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 Line[SM] 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 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 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.
- 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 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[SM] 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 “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 higher 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 your benefit plan, in addition to applicable (higher than in-network) deductibles and coinsurance amounts.

For Employees of VACE - $1,000 Plan

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Plan Deductible *Individual* *Family Maximum*	*Maximums Cross Accumulate* $1,000 $2,000	*Maximums Cross Accumulate* $3,000 $6,000
Calendar Year Out-of-Pocket Maximum *Individual / Family Maximum*	*Maximums Cross Accumulate* Excludes Plan Deductible $4,000/$8,000	*Maximums Cross Accumulate* Excludes Plan Deductible $8,000/$16,000
Coinsurance	CIGNA HealthCare pays 80% of eligible charges. You pay 20% of charges after plan deductible.	CIGNA HealthCare pays 60% of eligible charges. You pay 40% 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	Yes	Yes
Physician Services ***Primary Care Physician (PCP) Office Visit*** ***Specialty Physician Office Visit*** *Consultant and Referral Physician Services* *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*	 $30 copayment per office visit $30 copayment per office visit $30 copayment per office visit or actual charge, whichever is less No charge $30 copayment per office visit $30 copayment per office visit	 40% of charges** 40% of charges** 40% of charges** 40% of charges** 40% of charges** 40% 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 calendar year *Immunizations*	 $30 copayment per office visit No charge, no plan deductible $30 copayment per office visit No charge, no plan deductible	 Covered in-network only Covered in-network only Covered in-network only Covered in-network only
Mammograms, PSA, Pap Test ***<u>Note</u>****: 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 $30 copayment for associated wellness exam	40% of charges**
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.*	$150 copayment per admission, plus 20% of charges*	$150 deductible per admission, plus 40% of charges* Precertification required
Inpatient Hospital Doctor's Visits/Consultations *Inpatient Hospital Professional Services*	20% of charges* 20% of charges*	40% of charges** 40% of charges**

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Facility Services *Operating Room, Recovery Room, Procedure Room and Treatment Room including:* *Diagnostic/Therapeutic Lab and X-rays* *Anesthesia and Inhalation Therapy*	$75 copayment per facility visit, plus 20% of charges*	$75 deductible per facility visit, plus 40% of charges**
Physician and Outpatient Professional Services ***Note**: Non-surgical treatment procedures are not subject to the facility copayment.*	20% of charges*	40% of charges**
Laboratory and Radiology Services (includes preadmission testing)		
Physician's Office	$30 copayment per office visit	40% of charges**
Outpatient Hospital Facility	20% of charges*	40% of charges**
Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit)	No charge	No charge; *except if not a true emergency, then 40% of charges***
Independent X-Ray and/or Lab Facility	20% of charges*	40% of charges**
Independent X-Ray and/or Lab Facility (in conjunction with an Emergency Room visit)	No charge	No charge
Advanced Radiological Imaging *(MRIs, MRAs, CAT Scans, PET Scans, etc.)*		
Outpatient Facility	20% of charges*	40% of charges**
Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit)	No charge	No charge; *except if not a true emergency, then 40% of charges***
Physician's Office	No charge	40% of charges**
Short-Term Rehabilitative Therapy – (includes cardiac rehab, physical, speech, occupational, pulmonary rehab & cognitive therapy) 60 days maximum per calendar year# for all therapies combined ***Note**: therapy sessions provided as part of Home Health Care accumulate to the Short-Term Rehab Therapy maximum.*	$30 copayment per office visit	40% of charges**
Chiropractic Services (subject to medical necessity) - Unlimited day maximum per calendar year#	$30 copayment per office visit	40% of charges**
Emergency and Urgent Care Services		
Physician's Office – PCP or Specialty Physician	$30 copayment per office visit	*Care will be provided at in-network levels if it meets the "prudent layperson" definition of an emergency. Otherwise 40% of charges***
Hospital Emergency Room	$150 copayment per visit (copay waived if admitted)	
Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician)	No charge	
Urgent Care Facility or Outpatient Facility	$75 copayment per visit (copay waived if admitted)	
Ambulance	20% of charges*	

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Maternity Care Services		
Initial Office Visit to Confirm Pregnancy	$30 copayment per office visit	40% of charges**
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (total maternity fee)	20% of charges*	40% of charges**
Office Visits not included in the total maternity fee performed by OB or Specialty Physician	$30 copayment per office visit	40% of charges**
Delivery - Facility (Inpatient Hospital/Birthing Center Charges)	$150 copayment per admission, plus 20% of charges*	$150 deductible per admission, plus 40% of charges* Precertification required
Inpatient Services at Other Health Care Facilities ***Skilled Nursing, Rehabilitation and Sub-Acute Facilities*** 60 days maximum per calendar year# combined for all facilities listed	20% of charges*	40% of charges**
Home Health Services - *Includes outpatient private duty nursing when approved as medically necessary,* 40 days maximum per calendar year#	20% of charges*	40% of charges**
Family Planning Services		
Office Visits (lab & radiology tests, counseling)	$30 copayment per office visit	40% of charges**
Vasectomy/Tubal Ligation (excludes reversals)		
Inpatient Facility	$150 copayment per admission, plus 20% of charges*	$150 deductible per admission, plus 40% of charges* Precertification required
Outpatient Facility Services	$75 copayment per facility visit, plus 20% of charges*	$75 deductible per facility visit, plus 40% of charges**
Physician's Services – Inpatient or Outpatient	20% of charges*	40% of charges**
Physician's Office	$30 copayment per office visit	40% of charges**
Infertility Services		
Office Visit (lab & radiology tests, counseling)	$30 copayment per office visit	Covered in-network only
Treatment/Surgery (excludes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.)		
Inpatient Facility	$150 copayment per admission, plus 20% of charges*	Covered in-network only
Outpatient Facility Services	$75 copayment per facility visit, plus 20% of charges*	Covered in-network only
Physician's Services – Inpatient or Outpatient	20% of charges*	Covered in-network only
Clinically Severe Obesity/Bariatric Surgery		
Physician's Office	$30 copayment per office visit	40% of charges**
Inpatient Facility	$150 copayment per admission, plus 20% of charges*	$150 deductible per admission, plus 40% of charges** Precertification required
Outpatient Facility	$75 copayment per facility visit, plus 20% of charges*	$75 deductible per facility visit, plus 40% of charges**
Physician's Services – Inpatient or Outpatient	20% of charges*	40% of charges**

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
TMJ – Surgical and Non-surgical: case-by-case basis. Subject to medical necessity, including appliances & orthodontic treatment.		
Physician's Office	$30 copayment per office visit	40% of charges**
Inpatient Facility	$150 copayment per admission, plus 20% of charges*	$150 deductible per admission, plus 40% of charges* Precertification required
Outpatient Facility Services	$75 copayment per facility visit, plus 20% of charges*	$75 deductible per facility visit, plus 40% of charges**
Physician's Services – Inpatient or Outpatient	20% of charges*	40% of charges**
Mental Health ***Inpatient*** ***Acute:*** *Based on a ratio of 1:1* ***Partial:*** *Based on a ratio of 2:1* ***Residential:*** *Based on a ratio of 2:1*	$150 copayment per admission, plus 20% of charges* *Unlimited days maximum per calendar year#*	$150 deductible per admission, plus 40% of charges* Precertification required *30 days maximum per calendar year#*
Outpatient Individual	$30 copayment per visit *Unlimited visits maximum per calendar year#*	40% of charges** *20 visits maximum per calendar year#*
Group Therapy Mental Health *– combined maximum with Outpatient Individual Mental Health services based on a ratio of 1:1*	$30 copayment per session	40% of charges**
Intensive Outpatient Mental Health*– Unlimited program maximum per calendar year# based on a ratio of 1:1 with outpatient Mental Health visits*	$50 per program copayment, plus 20% of charges; no plan deductible	40% of charges**
Substance Abuse ***Inpatient*** ***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*	$150 copayment per admission, plus 20% of charges* *Unlimited days maximum per calendar year#*	$150 deductible per admission, plus 40% of charges* Precertification required *30 days maximum per calendar year#*
Outpatient Individual	$30 copayment per visit *Unlimited visits maximum per calendar year#*	40% of charges** *20 visits maximum per calendar year#*
Intensive Outpatient Substance Abuse *– Unlimited program maximum per calendar year# based on a ratio of 1:1 with outpatient Substance Abuse visits*	$50 per program copayment, plus 20% of charges; no plan deductible	40% of charges**
Durable Medical Equipment Unlimited maximum per calendar year#	20% of charges*	40% of charges**
External Prosthetic Appliances Unlimited maximum per calendar year#	20% of charges*	40% of charges**
Vision Care		
Eye Exam every 24 months	$20 allowance per exam	
Reimbursement toward purchase of a pair of lenses or contact lenses every 24 months	Maximum Reimbursement Allowance: Single Vision Lenses: $15 Bifocal Lenses: $30 Trifocal Lenses: $42 Lenticular Lenses: $54 Progressive Lenses: Not covered Contact Lenses - Elective: $30 Therapeutic: $72	
Reimbursement toward purchase of frames every 24 months	Frames $15	

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Prescription Drugs ***CIGNA Pharmacy Retail Drug Program***		
Generic Drugs	50% of charges per 30-day supply for generic drugs	Covered in-network only
Brand Name Drugs	50% of charges per 30-day supply for brand name drugs	Covered in-network only
CIGNA Tel-Drug Mail Order Drug Program		
Generic Drugs	50% of charges per 90-day supply for generic drugs, after pharmacy deductible	Covered in-network only
Brand Name Drugs	50% of charges per 90-day supply for brand name drugs, after pharmacy deductible	Covered in-network only
Pharmacy Out of Pocket Maximum (Individual/Family)(Mail Order included)	$2,000 per individual/$4,000 per family	

Footnotes

* *Services are subject to calendar year deductible.*

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

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.*
- *Coverage for pre-existing conditions will not be covered under this plan unless continuously insured for one year.*

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, other than clinically severe 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 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.

Benefit Exclusions (continued)

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. 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. Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
17. Non-prescription drugs and investigational and experimental drugs, except as provided in the plan.
18. Routine foot care, however, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.
19. Genetic screening or pre-implantation genetic screening.
20. Fees associated with the collection or donation of blood or blood products.
21. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
22. All nutritional supplements and formulae are excluded, except infant formula needed for the treatment of inborn errors of metabolism.
23. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
24. 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.
25. 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; 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.

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