

CIGNA Health Benefit Plans

POS

CALLIFORNIA
Small Group Business



POS 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 a POS 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:

- Select your own primary care physician from a statewide network of over 38,700 primary and specialty care physicians
- Receive coverage from CIGNA HealthCare of California, Inc. which is accredited by the National Committee for Quality Assurance (NCQA)
- Take advantage of preventive care, health education and wellness programs regularly offered to members

CIGNA HealthCare of California, Inc. Eligibility

- GROUP SIZE:** 2 – 50 eligible employees.*
- EMPLOYEE ELIGIBILITY:** A minimum work week of 20 hours.
- PROPOSAL REQUESTS:** Please submit the request for proposal, medical history and census form for a quote to be generated.
- EFFECTIVE DATES:** The first of the month.
- RATE RENEWALS:** Rates are guaranteed for one year from the effective date to the renewal date.
- CONTRIBUTION/PARTICIPATION REQUIREMENTS** 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	POS	
	POS PLAN*	
	IN-NETWORK	OUT-OF-NETWORK
Deductible (Annual)	N/A	\$1,000/\$2,000
Lifetime Maximum	Unlimited	\$1,000,000
Professional Services – Office PCP/Specialist Visits, Preventive Care, Well Child Care ¹ – Prenatal Exams (after initial diagnosis) – Routine Immunizations – Laboratory and X-Ray – Advanced Imaging (MRI, MRA, CAT and PET Scans)	\$15/\$25 copay per visit No charge No charge No charge No charge after \$100 per procedure copay	60% after deductible 60% after deductible Not covered 60% after deductible \$200/procedure ded., then 60% after plan ded.
Outpatient Services – Physician or Surgeon – Operating and Recovery Room	No charge No charge after \$150 per visit copay	60% after deductible 60% after \$300 per visit deductible
Hospitalization Services	No charge after \$150 per day copay (up to 5 copays per admission)	60% after \$300 per day deductible and plan deductible (up to 5 copays per admission)
Emergency Health Coverage – Participating or Non-Participating Physician's Office – Hospital Emergency Room ² – Outpatient Facility or Urgent Care Facility	\$15/\$25 copay per visit No charge after \$100 per visit copay No charge after \$50 per visit copay	\$15/\$25 copay per visit No charge after \$100 per visit copay No charge after \$50 per visit copay
Ambulance Services	No charge	No charge
Prescription Drug Coverage (Limited to 30-day supply)³ – Generic Drugs** – Medically Necessary Name Brand Formulary (including supplies for the management and treatment of pediatric asthma) and Medically Necessary non-Formulary drugs** – Non-Medically Necessary Name Brand Formulary and Non-Medically Necessary non-Formulary drugs**	\$10 \$20 \$40	Not covered
Durable Medical Equipment	No charge up to \$3,500 maximum	Not covered
Mental Health Services – Inpatient Mental Health Services – Outpatient MH/SA – Outpatient Therapy – Group Therapy	\$100 copay per day (max. 8 copays/contract year combined with Substance Abuse Outpatient MH) \$40 copay per 20 visits \$20 copay/40 visits combined w/Substance Abuse	60% after deductible (up to 8 days/contract year for MH/SA combined) 60% after deductible to 20 visit combined max. 60% after deductible to 40 visit combined max.
Severe Mental Illness of a Member of Any Age and Serious Emotional Disturbances of a Child – Professional Services – Hospital Services	\$15/\$25 copay per visit No charge after \$150 copay (up to 5 copays per admission)	60% after deductible 60% after \$300 per day deductible and plan deductible (up to 5 copays per admission)
Chemical Dependency Services – Inpatient Substance Abuse Services – Outpatient Substance Abuse Therapy	\$100 copay per day (maximum of 8 days per contract year combined with MH) \$15 first 2 visits; \$40 next 3-20 visits	60% after deductible (up to 8 days per contract year for MH/SA combined) 60% after deductible to 20 visit combined max.
Home Health Services	No charge (100 day maximum)	60% after deductible, maximum 40 days, reduced by any in network visits
Other Health Care Facilities – Skilled Nursing and Rehabilitation	No charge (100 day maximum)	60% after deductible, maximum 40 days per year, reduced by any in network days
Outpatient Rehabilitation Therapy	\$15/\$25 copay per visit	60% after deductible, 20 visit maximum per year
Family Planning – Limited Benefit	\$15/\$25 copay per visit	60% after deductible
Out-of-Pocket Maximum – Individual/Family (Annual)	\$1,500/\$3,000	\$3,000/\$6,000
Infertility Treatment Option	Benefit is available by purchasing additional rider.	

* Infertility benefits are not included.

** Contraceptives included.

¹ Your PCP copay is the lower dollar amount.

² Copay waived if admitted.

³ This Rx plan uses an incentive formulary.

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. If you believe that the reason for your termination was your health status or requirements for health care services, you may request a review of this termination by the Director of the Department of Managed Health Care (DMHC). You must submit your request for review to the Director in writing. For more information, contact the HMO Help Center at 1-888-HMO-2219 or the Department's Website at www.hmoHELP.ca.gov. 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 health conditions that are required by state or local law to be treated in a public facility; provided, however, that this exclusion shall not operate to exclude coverage for services provided to a Member confined in a city or county jail or in a juvenile facility, solely because of such confinement, or for services provided to a Member while confined in a state hospital, solely because the services were provided in a state hospital.

■ 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.

■ Except as provided under CIGNA's Independent Review Process for Experimental and Investigational Therapies, medical, surgical or other health care procedures and treatments that are experimental or investigational.

■ 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 the "Services and Benefits" Section.

■ 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 Service Agreement or 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: In-Network – your Group Service Agreement; Out-of-Network – your Group Benefits Certificate.

This is only a partial listing of benefits; for a detailed summary of benefits, please refer to your Group Service Agreement and Certification Booklet for Out-of-Network benefits.

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