

# SUMMARY OF BENEFITS

*Your CIGNA HealthCare Open Access Plus plan*



**CIGNA HealthCare**

## Features that Add Value

- The convenience of **referral-free access** to physicians, and ....
- The option to select a **personal Primary Care Physician (PCP)** as your source for routine care and guidance when you need specialized care. As your needs change, so may your choice of doctors. That's why you can change your PCP for any reason.
- 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 benefits plans. Just 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; and 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 Customer Service, 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 your children through age 2 and any additional preventive care benefits described in the Benefits Highlights.
- CIGNA Well Aware for Better Health<sup>SM</sup> can **help you manage** certain chronic conditions.
- The CIGNA HealthCare Healthy Babies<sup>®</sup> program provides you with information to help you have a **healthy pregnancy and a healthy baby**.

## You Can Depend on CIGNA HealthCare

- **Quality comes first**. We select “participating providers” carefully. And we make sure you have a **wide range** of doctors to choose from.
- **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 your cost is lower.

## It's Your Choice

- When 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 the highest when you see “participating providers,” but you're still covered for visits to other providers.

**For Employees of  
NJ Small Group - Plan D**

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><b>Physician Services</b> <b>Primary Care Physician (PCP) Office Visit</b></p> <p><b>Specialty Physician Office Visit</b> <i>Consultant and Referral Physician Services</i></p> <p><i>Allergy Treatment/Injections - PCP or Specialty Physician</i></p> <p><i>Allergy Serum (dispensed by physician in office)</i></p> <p><i>Second Opinion Consultations (provided on voluntary basis)</i></p> <p><i>Surgery Performed in the Physician's Office- PCP or Specialty Physician</i></p>	<p>\$20 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.</p> <p>\$30 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.</p> <p>\$20 or \$30 copayment per office visit or actual charge, whichever is less</p> <p>No charge</p> <p>\$20 or \$30 copayment per office visit</p> <p>\$20 or \$30 copayment per office visit</p>	<p>40% of charges**</p> <p>40% of charges**</p> <p>40% of charges**</p> <p>40% of charges**</p> <p>40% of charges**</p> <p>40% of charges**</p>
<p><b>Preventive Care</b> <i>Routine Preventive Care for Children - birth to age 1 (including routine immunizations)</i></p> <p><i>Immunizations</i></p> <p><i>Routine Preventive Care for Children and Adults - from age 1 and above (including routine immunizations)</i></p> <p><b>Note:</b> <i>Well Woman OB/GYN visits are subject to the PCP's office visit copay</i></p> <p><i>Immunizations</i></p> <p><i>^^Charges for lab &amp; radiology services billed by a non network physician's office are subject to preventive care dollar maximum. Charges for lab &amp; radiology services billed by independent diagnostic facility or outpatient hospital do NOT apply to preventive care dollar maximum</i></p>	<p>\$20 or \$30 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.</p> <p>No charge, no plan deductible</p> <p>\$20 or \$30 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.</p> <p>No charge, no plan deductible</p>	<p>No charge and subject to a \$750 preventive care maximum.</p> <p>No charge and subject to the above \$750 preventive care maximum.</p> <p>No charge and subject to a \$500 maximum</p> <p>No charge and subject to the above \$500 maximum</p>
<p><b>Mammograms, PSA, Pap Test</b> <i>(Mammogram charges billed by a non network provider do apply to preventive care dollar maximum regardless of place of service. PSA and Pap Test charges if billed by a non network physician's office do apply to the preventive care dollar maximum.)</i></p>	<p>No charge</p>	<p>No charge and subject to the above \$500 preventive care maximum. Once the max is reached, coverage will still be provided for mammograms and colorectal screening at 40% of charges**</p>
<p><b>Inpatient Hospital Services including:</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></p>	<p>10% after deductible Precertification required</p>	<p>\$1,000 copay per admission, plus 40% of charges* Precertification required</p>
<p><b>Inpatient Hospital Doctor's Visits/Consultations</b> <i>Inpatient Hospital Professional Services</i></p>	<p>10% after deductible 10% after deductible</p>	<p>40% of charges** 40% of charges**</p>
<p><b>Outpatient Facility Services includes:</b> <i>Operating Room, Recovery Room, Procedure Room and Treatment Room and Observation Room including:</i> <i>Diagnostic/Therapeutic Lab and X-rays</i> <i>Anesthesia and Inhalation Therapy</i> <i>Physician &amp; Outpatient Professional Services</i></p>	<p>10% after deductible  10% after deductible</p>	<p>\$500 copay per facility visit, plus 40% of charges**  40% of charges**</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><b>Laboratory and Radiology Services (includes preadmission testing)</b>  <b>Advanced Radiological Imaging (MRIs, CAT Scans, PET Scans, etc.)</b></p> <p><b>Other Laboratory and Radiology Services</b>  Physician's Office  Outpatient Hospital Facility  Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit)  Independent X-Ray and/or Lab Facility  Independent X-Ray and/or Lab Facility (in conjunction with an Emergency Room visit)</p>	<p>\$100 copayment per procedure, plus 10% of charges after deductible</p> <p>\$20 or \$30 copayment per office visit  10% after deductible  No charge</p> <p>10% after deductible  No charge</p>	<p>\$200 copay per procedure, plus 40% of charges**</p> <p>40% of charges**  40% of charges**  No charge (except if not a true emergency, then 40% of charges**)  40% of charges**  No charge</p>
<p><b>Short-Term Rehabilitative Therapy and Chiropractic Services</b> (includes cardiac rehab, physical, speech, occupational, chiropractic, pulmonary rehab &amp; cognitive therapy) - 60 visits maximum per calendar year# for all therapies combined</p> <p><u>Note:</u> therapy sessions provided as part of Home Health Care accumulate to the Short-Term Rehab Therapy maximum.</p>	<p>\$20 or \$30 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.</p>	<p>40% of charges**</p>
<p><b>Emergency and Urgent Care Services</b>  Physician's Office – PCP or Specialty Physician</p> <p>Hospital Emergency Room</p> <p>Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician)</p> <p>Urgent Care Facility or Outpatient Facility</p> <p>Ambulance</p>	<p>\$20 or \$30 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.</p> <p>\$100 copayment per visit (copay waived if admitted) after deductible</p> <p>No charge</p> <p>\$50 copayment per visit (copay waived if admitted) after deductible</p> <p>No charge</p>	<p>Care will be provided at in-network levels if it meets the "prudent layperson" definition of an emergency. Otherwise 40% of charges**</p>
<p><b>Maternity Care Services</b>  Initial Office Visit to Confirm Pregnancy</p> <p>All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (total maternity fee)</p> <p>Office Visits not included in the total maternity fee performed by OB or Specialty Physician</p> <p>Delivery - Facility (Inpatient Hospital/Birthing Center Charges)</p>	<p>\$20 or \$30 copayment for initial office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.</p> <p>10% after deductible</p> <p>\$20 or \$30 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services performed and billed.</p> <p>10% after deductible, precertification required</p>	<p>40% of charges**</p> <p>40% of charges**</p> <p>40% of charges**</p> <p>\$1,000 copay per admission, plus 40% of charges*, precertification required</p>
<p><b>Inpatient Services at Other Health Care Facilities Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities</b>-60 days maximum per calendar year# combined for all facilities listed</p>	<p>10% after deductible</p>	<p>40% of charges**</p>
<p><b>Home Health Services (Includes outpatient private duty nursing when approved as medically necessary - 60 days maximum per calendar year#</b></p>	<p>10% after deductible</p>	<p>40% of charges**</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><b>Family Planning Services</b> Office Visits (lab &amp; radiology tests, counseling)</p> <p>Vasectomy/Tubal Ligation (excludes reversals) Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services – Inpatient or Outpatient Physician's Office</p>	<p>\$20 or \$30 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services performed and billed.</p> <p>10% after deductible, precertification required</p> <p>10% after deductible</p> <p>10% after deductible</p> <p>\$20 or \$30 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services performed and billed.</p>	<p>40% of charges**</p> <p>\$1,000 copay per admission, plus 40% of charges*, precertification required</p> <p>\$500 copay per facility visit, plus 40% of charges**</p> <p>40% of charges**</p> <p>40% of charges**</p>
<p><b>Infertility Services</b> Office Visit (lab &amp; radiology tests, counseling) PCP or Specialty Physician</p> <p>Treatment/Surgery (includes artificial insemination) (excludes in-vitro fertilization, GIFT, ZIFT, etc.) Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p>	<p>\$20 or \$30 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services performed and billed.</p> <p>10% after deductible, precertification required</p> <p>10% after deductible</p> <p>10% after deductible</p>	<p>40% of charges**</p> <p>\$1,000 copay per admission, plus 40% of charges*, precertification required</p> <p>\$500 copay per facility visit, plus 40% of charges**</p> <p>40% of charges**</p>
<p><b>TMJ – Surgical and Non-Surgical</b>-case-by-case basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity. Physician's Office</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p>	<p>\$20 or \$30 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services performed and billed.</p> <p>10% after deductible, precertification required</p> <p>10% after deductible</p> <p>10% after deductible</p>	<p>40% of charges**</p> <p>\$1,000 copay per admission, plus 40% of charges*, precertification required</p> <p>\$500 copay per facility visit, plus 40% of charges**</p> <p>40% of charges**</p>
<p><b>Biologically-based Mental Health Services</b> Inpatient</p> <p>Outpatient</p>	<p>10% after deductible, precertification required</p> <p>\$30 copayment per office visit</p>	<p>\$1,000 copay per admission, plus 40% of charges*, precertification required</p> <p>40% of charges**</p>
<p><b>Mental Health and Substance Abuse</b> Inpatient - 30 days maximum per calendar year#</p> <p><b>Mental Health</b> Acute: Based on a ratio of 1:1 Partial: Based on a ratio of 2:1 Residential: Based on a ratio of 2:1</p> <p><b>Substance Abuse</b> Acute Detox: Based on a ratio of 1:1 (requires 24 hour nursing) Acute Inpatient Rehab: Based on a ratio of 1:1 (requires 24 hour nursing) Partial: Based on a ratio of 2:1 Residential: Based on a ratio of 2:1</p> <p>Outpatient – 20 visits maximum per calendar year#</p> <p><b>Note: The maximum limitations do not apply to inpatient or outpatient treatment services for Alcoholism</b></p>	<p>10% after deductible, precertification required</p> <p>\$30 copayment per office visit</p>	<p>40% of charges*, precertification required</p> <p>40% of charges**</p>

<b><i>Durable Medical Equipment</i></b> \$1,000 maximum per calendar year#	10% after deductible	40% of charges**
<b><i>External Prosthetic Appliances</i></b> \$200 EPA deductible per calendar year \$1,000 maximum per calendar year#	10% after deductible	40% of charges**

<b>BENEFIT HIGHLIGHTS</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Prescription Drugs</b> <b>CIGNA Pharmacy Retail Drug Program</b> <i>Includes oral contraceptives and contraceptive devices</i>	\$15 per 30-day supply for generic drugs \$30 per 30-day supply for preferred brand-name drugs \$50 per 30 day supply for non-preferred brand-name drugs	Covered in-network only
<b>CIGNA Tel-Drug Mail Order Drug Program</b>	\$30 per 90-day supply for generic drugs \$60 per 90-day supply for preferred brand-name drugs \$100 per 90-day supply for non-preferred brand-name drugs	

<b>OTHER BENEFIT INFORMATION</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Calendar Year Plan Deductible</b> <i>Individual</i> <i>Family</i>	\$500 \$1,000	\$1,500 \$3,000
<b>Calendar Year Out-of-Pocket Maximum</b> <i>Individual</i> <i>Family</i>	\$2,000 \$4,000	Including Plan Deductible \$6,000 \$12,000
<b>Coinsurance</b>	CIGNA HealthCare pays 90% of eligible charges. You pay 10% of charges.	CIGNA HealthCare pays 60% of eligible charges. You pay 40% of charges after the plan deductible.
<b>Precertification -Inpatient – PHS+</b> <i>(required for all inpatient admissions)</i>	Coordinated by your physician	Participant must obtain approval for inpatient admission; subject to penalty/reduction or denial for non-compliance
<b>Precertification – Outpatient – PHS+</b> <i>(required for selected outpatient procedures and diagnostic testing or outpatient services)</i>	Coordinated by your physician	Participant must obtain approval for selected outpatient procedures and diagnostic testing; subject to penalty/reduction or denial for non-compliance.
<b>Lifetime Maximum</b>	Unlimited	\$5,000,000
<b>Pre-existing Condition Limitation</b>	Yes	Yes

\*Services are subject to calendar year deductible

\*\*Services are subject to calendar year deductible and reasonable and customary charge limitations.

# In-network and out-of-network services apply to the same treatment or dollar maximum.

Footnotes:

Regarding In-Network and Out-of-Network Services:

- Once the out-of-pocket maximum is reached, the plan pays 100% of eligible charges for the remainder of the plan year.
- All inpatient hospital admissions and certain outpatient surgical and diagnostic procedures require Preadmission Certification and Continued Stay Review. Failure to obtain Preadmission Certification and/or Continued Stay Review may result in non-compliance penalties and/or reduction of benefits. Call the toll-free number on your CIGNA HealthCare ID Card.
- Coverage for pre-existing conditions will not be covered under this plan unless continuously insured for one year.

Regarding In-Network Services: All services must be provided by one of the participating providers on our list in order to be covered.

Regarding Out-of-Network Services: Your out-of-pocket costs will be higher than with a participating provider.

## Case Management

Coordinated by CIGNA HealthCare. This is a service designed to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

## Benefit Exclusions.

These are examples of the exclusions in your plan. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control.

1. Any service or supply not described as covered in the Covered Expenses section of the plan.
2. Any medical service or device that is not medically necessary.
3. Treatment of an illness or injury which is due to war or care for military service disabilities treatable through governmental services.
4. Any services and supplies for or in connection with experimental, investigational or unproven services.
5. 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
6. 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.
7. 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.
8. Court ordered treatment or hospitalizations
9. 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. Cryopreservation of donor sperm and eggs are also excluded from coverage.
10. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction.
11. Medical and hospital care and costs for the child of a Dependent, unless this infant child is otherwise eligible under the plan.
12. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance.
13. Consumable medical supplies other than ostomy supplies and urinary catheters.
14. Private hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
15. 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.
16. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
17. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
18. Non-prescription drugs and investigational and experimental drugs, except as provided in the plan
19. Routine foot care, however, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary. Genetic screening or pre-implantation genetic screening.
20. Fees associated with the collection or donation of blood or blood products.
21. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
22. All nutritional supplements and formulae are excluded, except infant formula needed for the treatment of inborn errors of metabolism.
23. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
24. Expenses incurred for medical treatment by a person age 65 or older, who is covered under the plan as a retiree, or his dependent, when payment is denied by the Medicare plan because treatment was not received from a participating provider of the Medicare plan.
25. Expenses incurred for medical treatment when payment is denied by the primary plan because treatment was not received from a participating provider of the primary plan.
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; Rolwing; 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.

## These Are Only the Highlights

*As you can see, the plan is designed to combine in-depth coverage with cost-effective prices. 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.*

*"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.*

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