

SUMMARY OF BENEFITS



Your CIGNA HealthCare Open Access Plus plan

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 LineSM 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 health and wellness programs and services often not covered by many 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**. With national and independent pharmacies participating across the country, you can have your prescription filled **wherever you go**. CIGNA Home Delivery Pharmacy 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 web site that combines helpful easy-to-use tools with personalized benefits information to help you make the most of your plan.
- **We Speak Many Languages**SM. 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 Benefits 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.
- **CIGNA Healthy Pregnancies, Healthy Babies**SM is designed to help prevent complications during pregnancy and improve the chances for healthy pregnancies and deliveries. The program aims to identify expectant mothers with risk factors, and help them lower their risk of complications with patient education, wellness programs and targeted support from nurse case managers.
- The **CIGNA Comprehensive Oncology Program**SM promotes cancer prevention and early detection through personalized care management, educational tools, benefit counseling, and other resources.

You Can Depend on CIGNA HealthCare

- **Quality comes first**. We select "preferred 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. 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 "preferred 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

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Your CIGNA HealthCare Open Access Plus plan

your benefit plan, in addition to applicable (higher than in-network) deductibles and coinsurance amounts.

**Open Access Plus \$20 copay plan (RX
\$5/\$20/\$35) OAP4 – Nurses/UPSEU**

BENEFIT INFORMATION	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Plan Deductible		
<i>Individual</i>	None	\$1,000
<i>Two Person</i>	None	\$2,000
<i>Family Maximum</i>	None	\$2,500
Calendar Year Out-of-Pocket Maximum		
<i>Individual</i>	None	\$7,500
<i>Two Person</i>	None	\$12,500
<i>Family Maximum</i>	None	\$15,000
Coinsurance	CIGNA HealthCare pays 100% of eligible charges. You pay 0% of charges.	CIGNA HealthCare pays 70% of eligible charges. You pay 30% of charges after 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.
Lifetime Maximum	Unlimited	Unlimited
Pre-existing Condition Limitation	No	No
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician Services		
Primary Care Physician (PCP) Office Visit	\$20 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**
Specialty Physician Office Visit	\$20 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**
<i>Consultant and Referral Physician Services</i>		
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	\$20 copayment per office visit or actual charge, whichever is less	30% of charges**
Allergy Serum (dispensed by physician in office)	No charge	30% of charges**
Second Opinion Consultations (provided on voluntary basis)	\$20 copayment per office visit	30% of charges**
Surgery Performed in the Physician's Office- PCP or Specialty Physician	\$20 copayment per office visit	30% of charges**
Preventive Care		
Routine Preventive Care for Children through age 2 (including routine immunizations)	No charge.	30% of charges**
Immunizations	No charge	30% of charges**
Routine Preventive Care for Children and Adults from age 3 (including routine immunizations)	No charge	30% of charges**
Unlimited maximum per calendar year		
Immunizations	No charge	30% of charges**
Mammograms, PSA, Pap Test	No charge	30% of charges**
Note: 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 for associated wellness exam	

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<i>Inpatient Hospital Services including:</i> <i>Semi-Private Room and Board</i> <i>Diagnostic/Therapeutic Lab and X-ray</i> <i>Drugs and Medication</i> <i>Operating and Recovery Room</i> <i>Radiation Therapy and Chemotherapy</i> <i>Anesthesia and Inhalation Therapy</i> <i>MRIs, MRAs, CAT Scans, PET Scans, etc.</i>	\$150 copayment per admission	30% of charges* Precertification required
<i>Inpatient Hospital Doctor's Visits/Consultations</i> <i>Inpatient Hospital Professional Services</i>	No charge No charge	30% of charges** 30% of charges**
<i>Outpatient Facility Services includes:</i> <i>Operating Room, Recovery Room, Procedure Room and</i> <i>Treatment Room and Observation Room including:</i> <i>Diagnostic/Therapeutic Lab and X-rays</i> <i>Anesthesia and Inhalation Therapy</i> <i>Physician & Outpatient Professional Services</i>	\$150 copayment per facility visit No charge	30% of charges** 30% of charges**
<i>Laboratory and Radiology Services</i> <i>(includes preadmission testing)</i> <i>Physician's Office</i> <i>Outpatient Hospital Facility</i> <i>Emergency Room/Urgent Care Facility (billed by facility as</i> <i>part of the Emergency Room/Urgent Care visit)</i> <i>Independent X-Ray and/or Lab Facility</i> <i>Independent X-Ray and/or Lab Facility (in conjunction with</i> <i>an Emergency Room visit)</i>	No charge No charge No charge No charge No charge	30% of charges** 30% of charges** No charge; <i>except if not a true emergency,</i> <i>then 30% of charges**</i> 30% of charges** No charge
<i>Advanced Radiological Imaging</i> <i>(MRIs, MRAs, CAT Scans, PET Scans, etc.)</i> <i>Outpatient Facility</i> <i>Emergency Room (billed by facility as part of the</i> <i>Emergency Room visit)</i> <i>Physician's Office</i>	No charge No charge No charge	30% of charges** 30% of charges*; <i>except if not a true</i> <i>emergency, then 30% of charges**</i> 30% of charges**
<i>Short-Term Rehabilitative Therapy and Chiropractic</i> <i>Services--(includes physical, speech, occupational,</i> <i>chiropractic, pulmonary rehab & cognitive therapy)</i> Unlimited maximum per calendar year# for all therapies combined <i>Note:</i> <i>therapy sessions provided as part of Home Health</i> <i>Care accumulate to the Short-Term Rehab Therapy</i> <i>maximum.</i> <i>Outpatient Cardiac Rehabilitation –</i> Unlimited maximum per calendar year#	\$20 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed. No charge	30% of charges** 30% of charges**

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Other Therapy Services --Radiation Therapy --Chemotherapy for the treatment of cancer --Electroshock Therapy --Kidney Dialysis in a Hospital or free-standing dialysis center	\$20 copayment per office visit	30% of charges**
Emergency and Urgent Care Services <i>Physician's Office – PCP or Specialty Physician</i> <i>Hospital Emergency Room</i> <i>Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician)</i> <i>Urgent Care Facility or Outpatient Facility</i> <i>Ambulance</i>	\$20 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 (<i>copay waived if admitted</i>) No charge \$25 copayment per visit (<i>copay waived if admitted</i>) No charge	<i>Care will be provided at in-network levels if it meets the "prudent layperson" definition of an emergency. Otherwise 30% of charges**</i>
Maternity Care Services <i>Initial Office Visit to Confirm Pregnancy</i> 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. <i>All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (total maternity fee)</i> <i>Office Visits not included in the total maternity fee performed by OB or Specialty Physician</i> <i>Delivery - Facility (Inpatient Hospital/Birthing Center Charges)</i>	\$20 copayment for initial office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed. No charge \$20 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services performed and billed. \$150 copayment per admission	30% of charges** 30% of charges** 30% of charges** 30% of charges*, precertification required
Inpatient Services at Other Health Care Facilities <i>Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities</i> 180 days maximum per calendar year# combined for all facilities listed	No charge	30% of charges**
Home Health Services – Includes outpatient private duty nursing when approved as medically necessary Unlimited maximum per calendar year#; 16 hour maximum per day#	No charge	30% of charges**

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Family Planning Services Office Visits (lab & radiology tests, counseling)</p> <p>Vasectomy/Tubal Ligation (excludes reversals) Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services – Inpatient or Outpatient Physician's Office</p>	<p>\$20 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services performed and billed.</p> <p>\$150 copayment per admission</p> <p>\$150 copayment per facility visit</p> <p>No charge \$20 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services performed and billed.</p>	<p>30% of charges**</p> <p>30% of charges*, precertification required</p> <p>30% of charges**</p> <p>30% of charges** 30% of charges**</p>
<p>Infertility Services Office Visit (lab & radiology tests, counseling)-PCP or Specialty Physician</p> <p>Treatment/Surgery (includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.) Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services - Inpatient or Outpatient Unlimited lifetime maximum per member</p>	<p>\$20 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services performed and billed.</p> <p>\$150 copayment per admission</p> <p>\$150 copayment per facility visit</p> <p>\$20 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services performed and billed.</p>	<p>30% of charges**</p> <p>30% of charges*, precertification required</p> <p>30% of charges**</p> <p>30% of charges**</p>
<p>TMJ - Surgical and Non-Surgical-case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity. Physician's Office</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services - Inpatient or Outpatient</p>	<p>\$20 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services performed and billed.</p> <p>\$150 copayment per admission</p> <p>\$150 copayment per facility visit</p> <p>No charge</p>	<p>30% of charges**</p> <p>30% of charges*, precertification required</p> <p>30% of charges**</p> <p>30% of charges**</p>
<p>Mental Health Inpatient – Unlimited maximum per calendar year</p> <p>Outpatient Mental Health (includes Individual, Group Therapy and Intensive Outpatient services) – Unlimited maximum per calendar year</p> <p>Physician's Office</p> <p>Outpatient Facility</p> <p>Note: Non-surgical treatment procedures (including Intensive Outpatient) are not subject to the outpatient facility copayment or outpatient facility deductible.</p>	<p>\$150 copayment per admission</p> <p>\$20 copayment per office visit</p> <p>\$20 copayment per facility visit</p>	<p>30% of charges*, precertification required</p> <p>30% of charges**</p> <p>30% of charges**</p>
<p>Substance Abuse Inpatient – Unlimited maximum per calendar year</p> <p>Outpatient Substance Abuse (includes Individual and Intensive Outpatient services) – Unlimited maximum per calendar year</p> <p>Physician's Office</p> <p>Outpatient Facility</p> <p>Note: Non-surgical treatment procedures (including Intensive Outpatient) are not subject to the outpatient facility copayment or outpatient facility deductible.</p>	<p>\$150 copayment per admission</p> <p>\$20 copayment per office visit</p> <p>\$20 copayment per facility visit</p>	<p>30% of charges*, precertification required</p> <p>30% of charges**</p> <p>30% of charges**</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Durable Medical Equipment -includes diabetic equipment Unlimited maximum per calendar year	No charge	30% of charges**
External Prosthetic Appliances Unlimited maximum per calendar year	No charge	30% of charges**
Ostomy Related Services (medically necessary) Unlimited maximum per calendar year	No charge	30% of charges**
Acupuncture Includes Acupressure	\$20 per visit copay	30% of charges**
Wigs \$350 maximum per member per calendar year#	No charge	No charge
Hearing Aids	No charge	30% of charges**
Prescription Drugs		
<u>CIGNA Pharmacy Retail Drug Program</u> <i>Generic*** drugs on the Prescription Drug List for a 30-day supply</i>	\$5 copayment per prescription/refill	30% of charges**
<i>Brand Name*** drugs designated as preferred on the Prescription Drug List with no Generic equivalent for a 30-day supply</i>	\$20 copayment per prescription/refill	30% of charges**
<i>Brand Name*** drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List for a 30-day supply</i>	\$35 copayment per prescription/refill	30% of charges**
<u>CIGNA Home Delivery Pharmacy Program</u> <i>Generic*** drugs on the Prescription Drug List for a 100-day supply</i>	\$10 copayment per prescription/refill	Covered In Network Only
<i>Brand Name*** drugs designated as preferred on the Prescription Drug List with no Generic equivalent for a 100-day supply</i>	\$40 copayment per prescription/refill	
<i>Brand Name*** drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List for a 100-day supply</i>	\$70 copayment per prescription/refill	
***Designated as per generally-accepted industry sources and adopted by CG		

* Services are subject to calendar year deductible

** Out-of-network services are subject to calendar 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.

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, including Mental Health and Substance Abuse services.

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.
- All out-of-network hospital admissions 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.

Medical Benefit Exclusions (by way of example but not limited to):

Your plan provides coverage for medically necessary services. Your plan does not provide coverage for the following except as required by law:

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public school system or school district.
3. Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
4. Treatment of an illness or injury which is due to war, declared or undeclared.
5. Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
6. Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
7. Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be: Not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or The subject of review or approval by an Institutional Review Board for the proposed use, except as provided in the "Clinical Trials" section of "Covered Services and Supplies;" or The subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of "Covered Services and Supplies."
8. Cosmetic Surgery and Therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
9. The following services are excluded from coverage regardless of clinical indications: Dance therapy, movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
10. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. 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. Sound natural teeth are defined as natural teeth that are free of active clinical decay.
11. 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.
12. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under "Covered Services and Supplies."
13. Reversal of male and female voluntary sterilization procedures.
14. Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
15. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
16. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
17. Non-medical counseling or ancillary services, including, but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays or mental retardation.
18. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
19. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Inpatient Hospital Services," "Outpatient Facility Services," "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of "Covered Services and Supplies."
20. Private hospital rooms except as provided in the Home Health Services section of "Covered Services and Supplies".
21. Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
22. Artificial aids, including but not limited to elastic stockings, garter belts, corsets and dentures.

Benefit Exclusions-Continued:

23. Limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
24. Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
25. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
26. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
27. All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Covered Services and Supplies."
28. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
29. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
30. Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.
31. Dental implants for any condition.
32. Blood administration for the purpose of general improvement in physical condition.
33. All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
34. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
35. Telephone, e-mail & Internet consultations and telemedicine.

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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