

SUMMARY OF BENEFITS

INDIVIDUAL PLANS CONNECTICUT OPEN ACCESS 5000



| BENEFIT | IN NETWORK | OUT OF NETWORK |
|---|---|---|
| Annual Individual Deductible | \$5,000 | \$10,000 |
| Annual Family Deductible | \$10,000 | \$20,000 |
| <i>All benefits listed below are subject to the Deductible unless otherwise noted</i> | | |
| Coinsurance | CIGNA pays 80% of eligible charges | CIGNA pays 60% of eligible charges |
| Individual Out of Pocket Maximum | \$5,000 | \$10,000 |
| Family Out of Pocket Maximum | \$10,000 | \$20,000 |
| <i>Copays, Deductibles and pharmacy charges do not apply to the out of pocket maximum</i> | | |
| Lifetime Maximum | \$5,000,000 per member | |
| PHYSICIAN SERVICES | | |
| Office Visit Primary Care Physician Specialist | CIGNA pays 80% | CIGNA pays 60% |
| Inpatient Physician Services and all In-Hospital Care | CIGNA pays 80% | CIGNA pays 60% |
| Surgery (in any setting) | CIGNA pays 80% | CIGNA pays 60% |
| PREVENTIVE CARE | | |
| Children (through age 3) Office Visit Flu Shot Lab Work Routine Screenings Immunizations | CIGNA pays 80% | CIGNA pays 60% |
| Preventive Care (age 4 and older) Office Visit, Lab Work, Immunizations, Flu Shot | After Deductible, CIGNA pays 80% up to a maximum payment of \$200 per calendar year | After Deductible, CIGNA pays 60% up to a maximum payment of \$200 per calendar year |
| Mammogram, Contraceptive Services & Devices, Pap Smear, PSA Screening and Colorectal Cancer Screening and the associated office visit | CIGNA pays 80% | CIGNA pays 60% |
| INPATIENT HOSPITAL FACILITY SERVICES | | |
| In-Hospital Services (semi-private inpatient room and board, pharmacy, x-ray and laboratory, operating room, etc.) | CIGNA pays 80% | CIGNA pays 60% |
| OUTPATIENT SERVICES | | |
| Lab, X-ray, Ultrasound | CIGNA pays 80% | CIGNA pays 60% |
| CT Scan and MRI | CIGNA pays 80% | CIGNA pays 60% |
| Cardiac/Pulmonary Rehabilitation 36 visit maximum per year, in- and out-network combined | CIGNA pays 80% | CIGNA pays 60% |
| Physical Therapy, and Occupational Therapy 24 visit maximum per year for combined services, both in- and out-of-network | After plan Deductible, CIGNA pays a maximum of \$40 per visit | After plan Deductible, CIGNA pays a maximum of \$40 per visit |

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|--|---|---|
| OUTPATIENT SERVICES | | |
| Outpatient Surgery Facility charge | CIGNA pays 80% | CIGNA pays 60% |
| EMERGENCY & URGENT CARE SERVICES | | |
| Hospital Emergency Room | CIGNA pays 80% | CIGNA pays 80% |
| Urgent Care Services | CIGNA pays 80% | CIGNA pays 60% |
| Ambulance | CIGNA pays 80% | CIGNA pays 80% |
| OTHER HEALTH CARE FACILITIES | | |
| Skilled Nursing Facility, Rehabilitation Hospital and Sub-acute Facilities <i>\$400 maximum per day, 100 day maximum per year for combined services, both in- and out-of-network</i> | After plan Deductible CIGNA pays \$400 maximum payment per day | After plan Deductible CIGNA pays \$400 maximum payment per day |
| Home Health <i>80 visit maximum per year, in- and out-of-network combined</i> | Annual Deductible Waived, \$50 Home Health Deductible applies then CIGNA pays 80% | Annual Deductible Waived, \$50 Home Health Deductible applies then CIGNA pays 75% |
| Hospice | CIGNA pays 80% | CIGNA pays 60% |
| DURABLE MEDICAL EQUIPMENT (DME) | | |
| <i>\$5,000 maximum per year, in- and out-of-network combined</i> | CIGNA pays 80% | CIGNA pays 60% |
| MENTAL HEALTH & SUBSTANCE ABUSE | | |
| Inpatient | CIGNA pays 80% | CIGNA pays 60% |
| Outpatient | CIGNA pays 80% | CIGNA pays 60% |
| PRESCRIPTION DRUGS (30-day supply) | | |
| Brand Name Prescription Drug Deductible <i>Per person, per year, in- and out-of-network combined</i> | \$500 | |
| Brand Name Calendar Year Maximum | \$5,000 Per Insured | |
| Generic | You pay \$10 | You pay 50% |
| Brand Name | You pay \$30 | You pay 50% |
| Non-Preferred Brand Name | You pay \$40 | You pay 50% |
| Self Injectables | You pay 30% | You pay 50% |
| MAIL ORDER DRUGS (90-day supply) | | |
| Generic | You pay \$25 | Not Applicable |
| Brand Name | You pay \$75 | Not Applicable |
| Non-Preferred Brand Name | You pay \$100 | Not Applicable |
| Self Injectables | You pay 30% | Not Applicable |

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INDIVIDUAL PLANS CONNECTICUT OPEN ACCESS 5000



EXCLUSIONS:

- Conditions which are **pre-existing** as defined in the Definitions section.
- Any **amounts in excess of maximum amounts of Covered Expenses** stated in this Policy.
- Services **not specifically listed** in this 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.
- For or in connection with an Injury or Illness arising out of, or in the course of, any employment for wage or profit. For Medical Benefits, this will not apply to any of the Policyholder's partners, proprietors or corporate officers. However, if payment is made for expenses in the event that third-party liability is determined and satisfied (whether by settlement, judgment, arbitration or otherwise), CIGNA shall be refunded the lesser of: (a) the amount of CIGNA's payment for such expenses; or (b) the amount actually received from the third party for such expenses. In the event that a **workers' compensation** claim is filed, CIGNA shall have a lien on the proceeds of any award or settlement to the extent of its payment of benefits.
- Any services provided by a local, state or federal **government agency**, except (a) when payment under this Policy is expressly required by federal or state law.
- If the Insured Person is enrolled in **Medicare** for part A or B CIGNA will provide claim payment according to this Policy minus any amount paid by Medicare, not to exceed the amount 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). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.
- 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**, including but not limited to: bathing, eating, dressing, or other Custodial Care, self-care activities or homemaker services, and services primarily for rest, domiciliary or convalescent care.
- 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.

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INDIVIDUAL PLANS CONNECTICUT OPEN ACCESS 5000



- **Dental services**, dentures, bridges, crowns, caps or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, except as specifically provided in this Policy.
- **Orthodontic Services**, braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction.
- **Dental Implants**: Dental materials implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of dental implants.
- **Hearing aids**, except as specifically provided in this Policy.
- Routine **hearing tests** except as provided under Well Baby and Well Child Care and Newborn Hearing Benefits.
- **Optometric services**, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in this Policy.
- An **eye surgery** solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), astigmatism and/or farsightedness (presbyopia).
- Outpatient **speech therapy**, except as specifically provided in this Policy.
- **Cosmetic surgery** or other services for beautification, to improve or alter appearance or self esteem or to treat psychological or psychosocial complaints regarding one's appearance including macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty/panniculectomy; rhinoplasty. This exclusion does not apply to Reconstructive Surgery to restore a bodily function or to correct a deformity caused by Injury or congenital defect of a Newborn child, or for Medically Necessary Reconstructive Surgery performed to restore symmetry incident to a mastectomy.
- **Aids or devices** that assist with nonverbal communication, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- **Non-Medical counseling or ancillary services**, including but not limited to: education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities and developmental delays.
- Services for **redundant skin surgery**, removal of skin tags, acupuncture, carinosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, rolfing, pyrotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, regardless of clinical indications.
- Procedures or treatments to change characteristics of the body to those of the opposite sex. This includes any medical, surgical or psychiatric treatment or study related to **sex change**.
- Treatment of **sexual dysfunction** impotence and/or inadequacy except if this is a result of an Accidental Injury, organic cause, trauma, infection, or congenital disease or anomalies.
- **Reversal** of male or female voluntary Sterilization.
- **Infertility services** when the infertility is caused by or related to voluntary Sterilization; Donor charges and services; Gestational carriers and surrogate parenting arrangements; and experimental, investigational or unproven infertility procedures or therapies.

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INDIVIDUAL PLANS CONNECTICUT OPEN ACCESS 5000



- All **non-prescription** Drugs, devices and/or supplies that are available over the counter or without a prescription.
- **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 including morbid obesity, or any care which involves weight reduction as a main method for treatment. This includes any morbid obesity surgery, even if the Insured Person has other health conditions that might be helped by a reduction of obesity or weight, or any program, product or medical treatment for weight reduction or any expenses of any kind to treat obesity, weight control or weight reduction.
- **Routine physical exams** or tests, except as specifically stated in this Policy.
- Charges by a provider for **telephone or email consultations**.
- 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 except as specifically provided in this Policy, etc.).
- **Educational services** except for Diabetes Self-Management Training Program, and as specifically provided or arranged by CIGNA.
- **Nutritional counseling** or food supplements, except as stated in this 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/Medicine** except when provided during an inpatient Hospital confinement or as specifically provided under the benefits for Physical and/or Occupational Therapy/Medicine.
- **Self-administered Injectable Drugs**, except as stated in the Prescription Drug Benefits section of this Policy.
- **Syringes**, except as stated in the Policy.
- **All Foreign Country Provider** charges are excluded under this Policy except as specifically stated under Treatment received from Foreign Country Providers in the Benefits section of this Policy.
- **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.
- Routine **foot care** including the cutting or removal of corns or calluses; the trimming of nails, routine hygienic care and any service rendered in the absence of localized illness, injury or symptoms involving the feet.
- **Charges for which We are unable to determine Our liability** because the Insured Person failed, within 60 days, or as soon as reasonably possible to: (a) authorize Us to receive all the medical records and information We requested; or (b) provide Us with information We requested regarding the circumstances of the claim or other insurance coverage.
- Charges for the services of a **standby Physician**.

SUMMARY OF BENEFITS

INDIVIDUAL PLANS CONNECTICUT OPEN ACCESS 5000



- Charges for **animal to human organ transplants**.
- Charges for **Normal Pregnancy or Maternity Care**, including normal delivery, elective abortions or elective/non-emergency cesarean sections except as specifically stated under 'Complications of Pregnancy' in the 'Comprehensive Benefits' section of this Policy.
- **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 Policy. This plan is insured and/or administered by Connecticut General Life Insurance Company, a CIGNA Company.

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