# SUMMARY OF BENEFITS Connecticut General Life Insurance Co.

## Arizona Small Business Association – 2012 HDHP Option 1
## Open Access Plus Coinsurance Plan

| Annual deductibles and maximums | In-network | Out-of-network |
|---|---|---|
| **Lifetime maximum** | Unlimited<br>per individual | |
| **Pre-Existing Condition Limitation (PCL)** | Applies | Applies |
| **Coinsurance** | You pay 25%<br>Plan pays 75%<br>after the deductible is met | You pay 50%<br>Plan pays 50%<br>after the deductible is met |
| **Maximum Reimbursable Charge**<br>• Determined based on the lesser of:<br>  • the health care professional's normal charge for a similar service; or<br>  • a percentage of a fee schedule developed by CIGNA that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area.<br>• In some cases, the Medicare based fee schedule will not be used and the maximum reimbursable charge for covered services is determined based on the lesser of:<br>  • the health care professional's normal charge for a similar service or supply; or<br>  • the amount charged for that service by 80% of the health care professionals in the geographic area where it is received.<br>• Out-of-network services are subject to a calendar year deductible and maximum reimbursable charge limitations. | N/A | 110% |
| **Calendar year deductible - COLLECTIVE**<br>• The amount you pay for out-of-network services counts towards both your in-network and out-of-network deductibles.<br>• All family members contribute towards the family deductible. The plan cannot pay an individual's claim until the total family deductible has been met, even if he or she has met the individual deductible.<br>• This plan includes a combined Medical/Rx deductible.<br>• Mail order pharmacy costs contribute to the deductible. | **Employee**<br>$3,000<br><br>**Employee and Family**<br>$6,000 | **Employee**<br>$6,000<br><br>**Employee and Family**<br>$12,000 |
| **Calendar year out-of-pocket maximum**<br>• The amount you pay for out-of-network services counts towards both your in-network and out-of-network out-of-pocket maximums.<br>• All family members contribute towards the family OOP. An individual cannot have claims covered at 100% until the total family OOP maximum has been satisfied.<br>• Deductibles count towards your out-of-pocket maximum.<br>• Mental health and substance abuse services count towards your out-of-pocket maximum.<br>• This plan includes a combined Medical/Rx OOP maximum.<br>• Mail order pharmacy costs contribute to the OOP maximum. | **Employee**<br>$5,950<br><br>**Employee and Family**<br>$11,900 | **Employee**<br>$15,000<br><br>**Employee and Family**<br>$30,000 |

| Benefits | In-network | Out-of-network |
|---|---|---|
| **Physician services** | | |
| **Office visit**<br>• Primary care physician and specialist office visits | You pay 25%<br>Plan pays 75%<br>after the deductible is met | You pay 50%<br>Plan pays 50%<br>after the deductible is met |
| **Physician services (hospital)**<br>• In hospital visits and consultations<br>• Inpatient services<br>• Outpatient services | You pay 25%<br>Plan pays 75%<br>after the deductible is met | You pay 50%<br>Plan pays 50%<br>after the deductible is met |
| **Surgery (in a physician's office)** | You pay 25%<br>Plan pays 75%<br>after the deductible is met | You pay 50%<br>Plan pays 50%<br>after the deductible is met |
| **Preventive care** | | |
| **Children (through age 2)**<br>• Office visit<br>• In-network immunizations are covered at no charge.<br>• Out-of-network immunizations are not covered. | No Charge | Not covered |
| **Adults and children (age 3 and older)**<br>• Unlimited calendar year maximum<br>• In-network immunizations are covered at no charge after the deductible is met.<br>• Out-of-network immunizations are not covered.<br>• | No Charge | Not covered |
| **Mammogram, PSA, Pap Smear** | No charge | You pay 50%<br>Plan pays 50%<br>after the deductible is met |
| **Inpatient hospital facility services** | | |
| **Semi-private room and board and other non-physician services**<br>• Inpatient room and board, pharmacy, x-ray, lab, operating room, surgery, etc. | You pay 25%<br>Plan pays 75%<br>after the deductible is met | You pay 50%<br>Plan pays 50%<br>after the deductible is met |
| **Inpatient Professional Services**<br>• For services performed by surgeons, radiologists, pathologists and anesthesiologists | You pay 25%<br>Plan pays 75%<br>after plan deductible is met | You pay 50%<br>Plan pays 50%<br>after the deductible is met |
| **Multiple surgical reduction**<br>• Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery. | Included | Included |
| **Outpatient services** | | |
| **Outpatient surgery (facility charges)** | You pay 25%<br>Plan pays 75%<br>after the deductible is met | You pay 50%<br>Plan pays 50%<br>after the deductible is met |

**Arizona Small Business Association - 2012 ER HDHP Option 1**
**Open Access Plus Coinsurance Plan**

| Benefits | In-network | Out-of-network |
|---|---|---|
| **Outpatient Professional Services**<br>• For services performed by surgeons, radiologists, pathologists and anesthesiologists | You pay 25%<br>Plan pays 75%<br>after the deductible is met | You pay 50%<br>Plan pays 50%<br>after the deductible is met |
| **Physical, occupational, , chiropractic, cognitive and speech therapy**<br>• Limited to 20 days per calendar year for all therapies combined<br>• Includes physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation and cognitive therapy<br>• Includes cardiac rehabilitation<br>• Therapy days, provided as part of an approved Home Health Care plan, accumulate to the outpatient short term rehab therapy maximum.<br>• **No limits will be applied to subluxation or spinal manipulation chiropractic services.** | You pay 25%<br>Plan pays 75%<br>after the deductible is met | You pay 50%<br>Plan pays 50%<br>after the deductible is met |
| **Lab and X-ray** | | |
| **Lab and X-ray**<br>• Physician's office<br>• Outpatient hospital facility<br>• Emergency room<br>• Independent X-ray and/or lab facility<br>• Independent X-ray and/or lab facility as part of an emergency room visit | You pay 25%<br>Plan pays 75%<br>after the deductible is met | You pay 50%<br>Plan pays 50%<br>after the deductible is met |
| **Advanced radiological imaging**<br>• MRI, MRA, CAT Scan, PET Scan, etc.<br>• Inpatient hospital facility, outpatient hospital facility, emergency room, urgent care facility or physician's office | You pay 25%<br>Plan pays 75%<br>after the deductible is met | You pay 50%<br>Plan pays 50%<br>after the deductible is met |
| **Emergency and urgent care services** | | |
| **Hospital emergency room**<br>• Includes radiology, pathology and physician charges<br>• Out-of-network services are covered at the in-network rate. | You pay 25%<br>Plan pays 75%<br>after the deductible is met | |
| **Ambulance**<br>• Out-of-network services are covered at the in-network rate only if it is a true emergency. If not a true emergency, the out-of-network rate is charged. | You pay 25%<br>Plan pays 75%<br>after the deductible is met | |
| **Urgent care services**<br>• Out-of-network services are covered at the in-network rate. | You pay 25%<br>Plan pays 75%<br>after the deductible is met | |
| **Other health care facilities** | | |
| **Skilled nursing facility, rehabilitation hospital and other facilities**<br>• 60 days per calendar year | You pay 25%<br>Plan pays 75%<br>after the deductible is met | You pay 50%<br>Plan pays 50%<br>after the deductible is met |

| Benefits | In-network | Out-of-network |
|---|---|---|
| **Home health care**<br>• Unlimited days per calendar year | You pay 25%<br>Plan pays 75%<br>after the deductible is met | You pay 50%<br>Plan pays 50%<br>after the deductible is met |
| **Hospice**<br>• Inpatient services<br>• Outpatient services | You pay 25%<br>Plan pays 75%<br>after the deductible is met | You pay 50%<br>Plan pays 50%<br>after the deductible is met |
| **Other health care services** | | |
| **Durable medical equipment**<br>• Unlimited calendar year maximum | You pay 25%<br>Plan pays 75%<br>after the deductible is met | You pay 50%<br>Plan pays 50%<br>after the deductible is met |
| **External prosthetic appliances (EPA)**<br>• Unlimited calendar year maximum | You pay 25%<br>Plan pays 75%<br>after deductible is met | You pay 50%<br>Plan pays 50%<br>after deductible is met |
| **TMJ** | Not Covered | Not Covered |
| **Infertility**<br>• Coverage will be provided for the treatment of the underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness. | Not Covered | Not Covered |
| **Family planning**<br>• Office visits<br>• Inpatient hospital facility<br>• Outpatient facility<br>• Physician services<br>• Surgical services such as tubal ligation or vasectomy are covered (excluding reversals).<br>• Includes contraceptive devices<br>• Contributes to the preventive care maximum<br>• Subject to the plan's Preventive Care dollar maximum | Cost and reimbursement vary based on the facility in which it is performed | Cost and reimbursement vary based on the facility in which it is performed |
| **Mental health and substance abuse services** | | |
| Please note the following regarding Mental Health (MH) and Substance Abuse (SA) benefit administration:<br>• Substance Abuse includes Alcohol and Drug Abuse services.<br>• Transition of Care benefits are provided for a 90-day time period. | | |
| **Inpatient mental health services**<br>• Unlimited days per calendar year<br>• Mental health services are paid at 100% after you reach your out-of-pocket maximum. | You pay 25%<br>Plan pays 75%<br>after the plan deductible is met | You pay 50%<br>Plan pays 50%<br>after the plan deductible is met |
| **Outpatient mental health services**<br>• Unlimited visits per calendar year<br>• Mental health services are paid at 100% after you reach your out-of-pocket maximum.<br>• This includes group therapy mental health, and intensive outpatient mental health | You pay 25%<br>Plan pays 75%<br>after the plan deductible is met | You pay 50%<br>Plan pays 50%<br>after the plan deductible is met |

| Benefits | In-network | Out-of-network |
|---|---|---|
| **Inpatient substance abuse services**<br>• Unlimited days per calendar year<br>• Substance abuse services are paid at 100% after you reach your out-of-pocket maximum. | You pay 25%<br>Plan pays 75%<br>after the plan deductible is met | You pay 50%<br>Plan pays 50%<br>after the plan deductible is met |
| **Outpatient substance abuse services**<br>• Unlimited visits per calendar year<br>• Substance abuse services are paid at 100% after you reach your out-of-pocket maximum.<br>• This includes intensive outpatient substance abuse | You pay 25%<br>Plan pays 75%<br>after the plan deductible is met | You pay 50%<br>Plan pays 50%<br>after the plan deductible is met |
| **Prescription Drugs** | | |
| **CIGNA Pharmacy Plus three-tier coinsurance plan**<br>• No mandatory generics<br>• Self administered injectable– excludes infertility drugs<br>• Includes Oral Contraceptives | **Retail**<br>(30 day supply)<br>You pay:<br>Generic 30% *<br>Preferred brand 40%*<br>Non-Preferred Brand 50%*<br><br>**Home Delivery**<br>(90 Day supply)<br>You pay:<br>Generic 30% *<br>Preferred brand 40%*<br>Non-Preferred Brand 50%*<br><br>*After plan deductible | Not Covered |
| **Pharmacy cost management program**<br>• Includes high blood pressure prescriptions<br>• Includes stomach acid prescriptions<br>• Includes high cholesterol prescriptions | High blood pressure<br>*Level of Intervention:*<br>Both a generic and then a preferred brand drug must be used prior to using the non-preferred brand drug<br>60 Days grace period<br>First Fill Pay and Educate included<br><br>Stomach acid<br>*Level of Intervention:*<br>Both a generic and then a preferred brand drug must be used prior to using the non-preferred brand drug<br>60 Days grace period<br>First Fill Pay and Educate included<br><br>High cholesterol<br>*Level of Intervention:*<br>A generic or a Preferred Brand drug must be used prior to using the Non-Preferred Brand drug<br>60 Days grace period<br>First Fill Pay and Educate included | |

| Benefits | In-network | Out-of-network |
|---|---|---|
| **Clinical Outcome Programs**<br>• Includes complex psychiatric case management<br>• Includes narcotic therapy management | | |
| **Specialty Pharmacy**<br>• Clinical Programs | Prior authorization required on specialty medications and quantity limits may apply.<br>TheraCare® Program | |
| **Specialty Pharmacy**<br>• Medication Access Option | Retail and/or Home Delivery | |
| **Vision care** | Not covered | |

## Definitions

**Deductible** – A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.

**Coinsurance** – After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called coinsurance.

**Copay** – A flat fee you pay for certain covered services such as doctor's visits or prescriptions.

**Out-of-pocket Maximum** – Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "maximum reimbursable charges" or negotiated fees for covered services.

**Place of service** – Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.

**Pre-existing condition limitation** – Applies to any injury or sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a physician during the 90 days before the earlier of the date a person begins an eligibility waiting period or becomes insured for these benefits. Coverage for the pre-existing condition is excluded until one year of the member being continuously insured and/or is satisfying a waiting period. Each insured will receive credit for the amount of any prior creditable coverage, provided the break between any such coverage was no more than 63 days (or the applicable timeframe required per state law). Usually the PCL is waived for the initial group, but if not, the insured will receive credit as explained above..

Not applicable to anyone under 19 years old.

## Maximizing your health care dollars

Log on to myCIGNA.com for resources to help you choose a health care professional or compare the cost and quality of medical services, medications and hospital care.

When you need a medical service or procedure, CIGNA offers you opportunities to save on prescription medicine, routine medical care, laboratory services, radiology scans, and outpatient surgery. Details are below:

**CIGNA Home Delivery Pharmacy** –You can save money and enjoy convenient home delivery by using CIGNA Home Delivery Pharmacy for your prescription medications. You can get up to a 90-day supply of your medication.

**Lab** – Save on lab services by using a free-standing laboratory instead of a hospital- or clinic-based lab.

**Urgent Care** – For non-emergency conditions that need attention before you can see your doctor, you can save money by going to an urgent care center instead of an Emergency Room (ER).

**Convenience Care** – For minor or routine conditions, go to a Convenience Care Clinic when your doctor is unavailable. Convenience Care Clinics are retail-based and often found in pharmacies or grocery stores.

**Radiology** – Costs for MRIs, PET, and CT scans can vary greatly. Non-hospital based outpatient radiology centers often cost much less than a hospital. CIGNA's network includes both hospitals and outpatient centers, so you can find a radiology center that's right for you.

**Outpatient Surgery** – Costs for colonoscopies, arthroscopies, and other outpatient procedures can vary greatly. Using a free-standing outpatient surgery center can save hundreds of dollars.

## Exclusions

**What's Not Covered (*not all-inclusive*):**

Your plan provides coverage for most medically necessary services. Examples of things your plan does not cover, unless required by law, include (but aren't limited to):

- Services provided through government programs
- Services that aren't medically necessary
- Experimental, investigational or unproven services
- Services for an injury or illness that occurs while working for pay or profit including services covered by Worker's Compensation benefits
- Cosmetic services
- Dental care, unless due to accidental injury to sound natural teeth
- Infertility Services
- Reversal of sterilization procedures
- Genetic screenings
- Obesity surgery and services
- Non-prescription and anti-obesity drugs
- Custodial and other non-skilled services
- Weight loss programs
- Hearing aids
- Treatment of TMJ Disorder
- Acupuncture
- Treatment of sexual dysfunction
- Travel immunizations
- Telephone, email and internet consultations in the absence of a specific benefit
- Eyeglass lenses and frames, contact lenses and surgical vision correction

**These are only the highlights**

This summary outlines the highlights of your plan. For a complete list of both covered and not-covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence.

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