

# CIGNA OPEN ACCESS PLUS COVERAGE

## MEDICAL BENEFIT SUMMARY FOR COTOPAXI SCHOOL DISTRICT EFFECTIVE DECEMBER 1, 2010 BASE PLAN

Network: GWH-CIGNA Open Access Plus

GENERAL SERVICES	NETWORK SERVICES	NON-NETWORK SERVICES
<b>Physician Office Visit</b>	Primary Practitioner \$40 Copay Specialist \$60 Copay	50% after calendar year deductible
<b>Urgent Care Visit</b> • Includes Lab & X-ray	20% after calendar year deductible	50% after calendar year deductible
<b>Outpatient Surgery Deductible</b>	\$0	\$500
<b>Preventive Care</b> • Office Visit 100% • 100% Coverage, no deductible for Lab & X-Ray performed as part of physical by a network provider, immunizations and other services performed as part of physical	100% Coverage (Copays, Coinsurance, Deductibles Do Not Apply)	50% after calendar year deductible
<b>Performance Pharmacy Plan (includes contraceptives)</b> If you request a brand-name drug when a generic is available, you are liable for the difference between the brand-name and generic price in addition to the brand-name copay.	Tier 1: \$15 Generic Copay Tier 2: \$40 Tier 2 Brand Tier 3: \$70 Tier 3 Brand Mail Order 2x Retail Copay for a 90 day supply For Medicare Part D purposes, this drug plan is considered Creditable.	Appropriate copay level +50% of the full cost of the prescription
<b>Coinsurance</b>	20%	50%
<b>Calendar Year Deductible</b>	\$2,500 Individual \$5,000 Per Family	\$5,000 Individual \$10,000 Per Family
<b>Per-Confinement Deductible</b>	\$0	\$500
<b>Out of Pocket Annual Maximum</b>	\$5,000 Individual \$10,000 Per Family	\$8,000 Individual \$16,000 Per Family
<b>Lifetime Maximum</b>	Unlimited	
<b>Emergency Room Care</b> • Includes Lab & X-ray	Subject to 20% after in-network calendar year deductible regardless of network status.	
<b>Ambulance</b>	20% after in-network calendar year deductible, regardless of network status.	
<b>Office Surgery</b>	100%, no deductible	50%
<b>Office Services</b> • Office X-ray & Lab (performed and billed by the office)	20%	50%
<b>Office High Technology Radiology Services</b>	20% after calendar year deductible	50% after calendar year deductible
<b>Outpatient Lab and X-Ray</b>	100%, no deductible	50%
<b>Outpatient High Technology Radiology Services</b>	20% after calendar year deductible	50% after calendar year deductible

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<b>Durable Medical Equipment</b> <ul style="list-style-type: none"> <li>• Unlimited Per Calendar Year Maximum</li> <li>• Unlimited Lifetime Maximum</li> </ul>	20% after calendar year deductible for other services	50% after calendar year deductible
<b>HOSPITAL SERVICES</b>		
<b>Inpatient Hospital Services</b> <ul style="list-style-type: none"> <li>• Including anesthesia</li> <li>• Requires pre-certification</li> <li>• Lab &amp; X-Ray based on Facility Network Status.</li> </ul>	Facility Charges: 20% after calendar year deductible Non-Facility Charges: 20% after calendar year deductible	Facility Charges: 50% after \$500 per-confinement deductible Non-Facility Charges: 50% after calendar year deductible
<b>Outpatient Hospital Services</b> <ul style="list-style-type: none"> <li>• Outpatient Surgery</li> <li>• Including anesthesia</li> <li>• Requires Precertification</li> <li>• Ambulatory Surgery</li> <li>• Lab &amp; X-Ray paid based on Facility Network Status</li> </ul>		
<b>Skilled Nursing Facility Care</b> <ul style="list-style-type: none"> <li>• 60 days per calendar year maximum</li> <li>• Requires pre-certification</li> </ul>	Facility Charges: 20% after calendar year deductible Non-Facility Charges: 20% after calendar year deductible	Facility Charges: 50% after \$500 per-confinement deductible Non-Facility Charges: 50% after calendar year deductible
<b>Hospice Care</b>		
<b>Home Health Care</b> <ul style="list-style-type: none"> <li>• Up to 1 visit per day/60 visits per calendar year maximum</li> </ul>	20% after calendar year deductible	50% after calendar year deductible
<b>MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES</b>		
<b>Inpatient Mental Health and Chemical Dependency</b> <ul style="list-style-type: none"> <li>• Unlimited Days per Calendar Year</li> <li>• Unlimited Days per Lifetime</li> <li>• Services require pre-certification</li> </ul>	Facility Charges: 20% after calendar year deductible  Non-Facility Charges: 20% after calendar year deductible	Facility Charges: 50% after \$500 per-confinement deductible  Non-Facility Charges: 50% after calendar year deductible
<b>Outpatient Mental Health and Chemical Dependency</b> <ul style="list-style-type: none"> <li>• Unlimited Visits per Calendar Year</li> </ul>	\$60 Copay	50% after calendar year deductible
<b>THERAPY SERVICES</b>		
<b>Outpatient Physical Therapy</b> <ul style="list-style-type: none"> <li>• 20 Visits Per Calendar Year Maximum</li> </ul>	\$60 Copay	50% after calendar year deductible
<b>Speech Therapy, Hearing Therapy and Occupational Therapy</b> <ul style="list-style-type: none"> <li>• 20 Visits Per Calendar Year Maximum</li> </ul>	\$60 Copay	50% after calendar year deductible
<b>Chiropractic Services</b> <ul style="list-style-type: none"> <li>• Unlimited Visits Per Calendar Year</li> </ul>	\$60 Copay	50% after calendar year deductible
<b>ADDITIONAL SERVICES</b>	<b>NETWORK SERVICES</b>	<b>NON-NETWORK SERVICES</b>
<b>Family Planning</b> <ul style="list-style-type: none"> <li>• Tubal Ligations and Vasectomies</li> <li>• Requires pre-certification</li> <li>• Includes infertility testing for diagnosis only.</li> </ul>	Varies based on the facility in which it is performed	Varies based on the facility in which it is performed

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## Out-of Area Services

- ER and Ambulance paid the same regardless of Network
- Preventive Care Services covered at 100%

For all other services the member pays: 20% Coinsurance and Network Deductibles

More highlights of your CIGNA Health Plan are listed below. This list is not all inclusive; the Summary Plan Description provides detailed information about your plan, exclusions, and coverage limitations. In the event of a conflict between this document and your Summary Plan Description or Master Plan Document, the Summary Plan Description or Master Plan Document will control.

## COMPLEMENTARY ALTERNATIVE MEDICINE DISCOUNT PROGRAM

- Receive 20% savings for services received from an ACN Group Inc., network acupuncturist, massage therapist, dietitian, nutritionist, or naturopathic doctor.
- Access [myCIGNAforhealth.com](http://myCIGNAforhealth.com) for an overview of the program, examples of services provided by Alternative Care practitioners and information on how to look up a provider.
- ACN Group Inc., and its alternative care providers are solely responsible for the services and products they provide.

## ONLINE HEALTH AND WELLNESS TOOLS

- All enrolled members have access to a personalized wellness focused website with information regarding nutrition, lifestyle and fitness.
- Health articles are available and updated daily for many different conditions.
- Pharmaceutical information, including drug interactions and supplement information is available online.
- Through the CareCompare tool, you can compare facilities based on many different criteria including cost, number of treatments provided by category, average length of stay and others.
- Through the secure website, you can also check the status of your claims, find in-network providers, view your benefit specifics and find claim forms.

## AWARD WINNING DISEASE MANAGEMENT PROGRAM

- CIGNA nurses work directly with enrolled members to help manage chronic conditions such as Asthma, Diabetes, Heart Failure, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, Pain Management, End Stage Renal Disease and Maternity Management.
- You may take online assessments to receive information about chronic diseases and send specific questions to a nurse through the Web site.

## PRESCRIPTION DRUG COVERAGE

- The mail order program provides a 90 day supply for a cost of 2x the appropriate retail copay.

## OUT OF POCKET MAXIMUM

Once you reach the individual or family out-of-pocket maximum (non-covered benefits are excluded from this total) in any one calendar year, covered services will be payable at 100% for the remainder of the year.

## PLAN COVERAGE FOR NON-NETWORK PROVIDERS WITHIN A NETWORK AREA

The allowable covered expense for non-network services is based upon the Average Contract Rates (ACR) for network providers in the area where services are rendered. Members are fully responsible for any amount over the ACR as well as any applicable deductibles and coinsurance. With CIGNA medical management approval, hospital admissions resulting from an emergency may be exempt from ACR.

## PRECERTIFICATION PENALTY

Pre-authorization is required on all inpatient admissions and outpatient surgery not performed in the doctors office. Network providers are contractually obligated to perform pre-authorization on behalf of their clients; the member must verify that a non-network provider performs the pre-authorization procedures. If a non-network provider does not get pre-treatment authorization or if a Member does not follow the recommended care plan, the first \$250 of charges will be considered ineligible.

- \* Outpatient Surgery
- \* Home Health Care
- \* Air Ambulance
- \* High Cost Drug
- \* Transplant Evaluations
- \* Hospital Admissions (including partial hospitalization programs for mental health)
- \* Skilled Nursing
- \* Renal Dialysis
- \* Durable Medical Equipment over \$500
- \* Genetic Testing

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\* High Tech Radiology (examples include CAT scans, PET scans and MRIs)

## GENERAL NOTICE OF PREEXISTING CONDITION EXCLUSION

- This Plan may impose a Preexisting Condition Exclusion (PCE). This means that if you have a medical condition before coming to our Plan, you might have to wait a certain period of time before the Plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a three-month period. Generally, this three-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the three-month period ends on the day before the waiting period begins. The PCE does not apply to pregnancy or to a child who is enrolled in the Plan within 31 days after birth, adoption or placement for adoption.
- The Preexisting Condition Exclusion (PCE) is not applicable to anyone under age 19.
- This exclusion may last up to 12 months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the PCE if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior Plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.
- All questions about the PCE and creditable coverage should be directed to your HR/Benefits Director.

## BASE REIMBURSEMENT METHOD

- Average Contracted Rate (ACR). The allowable covered expense for non-network services is based upon the average contracted rates for network providers in the area where services are rendered. Members are fully responsible for any amount over the ACR as well as any applicable deductibles and coinsurance. With CIGNA medical management approval, hospital admissions resulting from an emergency may be exempt from ACR.

## SPECIAL ENROLLMENT RIGHTS NOTICE

- If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health Plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for the other coverage or if the employer stops contributing towards your or your dependents' other coverage. However, you must request enrollment within 31 days after your or your dependents' other coverage ends or after the employer stops contributing toward the other coverage.
- In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days of the marriage, birth, adoption or placement for adoption.
- To request special enrollment or obtain more information, contact your HR/Benefits Director.

## WHAT'S NOT COVERED (THIS IS NOT ALL INCLUSIVE)

- \* services that aren't medically necessary
- \* experimental or investigational treatments
- \* accidental injury that occurs while working for pay or profit
- \* sickness for which benefits are paid or payable under any Worker's Compensation or similar law
- \* services provided by government health plans
- \* cosmetic surgery, unless it correct deformities resulting from illness, breast reconstruction surgery after a mastectomy, or congenital defects of a newborn or adopted child or child placed for adoption.
- \* custodial care
- \* sex transformation
- \* surgical procedures for the improvement of vision that can be corrected through the use of glasses or contact lenses.
- \* vision therapy or orthoptic treatment
- \* reversal of sterilization procedures
- \* nonprescription drugs or anti-obesity drugs
- \* gene manipulation therapy
- \* smoking cessation programs \* Bariatric Surgery

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