

This is a summary of benefits for your Open Access Plus plan. All deductibles and plan out-of-pocket maximums accumulate in one direction toward in-network unless otherwise noted. Plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between in- and out-of-network unless otherwise noted. Pharmacy plan deductibles, out-of-pocket maximums, copays and annual maximums do not integrate with the employer medical program.

CIGNA HealthCare Benefit Summary
North Carolina Small Group OAP Plan A
Open Access Plus Copay Plan

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	\$2,000,000	\$2,000,000
Coinsurance Levels	80%	60% of Maximum Reimbursable Charge
Calendar Year Deductible		
<i>Individual</i>	\$1,500 per person	\$3,000 per person
<i>Family Maximum</i>	\$3,000 per family	\$6,000 per family
Out-of-Pocket Maximum		
<i>Individual</i>	\$4,000 per person	\$8,000 per person
<i>Family Maximum</i>	\$8,000 per family	\$16,000 per family
Physician's Services		
<i>Primary Care Physician's Office visit</i>	Non-compliance penalties, deductibles, copays or charges for mental health, alcohol and drug abuse benefits do not accumulate towards the out of pocket. No charge after \$25 PCP per office visit copay	Non-compliance penalties, deductibles, copays or charges for mental health, alcohol and drug abuse benefits do not accumulate towards the out of pocket. 60% after plan deductible
<i>Specialty Care Physician's Office Visit</i> <i>Office Visits</i> <i>Consultant and Referral Physician's Services</i>	No charge after \$50 Specialist per office visit copay	60% after plan deductible
Preventive Care		
<i>Routine Preventive Care for children through age 2 (including immunization)</i>	No charge after PCP or Specialist per office visit copay.	60% after plan deductible
<i>Immunizations</i>	No charge; no plan deductible	60% after plan deductible
<i>Routine Preventive Care for children and adults from age 3; subject to a \$250 maximum per calendar year (including routine immunization)</i>	No charge after the PCP or Specialist per office visit copay	60% after plan deductible
<i>Immunizations</i>	No charge; no plan deductible	60% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Mammograms, PSA, Pap Smear	80% after plan deductible if billed by an independent diagnostic facility or outpatient hospital. Note: the associated wellness exam will be covered at no charge after the PCP or Specialist per visit copay.	60% after plan deductible
Inpatient Hospital - Facility and Professional Services <i>Semi Private Room and Board</i> <i>Private Room</i> <i>Special Care Units (ICU/CCU)</i>	80% after plan deductible Limited to semi-private room negotiated rate Limited to semi-private room negotiated rate Limited to negotiated rate	60% after plan deductible Precertification required Limited to semi-private room rate Limited to semi-private room rate Limited ICU/CCU daily room rate
Outpatient Facility and Professional Services <i>Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room</i>	80% after plan deductible	60% after plan deductible
Emergency and Urgent Care Services <i>Hospital Emergency Room</i> <i>Urgent Care Facility or Outpatient Facility</i>	No charge after plan deductible and \$150 per visit copay* No charge after plan deductible and \$75 per visit copay* *waived if admitted	No charge after plan deductible and \$150 per visit copay* (except if not a true emergency, then 60% after plan deductible) No charge after plan deductible and \$75 per visit copay* (except if not a true emergency, then 60% after plan deductible) *waived if admitted
Inpatient Services at Other Health Care Facilities <i>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</i> 60 days combined maximum per calendar year	80% after plan deductible	60% after plan deductible
Laboratory and Radiology Services <i>(includes pre-admission testing)</i> Advanced Radiological Imaging <i>(i.e. MRI's, CAT Scans and PET Scans)</i> Other Laboratory and Radiology Services <i>Physician's Office</i> <i>Outpatient Hospital Facility</i>	80% after \$100 per procedure copay and plan deductible No charge after PCP or Specialist per visit copay 80% after plan deductible	60% after \$200 per procedure copay and plan deductible 60% after plan deductible 60% after plan deductible
<i>Independent X-ray and/or Lab facility</i>	80% after plan deductible	60% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Outpatient Short-Term Rehabilitative Therapy and Chiropractic Services 20 days combined maximum per calendar year</p> <p>Includes:</p> <ul style="list-style-type: none"> Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Chiropractic Therapy (includes Chiropractors) Pulmonary Rehab Cognitive Therapy 	No charge after PCP or Specialist per office visit copay.	60% after plan deductible
<p>Home Health Care 60 days maximum per calendar year (includes outpatient private duty nursing when approved as medically necessary)</p>	80% after plan deductible	60% after plan deductible
<p>Organ Transplant <i>Includes all medically appropriate, non-experimental transplants</i></p> <p><i>Travel Services Maximum- only available for Lifesource facilities</i></p>	100% at Lifesource center , otherwise 80% after plan deductible \$10,000	60% after plan deductible 10,000 combined with network
<p>Infertility Treatment <i>Services not covered include:</i></p> <ul style="list-style-type: none"> • <i>Testing performed specifically to determine the cause of infertility.</i> • <i>Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).</i> • <i>Artificial means of becoming pregnant are (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc).</i> <p>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>	Not Covered	Not Covered
<p>External Prosthetic Appliances \$1,000 maximum per calendar year Separate \$200 per calendar year EPA deductible</p>	80% after plan deductible	60% after plan deductible
<p>Durable Medical Equipment \$700 maximum per year</p>	80% after plan deductible	60% after plan deductible



BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Prescription Drugs CIGNA PharmacyPlus Retail Drug Program <i>Includes oral contraceptives and contraceptive devices</i>	\$20 per 30-day supply for generic drugs \$40 per 30-day supply for preferred brand-name drugs \$60 per 30-day supply for non-preferred brand-name drugs	In-network coverage only
CIGNA Tel-Drug Mail Order Drug Program <i>Includes oral contraceptives and contraceptive devices</i>	\$40 per 90-day supply for generic drugs \$80 per 90-day supply for preferred brand-name drugs \$120 per 90-day supply for non-preferred brand-name drugs	In-network coverage only
Mental Health and Substance Abuse (Combined) <i>Inpatient</i> <i>Outpatient</i> <i>Outpatient Group Therapy Mental Health (One group therapy session equals one individual therapy session)</i> <i>Intensive Outpatient</i> <i>Maximum: up to 3 programs per calendar year</i> <i>Based on a ratio of 1:1</i>	80% after plan deductible after \$200 per admission copay and plan deductible 25 days combined maximum per calendar year No charge after \$50 per visit copay; 20 visits combined maximum per calendar year No charge after \$25 per visit copay 80% after \$100 per program copay	60% after \$200 per admission deductible and plan deductible; 25 days combined maximum per calendar year 60% after plan deductible; 20 visits combined maximum per calendar year Subject to the same coinsurance and medical plan deductible as Outpatient MH visits 60% after \$100 per program deductible
Pre-existing Condition Limitation (PCL)	Applies to any injury or sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a physician during the 90 days before the earlier of the date a person begins an eligibility waiting period or becomes insured for these benefits. Coverage for the pre-existing condition is excluded until one year of being continuously insured and/or is satisfying a waiting period.	
Pre-Admission Certification - Continued Stay Review		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><i>Inpatient Pre-Admission Certification - Continued Stay Review</i> (required for all inpatient admissions)</p>	<p>Coordinated by Provider/PCP</p>	<p>Mandatory: Employee is responsible for contacting CIGNA Healthcare. Penalties for non-compliance:</p> <ul style="list-style-type: none"> - 50% penalty applied to hospital inpatient charges for failure to contact CIGNA Healthcare to precertify admission. - Benefits are denied for any admission reviewed by CIGNA Healthcare and not certified. - Benefits are denied for any additional days not certified by CIGNA Healthcare.
<p><i>Outpatient Prior Authorization</i> (required for selected outpatient procedures and diagnostic testing).</p>	<p>Coordinated by Provider/PCP</p>	<p>Mandatory: Employee is responsible for contacting CIGNA Healthcare. Penalties for non-compliance:</p> <ul style="list-style-type: none"> - 50% penalty applied to outpatient procedures/diagnostic testing charges for failure to contact CIGNA Healthcare to precertify. - Benefits are denied for any outpatient procedures/diagnostic testing reviewed by CIGNA Healthcare and not certified.

This Benefit Summary highlights some of the benefits available under your plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your Group Service Agreement or Certificate.

Benefits are insured and/or administered by Connecticut General Life Insurance Company.

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