthCare results in the facilities, or personnel being unavailable to provide or arrange for the provisions of a basic or supplemental health service or supplies in accordance with the Agreement, CIGNA HealthCare will make a good faith effort to provide or arrange for the provision of the services and supplies, taking into account the impact of the event. Under these extreme circumstances, the Member is advised to seek Emergency Services at the nearest emergency facility. The Healthplan will provide coverage and reimbursement as described in the Emergency Services and Urgent Care Section of the Agreement.

*NOTE: This information provides highlights. For a complete listing of Exclusions and Limitations, please refer to your Group Benefits Certificate.*

This is only a partial listing of benefits; for a detailed summary of benefits, please refer to your Group Benefits Certificate.

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