



**RTI International  
Open Access Plus Premier Plan**

**Notice of Grandfathered Plan Status**

This plan is being treated as a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your coverage may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at the phone number or address provided in your plan documents, to your employer or plan sponsor or an explanation can be found on CIGNA's website at [http://www.cigna.com/sites/healthcare\\_reform/customer.html](http://www.cigna.com/sites/healthcare_reform/customer.html).

If your plan is subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

If your plan is a nonfederal government plan or a church plan, you may also contact the U.S. Department of Health and Human Services at [www.healthreform.gov](http://www.healthreform.gov).

Annual deductibles and maximums	In-network	Out-of-network
<b>Lifetime maximum</b>	Unlimited per individual	
<b>Pre-Existing Condition Limitation (PCL)</b>	Applies	
<b>Coinsurance</b>	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
<b>Maximum Reimbursable Charge</b> <ul style="list-style-type: none"> <li>• Determined based on the lesser of:                             <ul style="list-style-type: none"> <li>• the health care professional’s normal charge for a similar service; or</li> <li>• 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.</li> </ul> </li> <li>• 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:                             <ul style="list-style-type: none"> <li>• the health care professional’s normal charge for a similar service or supply; or</li> <li>• the amount charged for that service by 80% of the health care professionals in the geographic area where it is received.</li> </ul> </li> <li>• Out-of-network services are subject to a calendar year deductible and maximum reimbursable charge limitations.</li> </ul>	N/A	150%
<b>Calendar year deductible</b> <ul style="list-style-type: none"> <li>• The amount you pay for out-of-network services counts towards both your in-network and out-of-network</li> </ul>	<b>Employee</b> \$300	<b>Employee</b> \$1,200

Plan Effective January 01, 2012



Annual deductibles and maximums	In-network	Out-of-network
<p>deductibles.</p> <ul style="list-style-type: none"> <li>After each family member meets his or her individual deductible, the plan will pay his or her claims, less any coinsurance amount. After the family deductible has been met, each individual's claims will be paid by the plan, less any coinsurance amount.</li> </ul>	<p><b>Employee and family</b> \$600</p>	<p><b>Employee and family</b> \$3,600</p>
<p><b>Calendar year out-of-pocket maximum</b></p> <ul style="list-style-type: none"> <li>The amount you pay for out-of-network services counts towards both your in-network and out-of-network out-of-pocket maximums.</li> <li>Deductibles do not contribute toward the out-of-pocket maximum.</li> <li>Mental health and substance abuse services count towards your out-of-pocket maximum.</li> <li>After each family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. After the family out-of-pocket maximum has been met, the plan will pay 100% of each individual's covered expenses.</li> </ul>	<p><b>Employee</b> \$1,800</p> <p><b>Employee and family</b> \$3,600</p>	<p><b>Employee</b> \$9,000</p> <p><b>Employee and family</b> \$18,000</p>

Benefits	In-network	Out-of-network
<b>Physician services</b>		
<p><b>Office visit</b></p>	<p><b>Primary care physician</b> You pay \$20 per visit</p> <p><b>Specialist</b> You pay \$35 per visit</p>	<p>You pay 30% Plan pays 70% after the deductible is met</p>
<p><b>Physician services (hospital)</b></p> <ul style="list-style-type: none"> <li>In hospital visits and consultations</li> <li>Inpatient</li> <li>Outpatient</li> </ul>	<p><b>Inpatient and outpatient services</b> You pay 10% Plan pays 90% after the deductible is met</p>	<p>You pay 30% Plan pays 70% after the deductible is met</p>
<p><b>Surgery (in a physician's office)</b></p>	<p><b>Primary care physician</b> You pay \$20 per visit</p> <p><b>Specialist</b> You pay \$35 per visit</p>	<p>You pay 30% Plan pays 70% per visit after the deductible is met</p>
<b>Preventive care</b>		
<p><b>Adults and children</b></p> <ul style="list-style-type: none"> <li>Immunizations</li> <li>Immunizations – Flu shots and Travel including outside the US are covered at no charge.</li> <li>Out-of-network immunizations are not covered.</li> </ul>	<p>100%, no plan deductible</p>	<p>In-network coverage only</p>



Benefits	In-network	Out-of-network
<p><b>Preventative - Mammogram, PSA, Pap Smear, Colonoscopy</b></p> <ul style="list-style-type: none"> <li>The first exam and all related charges</li> <li>Limited to one per calendar year</li> <li>If performed in the office, office visit copay applies</li> </ul> <p>AMA Guidelines apply</p>	<p>100%, no plan deductible</p>	<p>You pay 30% Plan pays 70% after the deductible is met</p>
<p><b>Diagnostic - Mammogram, PSA, Pap Smear, Colonoscopy</b></p> <ul style="list-style-type: none"> <li>Subsequent exams within Calendar year will be subject to applicable coinsurance and deductible</li> </ul>	<p>You pay 10% Plan pays 90% after the deductible is met, if billed by an independent diagnostic facility or outpatient hospital</p>	<p>You pay 30% Plan pays 70% after the deductible is met</p>
<b>Inpatient hospital facility services</b>		
<p><b>Semi-private room and board and other non-physician services</b></p> <ul style="list-style-type: none"> <li>Inpatient room and board, pharmacy, x-ray, lab, operating room, surgery, etc.</li> <li>Private room stays may result in extra charges for the patient.</li> </ul>	<p>\$0 copay per admission, then You pay 10% Plan pays 90% after the deductible is met</p>	<p>You pay 30% Plan pays 70% after the deductible is met</p>
<p><b>Inpatient Professional Services</b></p> <ul style="list-style-type: none"> <li>For services performed by surgeons, radiologists, pathologists and anesthesiologists</li> </ul>	<p>You pay 10% Plan pays 90% after the deductible is met</p>	<p>You pay 30% Plan pays 70% after the deductible is met</p>
<p><b>Multiple surgical reduction</b></p> <ul style="list-style-type: none"> <li>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.</li> </ul>	<p>Included</p>	<p>Included</p>
<b>Outpatient services</b>		
<p><b>Outpatient surgery (facility charges)</b></p> <ul style="list-style-type: none"> <li>Non-surgical treatment procedures are not subject to the facility copay.</li> </ul>	<p>\$0 copay per visit, then You pay 10% Plan pays 90% after the deductible is met</p>	<p>You pay 30% Plan pays 70% after the deductible is met</p>
<p><b>Outpatient Professional Services - Preventive</b></p> <ul style="list-style-type: none"> <li>Preventive – Radiologist</li> <li>Preventive - Pathologist</li> </ul>	<p>No charge, no plan deductible</p>	
<p><b>Outpatient Professional Services - Diagnostic</b></p> <ul style="list-style-type: none"> <li>For services performed by surgeons, radiologists, pathologists and anesthesiologists</li> <li>Diagnostic – Radiologist</li> <li>Diagnostic – Pathologist</li> <li>Diagnostic - Anesthesiologist</li> </ul>	<p>You pay 10% Plan pays 90% after the deductible is met</p>	<p>You pay 30% Plan pays 70% after the deductible is met</p>



Benefits	In-network	Out-of-network
<p><b>Physical, occupational, cognitive and speech therapy</b></p> <ul style="list-style-type: none"> <li>• 30 days per calendar year for all therapies</li> <li>• Includes physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation and cognitive therapy</li> <li>• Includes cardiac rehabilitation</li> <li>• Therapy days, provided as part of an approved Home Health Care plan, accumulate to the outpatient short term rehab therapy maximum.</li> </ul>	<p><b>Primary care physician</b> You pay \$20 per visit</p> <p><b>Specialist</b> You pay \$35 per visit</p>	<p>You pay 30% Plan pays 70% after the deductible is met</p>
<p><b>Chiropractic care</b></p> <ul style="list-style-type: none"> <li>• Limited to 20 days per calendar year</li> </ul>	<p><b>Primary care physician</b> You pay \$20 per visit</p> <p><b>Specialist</b> You pay \$35 per visit</p>	<p>You pay 30% Plan pays 70% after the deductible is met</p>
<b>Lab and X-ray</b>		
<p><b>Lab and X-ray</b></p> <ul style="list-style-type: none"> <li>• Physician's office</li> <li>• Outpatient hospital facility</li> <li>• Emergency room</li> <li>• Independent x-ray and/or lab facility</li> <li>• Independent x-ray and/or lab facility as part of an ER visit</li> </ul>	<p>Cost and reimbursement vary based on the facility in which it is performed</p>	<p>You pay 30% Plan pays 70% after deductible is met</p>
<p><b>Advanced radiological imaging</b></p> <ul style="list-style-type: none"> <li>• MRI, MRA, CAT Scan, PET Scan, etc.</li> <li>• Inpatient hospital facility, outpatient hospital facility, emergency room, urgent care facility or physician's office</li> </ul>	<p>Cost and reimbursement vary based on the facility in which it is performed</p>	<p>You pay 30% Plan pays 70% after the deductible is met</p>
<b>Emergency and urgent care services</b>		
<p><b>Hospital emergency room</b></p> <ul style="list-style-type: none"> <li>• Includes radiology, pathology and physician charges</li> <li>• Copay waived if admitted</li> <li>• Out-of-network services are covered at the in-network rate.</li> </ul>	<p>You pay a \$155 copay, then no charge</p>	
<p><b>Ambulance – Emergency Only</b></p> <ul style="list-style-type: none"> <li>• Out-of-network services are covered at the in-network rate when it is a true emergency.</li> </ul>	<p>You pay 10% Plan pays 90%</p>	
<p><b>Urgent care services</b></p> <ul style="list-style-type: none"> <li>• Out-of-network services are covered at the in-network rate.</li> <li>• Copay waived if admitted</li> </ul>	<p>You pay a \$35 copay, then no charge</p>	
<b>Other health care facilities</b>		
<p><b>Skilled nursing facility, rehabilitation hospital and other facilities</b></p> <ul style="list-style-type: none"> <li>• 60 days combined maximum per calendar year</li> </ul>	<p>You pay 10% Plan pays 90% after the deductible is met</p>	<p>You pay 30% Plan pays 70% after the deductible is met</p>



Benefits	In-network	Out-of-network
<b>Home health care</b> <ul style="list-style-type: none"> <li>100 days per calendar year</li> </ul>	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
<b>Hospice</b> Inpatient services Outpatient services	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
<b>Other health care services</b>		
<b>Durable medical equipment</b> <ul style="list-style-type: none"> <li>Calendar year maximum: Unlimited</li> </ul>	You pay 10% Plan pays 90% after the deductible is met	You pay 30% Plan pays 70% after the deductible is met
<b>External prosthetic appliances (EPA)</b> <ul style="list-style-type: none"> <li>Calendar year maximum: Unlimited</li> </ul>	You pay 10% Plan pays 90% after deductible is met	You pay 30% Plan pays 70% after deductible is met
<b>Hearing Aids</b> <ul style="list-style-type: none"> <li>Calendar year maximum: Unlimited</li> </ul>	You pay 10% Plan pays 90% after deductible is met	Not covered
<b>Cochlear Implants</b> <ul style="list-style-type: none"> <li>Calendar year maximum: Unlimited</li> </ul>	You pay 10% Plan pays 90% after deductible is met	Not covered
<b>TMJ, surgical and non-surgical</b>	Not covered	Not covered
<b>Infertility</b> <b>Office visit for testing, treatment and artificial insemination</b> <ul style="list-style-type: none"> <li>Inpatient hospital facility</li> <li>Outpatient hospital facility</li> <li>Physician services</li> <li>Surgical treatment limited to procedures to correct infertility, excluding In-vitro, GIFT, ZIFT, etc.</li> </ul>	Cost and reimbursement vary based on the facility in which it is performed	Not covered
<b>Family planning</b> <ul style="list-style-type: none"> <li>Office visits</li> <li>Inpatient hospital facility</li> <li>Outpatient facility</li> <li>Physician services</li> <li>Surgical services such as tubal ligation or vasectomy are covered (excluding reversals).</li> <li>Includes contraceptive devices</li> <li>Contributes to the preventive care maximum</li> <li>Subject to the plan's Preventive Care dollar maximum</li> </ul>	Cost and reimbursement vary based on the facility in which it is performed	Not covered
<b>Mental health and substance abuse services</b>		
Please note the following regarding Mental Health (MH) and Substance Abuse (SA) benefit administration: <ul style="list-style-type: none"> <li>Substance Abuse includes Alcohol and Drug Abuse services.</li> <li>Transition of Care benefits are provided for a 90-day time period.</li> </ul>		



Benefits	In-network	Out-of-network
<b>Inpatient mental health services</b> <ul style="list-style-type: none"> <li>Unlimited days per calendar year</li> <li>Mental health services are paid at 100% after you reach your out-of-pocket maximum.</li> </ul>	\$0 copay per admission, then You pay 10% Plan pays 90% after the medical plan deductible is met	deductible per admission, then You pay 30% Plan pays 70% after the medical plan deductible is met
<b>Outpatient mental health physician's office services</b> <ul style="list-style-type: none"> <li>Unlimited visits per calendar year</li> <li>Mental health and substance abuse services are paid at 100% after you reach your out-of-pocket maximum.</li> <li>This includes group therapy mental health and intensive outpatient mental health</li> </ul>	You pay \$20 per visit	You pay 30% Plan pays 70% after the deductible is met
<b>Inpatient substance abuse services</b> <ul style="list-style-type: none"> <li>Unlimited days per calendar year</li> <li>Substance abuse services are paid at 100% after you reach your out-of-pocket maximum.</li> </ul>	\$0 copay per admission, then You pay 10% Plan pays 90% after the medical plan deductible is met	admission, then You pay 30% Plan pays 70% after the medical plan deductible is met
<b>Outpatient substance abuse physician's office services</b> <ul style="list-style-type: none"> <li>Unlimited visits per calendar year</li> <li>Mental health and substance abuse services are paid at 100% after you reach your out-of-pocket maximum.</li> <li>This includes intensive outpatient substance abuse</li> </ul>	You pay \$20 per visit	You pay 30% Plan pays 70% after the deductible is met
<b>Prescription drugs</b>		
<b>CIGNA Pharmacy Drug Program</b> <ul style="list-style-type: none"> <li>Generic push</li> <li>Incentive Prescription Drug List</li> <li>Self administered injectable– excludes infertility drugs</li> <li>Includes oral contraceptives and contraceptive devices</li> <li>Lifestyle drugs – limited to sexual dysfunction</li> </ul>	<p style="text-align: center;"><b>Retail</b> (30 day supply) <u>You pay:</u> Generic \$10 Preferred Brand \$35 Non-Preferred Brand \$70</p> <p style="text-align: center;"><b>Home Delivery</b> (90 day supply) <u>You pay:</u> Generic \$20 Preferred Brand \$70 Non-Preferred Brand \$140</p>	<p style="text-align: center;">Not Covered</p>
<b>Pharmacy calendar year deductible</b> <ul style="list-style-type: none"> <li>Applies to retail only</li> <li>Does not apply to generics</li> <li>Applies to in-network only</li> </ul>	<p style="text-align: center;"><b>Individual</b> \$25</p> <p style="text-align: center;"><b>Family (aggregate)</b> \$50</p>	
<b>Specialty Pharmacy</b> <ul style="list-style-type: none"> <li>Clinical Programs</li> </ul>	Prior authorization required on specialty medications and quantity limits may apply. TheraCare® Program	



Benefits	In-network	Out-of-network
<b>Specialty Pharmacy</b> <ul style="list-style-type: none"><li>Medication Access Option</li></ul>	Retail and/or Home Delivery	
<b>Vision care</b>	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.

**Selection of a Primary Care Provider** – Your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, CIGNA may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit [www.mycigna.com](http://www.mycigna.com) or contact customer service at the phone number listed on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

**Direct Access to Obstetricians and Gynecologists** – You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit [www.mycigna.com](http://www.mycigna.com) or contact customer service at the phone number listed on the back of your ID card.

**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](http://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
- Reversal of sterilization procedures
- Genetic screenings
- Non-prescription and anti-obesity drugs
- Custodial and other non-skilled services
- Weight loss programs
- Treatment of TMJ Disorder
- Acupuncture
- 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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