

# SUMMARY OF BENEFITS

## Your CIGNA HealthCare Point-of-Service Open Access plan



CIGNA HealthCare

### Features that Add Value

- The **convenience of referral-free access to participating specialty physicians, and...**
- The **option of selecting a personal Primary Care Physician (PCP)** who is your source for routine care and for guidance when you need more than routine care.
- 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®** includes special offers on health and wellness programs and services often not covered by traditional benefit plans. To learn more, 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
  - 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.
- **We Speak Many Languages<sup>SM</sup>**. We offer the Language Line Services so that you can **talk with us** in 140 different languages. Just call Member Services, and ask for an interpreter to assist you.

### It's Your Health

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

- **Preventive care services** for every covered family member.
- **Your PCP can serve as your first contact** for care, advice and direction. He/she will recommend specialists and coordinate follow-up care. And, when you need to see a **participating specialist – no referral is required. Just make the appointment and go!**
- CIGNA Well Aware for Better Health<sup>SM</sup> can **help you manage** chronic conditions like asthma, diabetes or cardiac care.
- The CIGNA HealthCare Healthy Babies® program provides you with education and support to help you have a **healthy pregnancy and a healthy baby**. And there's no copayment for prenatal care office visits after the first visit that confirms you're pregnant.

### You Can Depend on CIGNA HealthCare

- **Quality comes first**. We select participating providers carefully. And we make sure you have a **wide range** of PCPs and specialists to choose from.
- We're **highly rated** by **independent evaluators** of quality, including the National Committee for Quality Assurance (NCQA).
- **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 you pay a lower copayment.

### It's Your Choice

When your PCP coordinates your care and 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 highest when you see participating providers, but you're still covered for visits to other providers.

*South Carolina Open Access POS Plan 10*

*CIGNA HealthCare of South Carolina, Inc.*

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<b>Primary Care Physician (PCP) Office Visit</b> <i>Preventive Care</i> <i>Well Child Care</i> <i>Periodic Physical Exams (Children and Adults)</i> <i>Routine Immunizations</i>  <i>Adult/Child Medical Care for Illness or Injury</i> <i>Surgery performed in a Physician's Office</i>	\$25 copayment per office visit  The office visit Copayment will be waived when immunization is the only service provided	Covered in-network only Covered in-network only  Covered in-network only  50% of charges* 50% of charges*
<b>Specialty Physician Office Visit</b> <i>Office Visits</i> <i>Surgery Performed in Physician's Office</i>	\$50 copayment per office visit	50% of charges*
<b>Inpatient Hospital Services</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> <i>Physician and Surgeon Services</i>	30% of charges per admission**       30% of charges**	50% of charges* Precertification applies       50% of charges*
<b>Outpatient Facility Services</b> <i>Operating Room, Recovery Room, Procedure Room and Treatment Room including:</i> <i>Diagnostic/Therapeutic Lab and X-rays</i> <i>Anesthesia and Inhalation Therapy</i> <i>Physician Services</i>	30% of charges per facility use**   30% of charges** 30% of charges** 30% of charges**	50% of charges*   Precertification applies  50% of charges*
<b>Laboratory and Radiology Services</b> <i>Advanced Radiological Imaging (MRIs, MRAs, CAT Scans and PET Scans)</i> <i>Other Laboratory and Radiology Services</i> <i>Outpatient hospital Facility</i> <i>Independent X-ray/Lab Facility</i>	\$200 copayment per procedure   30% of charges** No charge	\$400 Deductible per office visit, plus 50% of charges*   50% of charges* 50% of charges*
<b>Short-Term Rehabilitative Therapy and Chiropractic Services</b>	\$50 copayment per office visit <i>20 visits maximum per contract year</i>	50% of charges* <i>20 visits maximum per contract year#</i>
<b>Prescription Drugs</b> <b>CIGNA Pharmacy Plus Retail Drug Program</b> (Generic Push, Incentive Formulary Plan) <i>Includes oral contraceptives and devices, prenatal vitamins and diabetic supplies (lancets, glucose test strips and insulin syringes)</i> <b>Tel-Drug Rx Mail Order Drug Program</b>   <b>Pharmacy Deductible (Individual/Family)(Mail Order excl.)</b> <b>Pharmacy Out of Pocket Maximum (Individual/Family)</b>	\$15 per 30-day supply for generic drugs \$35 per 30-day supply for preferred brand name drugs \$60 per 30-day supply for non-preferred brand name drugs  \$30 per 90-day supply for generic drugs \$70 per 90-day supply for preferred brand name drugs \$120 per 90-day supply for non-preferred brand name drugs  None/None None/None	Covered in-network only       Covered in-network only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><b>Emergency and Urgent Care Services</b> <i>Physician's Office</i></p> <p><i>Hospital Emergency Room</i> <i>Participating Urgent Care Facility or Hospital Outpatient Facility</i> <i>Ambulance</i></p>	<p>PCP or Specialty Physician Office Visit Copayment</p> <p>\$150 Copayment per visit, waived if admitted \$75 Copayment per visit</p> <p>30% of charges**</p>	<p><i>Care will be covered at in-network levels if it meets the "prudent layperson" definition of an emergency. Copayment same as in-network.</i></p>
<p><b>Maternity Care Services</b> <i>Initial Office Visit to Confirm Pregnancy</i></p> <p><i>All subsequent Prenatal visits, Postnatal visits and Physician's Delivery charges</i> <i>Inpatient Hospital/Birthing Center Charges</i></p>	<p>PCP or Specialty Physician Office Visit Copayment</p> <p>30% of charges**</p> <p>30% of charges per admission**</p>	<p>50% of charges* 50% of charges*</p> <p>50% of charges* Precertification applies</p>
<p><b>Inpatient Services at Other Health Care Facilities</b> <i>Skilled Nursing, Rehabilitation and Sub-Acute Facilities</i></p>	<p>30% of charges** <i>60 days maximum per contract year**</i></p>	<p>50% of charges*, Precertification applies; <i>60 days maximum per contract year#</i></p>
<p><b>Home Health Services</b></p>	<p>No charge, <i>60 days per contract year, 16 hours per day maximum</i></p>	<p>50% of charges; <i>40 days maximum per contract year#*</i></p>
<p><b>Family Planning Services</b> <i>Office Visits (tests, counseling)</i> <i>Vasectomy/Tubal Ligation</i> <i>Inpatient Facility</i></p> <p><i>Outpatient Facility</i></p> <p><i>Surgery in Physician's Office</i></p>	<p>PCP or Specialty Physician Office Visit Copayment</p> <p>30% of charges per admission** 30% of charges per facility use**</p> <p>PCP or Specialty Physician Office Visit Copayment</p>	<p>50% of charges*</p> <p>50% of charges* Precertification applies 50% of charges* Precertification applies 50% of charges.* Precertification applies</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK										
<p><b>Mental Health and Substance Abuse (Non-Biologically Based)</b></p> <p><i>Inpatient Mental Health Services</i></p> <p><i>Outpatient Individual Mental Health Services</i></p> <p><i>Outpatient Mental Health Group Therapy</i></p> <p><i>Inpatient Substance Abuse Rehabilitation Services</i></p> <p><i>Outpatient Individual Substance Abuse Rehabilitation Services</i></p> <p><i>Outpatient Group Substance Abuse Rehabilitation Services</i></p> <p><i>Inpatient Substance Abuse Detoxification Services</i></p> <p><i>Outpatient Substance Abuse Detoxification Services</i></p> <p><b>Biologically Based Mental Health is covered same as any other illness</b></p>	<p>\$100 Copayment per day; 8 day maximum per contract year, includes substance abuse rehabilitation days.</p> <p>\$40 Copayment per visit; 20 visit maximum per contract year</p> <p>\$20 Copayment per session; 40 visit maximum per contract year, includes substance abuse rehabilitation visits</p> <p>\$100 Copayment per day; 8 day maximum per contract year, includes mental health days</p> <p>\$15 Copayment per visit for the first 2 visits and \$40 per visit thereafter; 20 visit maximum per contract year</p> <p>\$20 Copayment per visit; 40 visit maximum per contract year includes mental health group visits</p> <p>Same as Inpatient Hospital Copayment</p> <p>Same as Specialty Physician Office Visit copayment</p>	<p>Covered in-network only</p> <p>Same as Inpatient Hospital Same as any other illness</p>										
<p><b>Transplant Services</b></p> <p><b>Travel Maximum</b></p>	<p>Same as Inpatient Hospital Copayment</p> <p>\$10,000 maximum benefit per transplant/per lifetime</p>	<p>Covered in-network only</p>										
<p><b>Durable Medical Equipment</b></p>	<p>No charge, \$3,500 maximum benefit per contract year</p>	<p>Covered in-network only</p>										
<p><b>External Prosthetic Appliances</b></p>	<p>\$200 deductible; \$1,000 maximum benefit per contract year</p>	<p>Covered in-network only</p>										
<p><b>Vision Care</b> (no referral required)</p>	<p>\$10 Office Visit Copayment for eye exam every 24 months; Reimbursement toward purchase of a pair of glasses or contact lenses every 24 months:</p> <table data-bbox="716 1142 971 1283"> <tr> <td>Single Lens</td> <td>\$20</td> </tr> <tr> <td>Bifocal</td> <td>\$30</td> </tr> <tr> <td>Trifocal</td> <td>\$40</td> </tr> <tr> <td>Frames</td> <td>\$30</td> </tr> <tr> <td>Contact Lenses</td> <td>\$75</td> </tr> </table>	Single Lens	\$20	Bifocal	\$30	Trifocal	\$40	Frames	\$30	Contact Lenses	\$75	<p>Covered in-network only</p>
Single Lens	\$20											
Bifocal	\$30											
Trifocal	\$40											
Frames	\$30											
Contact Lenses	\$75											

**OTHER BENEFIT INFORMATION**

<b>Contract Year Deductible</b>		
<i>Individual</i>	\$1,000	\$2,000
<i>Family</i>	\$2,000	\$4,000
<b>Contract Year Out-of-Pocket (OOP) Maximum</b>		
<i>Individual</i>	\$2,500 excludes deductible	\$5,000 excludes deductible
<i>Family</i>	\$5,000 excludes deductible	\$10,000 excludes deductible
<b>Coinsurance</b>	Applies to Physician, Inpatient Facility and Outpatient Facility services only. CIGNA HealthCare pays 70% of eligible charges. You pay 30% of charges after plan deductible	CIGNA HealthCare pays 50% of eligible charges. You pay 50% of charges after the plan deductible.
<b>Precertification (Inpatient, Outpatient, and MRI's)</b>	Handled by your physician	Participant must obtain approval
<b>Lifetime Maximum</b>	Unlimited	\$1,000,000
<b>Pre-existing Condition Limitation</b>	No	Yes

\*\* *In-network services are subject to contract year deductible.*

***In-network coinsurance and deductible waived for Covered Services where CIGNA has delegated claims administration to the provider group. Contact Member Services for further information.***

\* *Out-of-network services are subject to annual deductible and reasonable and customary charge limitations.*

# *Out-of-network treatment maximums are reduced by in-network services used.*

**Regarding In-Network Services:**

- *Services, other than emergency services, must be provided by/or authorized by a provider participating in the CIGNA HealthCare network, or by CIGNA Behavioral Care, Inc. in order to be covered at the in-network benefit level.*
- *Only Inpatient (including Mental Health and Substance Abuse) and Outpatient Facility copayments and coinsurance apply to the out-of-pocket maximum. These copayments and coinsurance are no longer required once out-of-pocket maximum is reached.*

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

- *You are responsible for obtaining pre-certification for all out-of-network hospital admissions, outpatient surgeries and MRI's. Penalty for non-compliance with precertification is 50%. Hospital admissions are subject to Continued Stay Review (CSR). Days that are not approved through CSR result in denial of benefits. The 50% penalty or cost of denied benefits does not apply to deductible or out-of-pocket maximum.*
- *Once the out-of-pocket maximum for out-of-network is reached, the plan pays 100% of eligible charges for the remainder of the plan year. The out-of-network inpatient copayment continues to apply.*
- *Pre-existing conditions are not covered unless twelve months of continuous coverage (including the waiting period) has elapsed.*

**Your plan does not provide coverage for the following except as required by law:**

1. Any service or supply not described as covered in the Covered Services section of the Agreement.
2. Any medical service or device that is not medically necessary.
3. Care for health conditions that are required by state or local law to be treated in a public facility or supplied by a public school system.
4. Treatment of an illness or injury which is due to war or care for military service disabilities treatable through governmental services.
5. Any services and supplies for or in connection with experimental, investigational or unproven services.
6. Treatment of TMJ disorder.
7. 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.
8. 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.
9. 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.
10. Court ordered treatment or hospitalizations.
11. 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.
12. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction.
13. Medical and hospital care and costs for the child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
14. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance.
15. Consumable medical supplies other than ostomy supplies and urinary catheters.
16. Private hospital rooms and/or private duty nursing except as covered under the Home Health Care provision.
17. 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
18. 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 member agreement.
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. 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; Orthognathic Surgeries; 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.

*This summary of benefits contains the highlights only. The specific benefits and exclusions are contained in your Group Service Agreement or certificate.*

*“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. Some Healthy Rewards are not available in all states. Additionally, not all Healthy Rewards programs are available to members of CIGNA HealthCare of California, Inc., CIGNA Dental Health of California, Inc. and CIGNA Behavioral Health of California, Inc. A discount program is NOT insurance, and the member must pay the entire discount charge. If your CIGNA HealthCare plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. Healthy Rewards programs are separate from your medical benefits.*

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