

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 LineSM 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 many 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.
- 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 LanguagesSM**. We offer Language Line Services so that you can **talk with us** in 150 different languages. Just call Customer Service, and ask for an interpreter to assist you.
- Our interactive voice response system helps you find what you need faster over the phone. Use the speech recognition feature for information on your benefits, level of coverage, claims status, and more.

It's Your Health

When you choose CIGNA HealthCare, you can take advantage of our **health and wellness** programs:

- We encourage you to use a **PCP** as a valuable resource and personal health advocate.
- **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 HealthSM can **help you manage** certain chronic conditions.
- The CIGNA HealthCare Healthy Babies[®] 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 and lower out-of-pocket costs. Your plan also offers the **freedom to choose** the providers you prefer — even if they aren't part of the network. Your benefits are higher when you see "preferred providers," but you're still covered for visits to other providers.

**For Employees of
Oberlin College
A-Plan**

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Physician Services Primary Care Physician (PCP) Office Visit</p> <p>Specialty Physician Office Visit <i>Consultant and Referral Physician Services</i></p> <p>Note: A copayment applies for OB/GYN visits. If your doctor is listed as a PCP in the provider directory, you will pay a PCP copayment. If your doctor is listed as a specialist, you will pay the specialist copayment.</p> <p>Allergy Treatment/Injections - PCP or Specialty Physician</p> <p>Allergy Serum (dispensed by physician in office)</p> <p>Second Opinion Consultations (provided on voluntary basis)</p> <p>Surgery Performed in the Physician's Office- PCP or Specialty Physician</p>	<p>\$15 copayment per office visit; 10% of charges, no deductible, for x-ray/lab services if billed by a separate facility.</p> <p>\$30 copayment per office visit; 10% of charges, no deductible, for x-ray/lab services if billed by a separate facility.</p> <p>\$15 or \$30 copayment per office visit or actual charge, whichever is less</p> <p>No charge</p> <p>\$15 or \$30 copayment per office visit</p> <p>10% of charges*</p>	<p>35% of charges**</p> <p>35% of charges**</p> <p>35% of charges**</p> <p>35% of charges**</p> <p>35% of charges**</p> <p>35% of charges**</p>
<p>Preventive Care Routine Preventive Care for Children through age 2 (including routine immunizations)</p> <p>Immunizations</p> <p>Routine Preventive Care for Children and Adults from age 3 (including routine immunizations) \$500 maximum per calendar year</p> <p>^^^ Charges for lab & radiology services billed by physician's office are subject to preventive care dollar maximum. Charges for lab & radiology services billed by independent diagnostic facility or outpatient hospital do NOT apply to preventive care dollar maximum.</p>	<p>\$15 or \$30 copayment per office visit; 10% of charges, no deductible, for x-ray/lab services if billed by a separate facility.</p> <p>No charge, no plan deductible</p> <p>\$15 or \$30 copayment per office visit; 10% of charges, no deductible, for x-ray/lab services if billed by a separate facility.^^^</p>	<p>Covered in-network only</p>
<p>Mammograms, PSA, Pap Test Note: Preventive care related services and diagnostic related services are paid at the same level of benefits as other x-ray and lab services.</p> <p>(Mammogram charges do NOT apply to preventive care dollar maximum regardless of place of service. PSA and Pap Test charges if billed by physician's office do apply to the preventive care dollar maximum; or if billed by independent diagnostic facility or outpatient hospital facility do NOT apply to the preventive care maximum.)</p>	<p>10% of charges, no deductible if billed by independent diagnostic facility or outpatient hospital; \$15 or \$30 copayment per visit for associated wellness exam</p>	<p>35% of charges**</p>
<p>Inpatient Hospital Services including: Semi-Private Room and Board Diagnostic/Therapeutic Lab and X-ray Drugs and Medication Operating and Recovery Room Radiation Therapy and Chemotherapy Anesthesia and Inhalation Therapy</p>	<p>10% of charges*</p>	<p>35% of charges* Precertification required</p>
<p>Inpatient Hospital Doctor's Visits/Consultations Inpatient Hospital Professional Services</p>	<p>10% of charges* 10% of charges*</p>	<p>35% of charges** 35% of charges**</p>
<p>Outpatient Facility Services includes: Operating Room, Recovery Room, Procedure Room and Treatment Room and Observation Room including: Diagnostic/Therapeutic Lab and X-rays Anesthesia and Inhalation Therapy Physician & Outpatient Professional Services</p>	<p>10% of charges* 10% of charges*</p>	<p>35% of charges** 35% of charges**</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Laboratory and Radiology Services (includes preadmission testing) Advanced Radiological Imaging (MRIs, CAT Scans, PET Scans, etc.) Other Laboratory and Radiology Services 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)	10% of charges, no deductible No charge 10% of charges, no deductible No charge 10% of charges, no deductible No charge	35% of charges** 35% of charges** 35% of charges** No charge (except if not a true emergency, then 35% of charges**) 35% of charges** No charge (except if not a true emergency then 35% of charges**)
Short-Term Rehabilitative Therapy and Chiropractic Services--(includes cardiac rehab, physical, speech, occupational, chiropractic, pulmonary rehab & cognitive therapy) <u>Note:</u> If multiple Outpatient services are provided on the same day, they constitute one day, but a separate copay will apply to the services provided by each participating provider.	\$15 or \$30 copayment per office visit; 10% of charges, no deductible, for x-ray/lab services if billed by a separate facility.	35% of charges**
Emergency and Urgent Care Services Physician's Office – PCP or Specialty Physician Hospital Emergency Room Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician) Urgent Care Facility or Outpatient Facility Ambulance	\$15 or \$30 copayment per office visit; 10% of charges, no deductible, for x-ray/lab services if billed by a separate facility. \$85 copayment per visit (copay waived if admitted) and plan deductible No charge, no deductible \$40 copayment per visit (copay waived if admitted) and plan deductible 10% of charges*	\$15 or \$30 copayment per office visit; 10% of charges, no deductible, for x-ray/lab services if billed by a separate facility. (except if not a true emergency, then 35% of charges**) \$85 copayment per visit (copay waived if admitted) and plan deductible (except if not a true emergency, then 35% of charges**) No charge, no deductible (except if not a true emergency, then 35% of charges**) \$40 copayment per visit (copay waived if admitted) and plan deductible (except if not a true emergency, then 35% of charges**) 10% of charges* (except if not a true emergency, then 35% of charges**)
Maternity Care Services Initial Office Visit to Confirm Pregnancy All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (total maternity fee) Office Visits not included in the total maternity fee performed by OB or Specialty Physician Delivery - Facility (Inpatient Hospital/Birthing Center Charges)	\$15 or \$30 copayment for initial office visit; 10% of charges, no deductible, for x-ray/lab services if billed by a separate facility. 10% of charges* \$15 or \$30 copayment per office visit; 10% of charges, no deductible, for x-ray/lab services if billed by a separate facility. 10% of charges*	35% of charges** 35% of charges** 35% of charges** 35% of charges*, precertification required
Inpatient Services at Other Health Care Facilities Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities	10% of charges*	35% of charges**
Home Health Services – 16 hour maximum per day# Multiple visits can occur in one day; with a visit defined as a period of 2 hours or less (e.g. maximum of 8 visits per day)	10% of charges*	35% of charges**

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Family Planning Services Office Visits (lab & radiology tests, counseling) (Charges for these services will NOT be Subject to Preventive Care dollar maximum) Vasectomy/Tubal Ligation (excludes reversals) Inpatient Facility Outpatient Facility Physician's Services – Inpatient or Outpatient Physician's Office</p>	<p>\$15 or \$30 copayment per office visit; 10% of charges, no deductible, for x-ray/lab services if billed by a separate facility.</p> <p>10% of charges* 10% of charges* 10% of charges* \$15 or \$30 copayment per office visit; 10% of charges, no deductible, for x-ray/lab services if billed by a separate facility.</p>	<p>Covered in-network only</p> <p>35% of charges*, precertification required 35% of charges** 35% of charges** 35% of charges**</p>
<p>Infertility Services Office Visit (lab & radiology tests, counseling)-PCP or Specialty Physician Treatment/Surgery (excludes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.) Inpatient Facility Outpatient Facility Physician's Services</p>	<p>\$15 or \$30 copayment per office visit; 10% of charges, no deductible, for x-ray/lab services if billed by a separate facility.</p> <p>10% of charges* 10% of charges* 10% of charges*</p>	<p>Covered in-network only</p>
<p>TMJ - Surgical and Non-Surgical-case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity. Physician's Office Inpatient Facility Outpatient Facility Physician's Services</p>	<p>\$15 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% of charges* 10% of charges* 10% of charges*</p>	<p>35% of charges**</p> <p>35% of charges*, precertification required 35% of charges** 35% of charges**</p>
<p>Mental Health Inpatient - 30 days maximum per calendar year# Acute: Based on a ratio of 1:1 Partial: Based on a ratio of 2:1 Residential: Based on a ratio of 2:1 Outpatient Group Therapy – combined maximum with Outpatient Individual Mental Health services based on a ratio of 1:1 Intensive Outpatient – 3 programs maximum per contract year based on a ratio of 1:1 with outpatient Mental Health visits</p>	<p>10% of charges*</p> <p>\$15 copayment per office visit</p> <p>\$15 copayment per office visit</p> <p>100% after \$50 per program copay</p>	<p>35% of charges*, precertification required</p> <p>35% of charges** 15 visits maximum per calendar year</p> <p>35% of charges**</p> <p>35% of charges** after \$100 per program deductible</p>
<p>Substance Abuse Inpatient - Lifetime maximum 90 days combined with outpatient visits# 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 Outpatient - Lifetime maximum 90 days combined with inpatient visits Intensive Outpatient – 3 programs maximum per contract year based on a ratio of 1:1 with outpatient Substance Abuse visits</p>	<p>10% of charges*</p> <p>\$15 copayment per office visit</p> <p>100% after \$50 per program copay</p>	<p>35% of charges*, precertification required 30 days maximum per calendar year#</p> <p>35% of charges**</p> <p>35% of charges** after \$100 per program deductible</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Durable Medical Equipment	10% of charges*	35% of charges**
External Prosthetic Appliances	10% of charges*	35% of charges**
Prescription Drugs- CIGNA Pharmacy Retail Drug Program <i>Generic</i> <i>Preferred Brand Name</i> <i>Non-Preferred Brand</i>	\$14 copayment per prescription/refill \$25 copayment per prescription/refill \$40 copayment per prescription/refill	Covered in-network only
CIGNA Tel-Drug Mail Order Drug Program <i>Generic</i> <i>Preferred Brand</i> <i>Non-Preferred Brand</i>	\$28 copayment per prescription/refill \$50 copayment per prescription/refill \$80 copayment per prescription/refill	
	<i>Note: \$0 copay for insulin syringes, needles, lancets, and glucose test strips – both Retail and Mail Order</i>	
OTHER BENEFIT INFORMATION	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Plan Deductible <i>Individual</i> <i>Family Maximum</i>	\$330 \$660	\$660 \$1,320
Calendar Year Out-of-Pocket Maximum <i>Individual</i> <i>Family Maximum</i>	Including Plan Deductible \$2,000 \$4,000	Including Plan Deductible \$4,000 \$8,000
Coinsurance	CIGNA HealthCare pays 90% eligible charges. You pay 10% charges after the plan deductible.	CIGNA HealthCare pays 65% eligible charges. You pay 35% of charges after the plan deductible.
Precertification -Inpatient – PHS+ (required for all inpatient admissions)	Coordinated by your physician	Participant must obtain approval for inpatient admission; subject to penalty/reduction or denial for non-compliance
Precertification – Outpatient – PHS+ (required for selected outpatient procedures and diagnostic testing or outpatient services)	Coordinated by your physician	Participant must obtain approval for selected outpatient procedures and diagnostic testing; subject to penalty/reduction or denial for non-compliance.
Lifetime Maximum	\$2,000,000#	\$2,000,000#
Pre-existing Condition Limitation	No	No

*Services are subject to calendar year deductible

**Services are subject to calendar year deductible and reasonable and customary charge/maximum reimbursable 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, except for Mental Health and Substance Abuse which continue to be paid at the levels specified.
- 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.

Regarding In-Network Services: All services must be provided by one of the preferred 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 preferred 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 artificial insemination, in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). 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.
20. Genetic screening or pre-implantation genetic screening.
21. Fees associated with the collection or donation of blood or blood products.
22. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
23. All nutritional supplements and formulae are excluded, except infant formula needed for the treatment of inborn errors of metabolism.
24. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
25. 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.
26. 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.
27. 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; Roling; 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.

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