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CALIFORNIA



BENEFIT	IN NETWORK	OUT OF NETWORK
This plan is intended to comply with the federal Patient Protection and Affordable Care Act. Provisions are subject to change as additional regulatory guidance becomes available.		
Annual Individual Deductible	\$2,000	\$4,000
Annual Family Deductible	\$4,000	\$8,000
All benefits listed below are subject to the deductible unless otherwise noted		
Coinsurance	You pay 30%	You pay 50%
Individual Out of Pocket Maximum	\$3,000	\$6,000
Family Out of Pocket Maximum	\$6,000	\$12,000
Individual/Family Copays, deductibles, Access Fees, and pharmacy charges do not apply to the out of pocket maximum		
Lifetime Maximum	Unlimited	
PHYSICIAN SERVICES		
Office Visit Primary Care Physician Specialist Physician	\$30 copay ¹ \$40 copay ¹	You pay 50%
Surgery (in any setting)	You pay 30%	You pay 50%
PREVENTIVE CARE		
Preventive Care for All Ages Routine physicals and other routine preventive services	You pay 0% ¹	You pay 50%
INPATIENT SERVICES		
Facility Services (Inpatient Room and Board, Pharmacy, Lab & X-ray, Operating Room, etc.)	You pay 30%	You pay 50%
Physician Services	You pay 30%	You pay 50%
OUTPATIENT SERVICES		
Lab, X-ray and Ultrasound	You pay 30%	You pay 50%
CT/PET Scan and MRI	You pay 30%	You pay 50%
Cardiac & Pulmonary Rehabilitation	You pay 30%	You pay 50%
Short Term Rehabilitative Therapy (Including Physical; Occupational and Speech Therapy) Calendar year maximum of 24 visits, combined in- and out- of network	You pay 30%	You pay 50%
Outpatient Surgery	You pay 30%	You pay 50%
EMERGENCY & URGENT CARE SERVICES		
Hospital Emergency Room \$100 Access Fee, waived if admitted	You pay 30%	You pay the same level as In-Network if it is an emergency as defined in your plan, otherwise You pay 50%
Outpatient Professional Services (Including Radiology, Pathology and ER Physician)	You pay 30%	
Urgent Care Services	You pay 30%	
Ambulance Emergency transport only	You pay 30%	

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OTHER HEALTH CARE FACILITIES		
Skilled Nursing Facility, Rehabilitation Hospital and Sub Acute Facilities <i>Calendar year maximum of 30 days, combined in- and out-of-network</i>	You pay 30%	Cigna pays 50%
Home Health	You pay 30%	Cigna pays 50%
Hospice <i>Calendar year maximum of 30 visits, combined in- and out- of- network</i>	You pay 30%	Cigna pays 50%
DURABLE MEDICAL EQUIPMENT (DME)		
Durable Medical Equipment	You pay 30%	Cigna pays 50%
MENTAL HEALTH & SUBSTANCE ABUSE		
Inpatient <i>(Includes Acute, Partial & Residential Treatment) Calendar year maximum of 30 days, combined in- and out- of- network</i>	You pay 30%	Cigna pays 50%
Outpatient <i>(Includes Individual, Group & Intensive Outpatient Treatment) Calendar year maximum of 20 visits, combined in- and out-of-network</i>	You pay 30%	Cigna pays 50%
PRESCRIPTION DRUGS		
Prescription Drug Deductible <i>Combined Retail & Home Delivery Pharmacy deductible only applies to Brand Name Drugs</i>	\$500 per member per year	
RETAIL PHARMACY		
Generic	You pay \$10 per 30-day supply	Cigna pays 50%
Brand Name	You pay \$35 per 30-day supply	Cigna pays 50%
Non-Preferred Brand Name	You pay \$60 per 30-day supply	Cigna pays 50%
Self-Administered Injectable Drugs	You pay 30%	Cigna pays 50%
HOME DELIVERY PHARMACY		
Generic	You pay \$25 per 90-day supply	Not Available
Brand Name	You pay \$85 per 90-day supply	Not Available
Non-Preferred Brand Name	You pay \$150 per 90-day supply	Not Available
Self-Administered Injectable Drugs	You pay 30%	Not Available

[†]Deductible waived

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EXCLUSIONS:

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

- Conditions which are **pre-existing** for any Insured Persons age 19 and older, as defined in the Definitions section.
- Any **amounts in excess of maximum amounts of Covered Expenses** stated in the Policy.
- Services **not specifically listed in the Policy as Covered Services**.
- Services or supplies that are **not Medically Necessary**.
- Services or supplies that Cigna considers to be for **Experimental Procedures or Investigative Procedures**.
- Services received **before the Effective Date** of coverage.
- Services received **after coverage ends**.
- Services for which You have **no legal obligation to pay** or for which no charge would be made if You did not have health plan or insurance coverage.
- Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any **workers' compensation**, employer's liability law or occupational disease law, even if the Insured Person does not claim those benefits.
- Conditions caused by: (a) an **act of war**; (b) the inadvertent release of nuclear energy when government funds are available for treatment of Illness or Injury arising from such release of nuclear energy; (c) an Insured Person participating in the **military service** of any country; (d) an Insured Person participating in an **insurrection, rebellion, or riot**.
- If the Insured Person is eligible for **Medicare**, any services covered by Medicare under parts A, B or D are excluded regardless of actual enrollment in Medicare or payment by Medicare for those services. However, for any Covered Services, if there is a balance remaining after the Medicare Payment, or the amount that Medicare would have paid had the Insured Person enrolled in the program, CIGNA will pay the remaining balance up to the Medicare allowable amount. In no event, however, will the actual amount CIGNA pays exceed the amount that CIGNA would have paid if it were the sole insurance carrier.
- Any services for which payment may be obtained from any local, state or federal **government agency** (except Medicaid), except when payment under the Policy is expressly required by federal or state law.
- Professional services received, or supplies purchased from, the Insured Person, a person who lives in the Insured Person's home or who is **related to the Insured Person** by blood, marriage or adoption.
- **Custodial Care**.
- Inpatient or outpatient services of a **private duty nurse**.
- Inpatient room and board charges in connection with a **Hospital stay primarily for environmental change or physical therapy**; Custodial Care or rest cures; services provided by a rest home, a home for the aged, a nursing home or any similar facility service.
- **Assistance in activities of daily living**.
- Inpatient room and board charges in connection with a Hospital stay primarily for **diagnostic tests** which could have been performed safely on an outpatient basis.
- Treatment of **Mental, Emotional or Functional Nervous Disorders** except as specifically provided in this Policy.
- **Smoking cessation** programs.
- Treatment of **substance abuse**, except as specifically provided in this Policy.
- **Dental services, orthodontic services and dental implants**, except as specifically provided in this Policy.

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- **Hearing aids** and routine **hearing tests** except as specifically stated in the Policy.
- **Optometric services, eye surgery** to correct refractive defects of the eye.
- **Cosmetic surgery.**
- **Aids or devices** that assist with nonverbal communication.
- **Non-Medical counseling or ancillary services.**
- Services for **redundant skin surgery**, removal of skin tags, acupressure, acupuncture, carinosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, rolfing, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, regardless of clinical indications.]
- **Sex change surgery.**
- Treatment of **sexual dysfunction, impotence, fertility and/or infertility** and **cryopreservation** of sperm or eggs.
- **Orthopedic shoes** (except when joined to braces) or shoe inserts, including orthotics.
- Services primarily for **weight reduction** or treatment of obesity.
- **Routine physical exams or tests**, that do not directly treat an actual illness, injury or condition, including those required by employment or government authority, including physical exams required for or by an employer, or for school or sports physicals, except as otherwise specifically stated in this Plan.
- Charges by a provider for **telephone or email consultations**, except as specifically provided in this Policy.
- Items which are furnished primarily for **personal comfort** or convenience (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for hygiene or beautification, including wigs etc.).
- **Educational services** except as specifically provided in this Policy.
- **Nutritional counseling** or food supplements, except as stated in the Policy.
- **Durable medical equipment** not specifically listed as Covered Services in the Covered Services section of this Policy. Excluded durable medical equipment includes, but is not limited to: orthopedic shoes or shoe inserts; air purifiers, air conditioners, humidifiers; exercise equipment, treadmills; spas; elevators; supplies for comfort, hygiene or beautification; disposable sheaths and supplies; correction appliances or support appliances and supplies such as stockings.
- **Physical and/or Occupational Therapy**, except as specifically stated in the Policy.
- Any **off label cancer drug** that has been prescribed for a specific type of cancer for which use of the drug has not been approved by the U.S. Food and Drug Administration (US FDA) except as specifically stated in the Policy.
- **Self-administered Injectable Drugs**, except as stated in the Prescription Drug Benefits section of this Policy.
- All **non-injectable** prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in the Prescription Drug benefits section of this Policy.
- Any **Infusion or Injectable Specialty Prescription Drugs** that require Physician supervision, except as otherwise stated in this Policy. If not provided by an approved Participating Provider specifically designated to supply that specialty prescription. Infusion and Injectable Specialty drugs include, but are not limited to, hemophilia factor and supplies, enzyme replacements and intravenous immunoglobulin.
- **Syringes**, except as stated in the Policy.
- **All Foreign Country Provider** charges.
- **Growth Hormone Treatment** except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the Insured Person's condition.

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- Routine **foot care**.
- Charges for **animal to human organ transplants**.
- **Claims** received by Cigna after 15 months from the date service was rendered, except in the event of a legal incapacity.

These Are Only the Highlights

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.

Rates will vary by plan design including the amount of plan deductibles, coinsurance, and out-of-pocket maximums. Rates may vary based on age, geographic location, and the plan and plan deductible selected.

Medical rates are guaranteed for a rating period of twelve months effective when the insurance policy is issued with the exception of any policy amendment activities, such as any benefit changes, switching to a different plan, adding or dropping dependents and moving to a different rating area. Eligibility for medical rates is based upon residential zip code. After the initial guarantee for medical rates, rates are subject to change upon 60 days notice.

These rates are the Cigna standard rates. Enrollment in a Cigna Open Access, Open Access Value or Health Savings Plan is subject to medical underwriting guidelines established by the health plan, and your rate may vary based upon tobacco usage and the results of the medical underwriting risk assessment process. You may be declined coverage because of a health condition (this does not apply to Child-only policies). If you are issued a policy, and are 19 years of age or older, certain medical conditions may not be covered for a specified length of time if those conditions are related to a medical condition that existed prior to the date of coverage.

This medical insurance policy (CAIND2012) has exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued. For costs and additional details about coverage, contact Connecticut General Life Insurance Company at 900 Cottage Grove Road, Hartford, CT 06152 or call 1-866-GET-CIGNA.

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