SUMMARY OF BENEFITS

Your CIGNA HealthCare Open Access Plus plan

CIGNA HealthCare

Features that Add Value

- Your plan offers the **convenience of referral-free access to doctors**, 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℠ connects you **to trained 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 programs and services designed to enhance your health and wellness. Just call 1.800.870.3470 or visit our web site at www.cigna.com.
- Prescription drug coverage is a **part of your plan**. With national and independent pharmacies participating across the country, you can have your prescription filled **wherever you go**. CIGNA Tel-Drug gives you quick, **convenient** delivery of your medications right to your home.
- **CIGNA Behavioral Advantage** emphasizes the mind-body connection. The program provides support from medical and mental health case managers, as well as a number of tools and resources, to help you take control of your health and wellness.

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. Once you enroll, register for myCIGNA.com, our convenient, secure website that combines helpful easy-to-use tools with personalized benefits information to help you make the most of your plan.
- **We Speak Many Languages℠**. 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.

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 Benefit Highlights.
- **CIGNA Well Informed** provides members with customized medical and wellness information to help them make healthier choices, better understand a diagnosis or treatment, and manage their health. The program includes personalized letters and other educational information to help you improve your health. Only you, your doctor and CIGNA have access to this information.
- CIGNA Well-Aware for Better Health® 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 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. Participating providers charge a discounted rate for CIGNA members. If you use a non-network provider, the provider may bill you for the difference between the billed charge and the allowed amount under your benefit plan, in addition to applicable (higher than in-network) deductibles and coinsurance amounts.

For Employees of County of Loudoun, VA

OAP - ASO

Revised 09/01/09

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Contract Year Plan Deductible *Individual* *Family Maximum*	*Maximums Cross Accumulate* $200 $600	*Maximums Cross Accumulate* $500 $1,500
Contract Year Out-of-Pocket Maximum *Individual / Family Maximum*	*Maximums Cross Accumulate* Includes Plan Deductible $1,000/$2,000	*Maximums Cross Accumulate* Includes Plan Deductible $2,500/$5,000
Coinsurance	CIGNA HealthCare pays 90% of eligible charges. You pay 10% of charges after plan deductible.	CIGNA HealthCare pays 70% of eligible charges. You pay 30% of charges after plan deductible.
Precertification -Inpatient – PHS+ *(required for all inpatient admissions)* ***Precertification – Outpatient – PHS+*** *(required for selected outpatient procedures and diagnostic testing or outpatient services)*	Coordinated by your physician Coordinated by your physician	Participant must obtain approval for inpatient admission; subject to penalty/reduction or denial for non-compliance Participant must obtain approval for selected outpatient procedures and diagnostic testing; subject to penalty/reduction or denial for non-compliance
Lifetime Maximum	Unlimited	$1,000,000#
Pre-existing Condition Limitation	No	No
Physician Services ***Primary Care Physician (PCP) Office Visit*** ***Specialty Physician Office Visit*** *Consultant and Referral Physician Services* ***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.* *Allergy Treatment/Injections - PCP or Specialty Physician* *Allergy Serum (dispensed by physician in office)* *Second Opinion Consultations (provided on voluntary basis)* *Surgery Performed in the Physician's Office- PCP or Specialty Physician*	$15 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed. $30 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed. $15 or $30 copayment per office visit or actual charge, whichever is less No charge $15 or $30 copayment per office visit $15 or $30 copayment per office visit	30% of charges** 30% of charges** 30% of charges** 30% of charges** 30% of charges** 30% of charges**
Preventive Care *Routine Preventive Care for Children through age 2 (including routine immunizations)* *Immunizations* *Routine Preventive Care for Children and Adults from age 3 (including routine immunizations)* Unlimited maximum per contract year# *Immunizations*	$15 or $30 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed. No charge, no plan deductible $15 or $30 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed. No charge, no plan deductible	30% of charges** 30% of charges** 30% of charges** 30% of charges**
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 based on place of service.*	No charge* if billed by independent diagnostic facility or outpatient hospital $15 or $30 copayment for associated wellness exam	30% of charges**

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
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* *MRIs, MRAs, CAT Scans, PET Scans, etc.*	$200 copayment per admission, plus 10% of charges*	$400 deductible per admission, plus 30% of charges* Precertification required
Inpatient Hospital Doctor's Visits/Consultations *Inpatient Hospital Professional Services*	10% of charges* 10% of charges*	30% of charges** 30% of charges**
Outpatient Facility Services *Operating Room, Recovery Room, Procedure Room and Treatment Room including:* *Diagnostic/Therapeutic Lab and X-rays* *Anesthesia and Inhalation Therapy* *Physician and Outpatient Professional Services* ***Note**: Non-surgical treatment procedures are not subject to the facility copayment.*	$100 copayment per facility visit, plus 10% of charges* 10% of charges*	$200 deductible per facility visit, plus 30% of charges** 30% of charges**
Laboratory and Radiology Services (includes preadmission testing) *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)*	$15 or $30 copayment per office visit 10% of charges* No charge 10% of charges* No charge	30% of charges** 30% of charges** No charge; *except if not a true emergency, then 30% of charges*** 30% of charges** No charge
Advanced Radiological Imaging *(MRIs, MRAs, CAT Scans, PET Scans, etc.)* *Outpatient Facility* *Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit)* *Physician's Office*	10% of charges* No charge No charge	30% of charges** No charge; *except if not a true emergency, then 30% of charges*** 30% of charges**
Short-Term Rehabilitative Therapy and Cardiac Rehabilitation – (includes cardiac rehab, physical, speech, occupational, pulmonary rehab & cognitive therapy) 90 days maximum per contract year# for all therapies combined ***Note**: therapy sessions provided as part of Home Health Care accumulate to the Short-Term Rehab Therapy maximum.*	$15 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.	30% of charges**
Chiropractic Services $500 maximum per contract year#	$15 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.	30% 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; No charge after office visit copay if only x-ray and/or lab services are performed and billed. $100 copayment per visit* (copay waived if admitted) No charge* $50 copayment per visit* (copay waived if admitted) 10% of charges*	*Care will be provided at in-network levels if it meets the "prudent layperson" definition of an emergency. Otherwise 30% of charges***

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Maternity Care Services *Initial Office Visit to Confirm Pregnancy* ***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.*	$15 or $30 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.	30% of charges**
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (total maternity fee)	10% of charges*	30% of charges**
Office Visits not included in the total maternity fee performed by OB or Specialty Physician	$15 or $30 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.	30% of charges**
Delivery - Facility (Inpatient Hospital/Birthing Center Charges)	$200 copayment per admission, plus 10% of charges*	$400 deductible per admission, plus 30% of charges* Precertification required
Inpatient Services at Other Health Care Facilities ***Skilled Nursing, Rehabilitation and Sub-Acute Facilities*** 100 days maximum per contract year# combined for all facilities listed	10% of charges*	30% of charges**
Home Health Services *- Includes outpatient private duty nursing when approved as medically necessary,* Unlimited days maximum per contract year#; 16 hour maximum per day#	10% of charges*	30% of charges**
Family Planning Services *Office Visits (lab & radiology tests, counseling)*	$15 or $30 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.	30% of charges**
Vasectomy/Tubal Ligation (excludes reversals) *Inpatient Facility*	$200 copayment per admission, plus 10% of charges*	$400 deductible per admission, plus 30% of charges* Precertification required
Outpatient Facility Services	$100 copayment per facility visit, plus 10% of charges*	$200 deductible per facility visit, plus 30% of charges**
Physician's Services – Inpatient or Outpatient	10% of charges*	30% of charges**
Physician's Office	$15 or $30 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.	30% of charges**
Infertility Services ***Note****: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.*	Not covered	Not covered

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
TMJ – Surgical and Non-surgical: case-by-case basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity.		
Physician's Office	$15 or $30 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.	30% of charges**
Inpatient Facility	$200 copayment per admission, plus 10% of charges*	$400 deductible per admission, plus 30% of charges* Precertification required
Outpatient Facility Services	$100 copayment per facility visit, plus 10% of charges*	$200 deductible per facility visit, plus 30% of charges**
Physician's Services – Inpatient or Outpatient	10% of charges*	30% of charges**
Mental Health and Substance Abuse		
Inpatient *– 30 days combined maximum per contract year#*	$200 copayment per admission, plus 10% of charges*	$400 deductible per admission, plus 30% of charges* Precertification required
Mental Health		
Acute: *Based on a ratio of 1:1*		
Partial: *Based on a ratio of 2:1*		
Residential: *Based on a ratio of 2:1*		
Substance Abuse		
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 Individual *– 52 visits combined maximum per contract year#*	$30 copayment per visit	30% of charges**
Intensive Outpatient Mental Health & Substance Abuse *– 3 programs maximum per contract year# based on a ratio of 1:1 with outpatient Mental Health/Substance Abuse visits*	$50 per program copayment	$50 per program deductible, plus 30% of charges; no plan deductible
Durable Medical Equipment $2,500 maximum per contract year#	10% of charges*	30% of charges**
External Prosthetic Appliances $2,500 maximum per contract year#	10% of charges*	30% of charges**
Prescription Drugs		
CIGNA Pharmacy Retail Drug Program		
*Generic*** drugs on the Prescription Drug List for a 30-day supply*	$5 copayment per prescription/refill	30% of charges per prescription/refill
*Brand Name*** drugs designated as preferred on the Prescription Drug List with no Generic equivalent for a 30-day supply*	$25 copayment per prescription/refill	30% of charges per prescription/refill
*Brand Name*** drugs designated as non-preferred on the Prescription Drug List for a 30-day supply*	$45 copayment per prescription/refill	30% of charges per prescription/refill
CIGNA Tel-Drug Mail Order Drug Program		
*Generic*** drugs on the Prescription Drug List for a 90-day supply*	$10 copayment per prescription/refill	Covered in-network only
*Brand Name*** drugs designated as preferred on the Prescription Drug List with no Generic equivalent for a 90-day supply*	$50 copayment per prescription/refill	Covered in-network only
*Brand Name*** drugs designated as non-preferred on the Prescription Drug List for a 90-day supply*	$90 copayment per prescription/refill	Covered in-network only
*****Designated as per generally-accepted industry sources and adopted by CG*		

Footnotes

* *Services are subject to contract year deductible.*

** *Out-of-network services are subject to the contract year deductible and maximum reimbursable charge limitations. Providers may bill the member the difference between their billed charge and the maximum reimbursable charge as determined by the benefit plan.*

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

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.*

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.*
- *All out-of-network hospital admissions and certain outpatient surgical and diagnostic procedures must be precertified and are subject to Continued Stay Review (CSR). A penalty applies to admissions which are not precertified. Non-approved admissions/days result in denial of benefits. The precertification penalty or cost of denied benefits does not apply to deductible or out-of-pocket maximum.*

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 services, 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, 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.

Benefit Exclusions (continued)

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; Macromastia or Gynecomastia Surgeries; Cosmetic Surgery and Therapies; Surgical Treatment of Varicose Veins; Rhinoplasty; Abdominoplasty/Panniculectomy; Blepharoplasty; Redundant Skin Surgery; Removal of Skin Tags; Acupressure; Craniosacral/cranial therapy; Dance Therapy, Movement Therapy; Applied Kinesiology; Rolfing; 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.

BSM37050
06
©2009 CIGNA Health Corporation