

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 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 LanguagesSM**. We offer Language Line Services so that you can **talk with us** in 150 different languages. Just call Customer Service, and ask for an interpreter to assist you.

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 VACE - \$2,500 Plan

OAP - VT

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Plan Deductible Individual Family Maximum	<i>Maximums Cross Accumulate</i> \$2,500 \$5,000	<i>Maximums Cross Accumulate</i> \$4,000 \$8,000
Calendar Year Out-of-Pocket Maximum Individual / Family Maximum	<i>Maximums Cross Accumulate</i> Includes Plan Deductible \$4,000/\$8,000	<i>Maximums Cross Accumulate</i> Includes 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)	Coordinated by your physician	Participant must obtain approval for inpatient admission; 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	\$30 copayment per office visit	40% of charges**
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.	\$50 copayment per office visit	40% of charges**
Allergy Treatment/Injections - PCP or Specialty Physician	\$30 or \$50 copayment per office visit or actual charge, whichever is less	40% of charges**
Allergy Serum (dispensed by physician in office)	No charge	40% of charges**
Second Opinion Consultations (provided on voluntary basis)	\$30 or \$50 copayment per office visit	40% of charges**
Surgery Performed in the Physician's Office- PCP or Specialty Physician	\$30 or \$50 copayment per office visit	40% of charges**
Preventive Care Routine Preventive Care for Children through age 2 (including routine immunizations)	No charge	Covered in-network only
Immunizations	No charge	Covered in-network only
Routine Preventive Care for Children and Adults from age 3 (including routine immunizations) Unlimited maximum per calendar year	No charge	Covered in-network only
Immunizations	No charge	Covered in-network only
Mammograms, PSA, Pap Test	No charge No charge 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
<p>Outpatient Facility Services <i>Operating Room, Recovery Room, Procedure Room and Treatment Room including:</i> <i>Diagnostic/Therapeutic Lab and X-rays</i> <i>Anesthesia and Inhalation Therapy</i> <i>Physician and Outpatient Professional Services</i> Note: <i>Non-surgical treatment procedures are not subject to the facility copayment.</i></p>	<p>\$75 copayment per facility visit, plus 20% of charges*</p> <p>20% of charges*</p>	<p>\$75 deductible per facility visit, plus 40% of charges**</p> <p>40% of charges**</p>
<p>Laboratory and Radiology Services (includes preadmission testing) <i>Physician's Office</i> <i>Outpatient Hospital Facility</i> <i>Emergency Room/Urgent Care Facility (billed by facility as 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 an Emergency Room visit)</i></p>	<p>\$30 or \$50 copayment per office visit</p> <p>20% of charges*</p> <p>No charge</p> <p>20% of charges*</p> <p>No charge</p>	<p>40% of charges**</p> <p>40% of charges**</p> <p>No charge; <i>except if not a true emergency, then 40% of charges**</i></p> <p>40% of charges**</p> <p>No charge</p>
<p>Advanced Radiological Imaging <i>(MRIs, MRAs, CAT Scans, PET Scans, etc.)</i> <i>Outpatient Facility</i> <i>Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit)</i> <i>Physician's Office</i></p>	<p>20% of charges*</p> <p>No charge</p> <p>No charge</p>	<p>40% of charges**</p> <p>No charge; <i>except if not a true emergency, then 40% of charges**</i></p> <p>40% of charges**</p>
<p>Short-Term Rehabilitative Therapy – <i>(includes cardiac rehab, physical, speech, occupational, pulmonary rehab & cognitive therapy)</i> 60 days maximum per calendar year# for all therapies combined Note: <i>therapy sessions provided as part of Home Health Care accumulate to the Short-Term Rehab Therapy maximum.</i> Chiropractic Services (subject to medical necessity) - Unlimited day maximum per calendar year#</p>	<p>\$30 or \$50 copayment per office visit</p> <p>\$30 or \$50 copayment per office visit</p>	<p>40% of charges**</p> <p>40% of charges**</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Emergency and Urgent Care Services <i>Physician's Office – PCP or Specialty Physician</i></p> <p><i>Hospital Emergency Room</i></p> <p><i>Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician)</i> <i>Urgent Care Facility or Outpatient Facility</i></p> <p><i>Ambulance</i></p>	<p>\$30 or \$50 copayment per office visit</p> <p>\$150 copayment per visit (copay waived if admitted) No charge</p> <p>\$75 copayment per visit (copay waived if admitted) 20% of charges*</p>	<p><i>Care will be provided at in-network levels if it meets the “prudent layperson” definition of an emergency. Otherwise 40% of charges**</i></p>
<p>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.</p> <p><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></p> <p><i>Delivery - Facility (Inpatient Hospital/Birthing Center Charges)</i></p>	<p>\$30 or \$50 copayment per office visit</p> <p>20% of charges*</p> <p>\$30 or \$50 copayment per office visit</p> <p>\$150 copayment per admission, plus 20% of charges*</p>	<p>40% of charges**</p> <p>40% of charges**</p> <p>40% of charges**</p> <p>\$150 deductible per admission, plus 40% of charges* Precertification required</p>
<p>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</p>	<p>20% of charges*</p>	<p>40% of charges**</p>
<p>Home Health Services - Includes outpatient private duty nursing when approved as medically necessary, 40 days maximum per calendar year#</p>	<p>20% of charges*</p>	<p>40% of charges**</p>
<p>Family Planning Services <i>Office Visits (lab & radiology tests, counseling)</i></p> <p><i>Vasectomy/Tubal Ligation (excludes reversals)</i> <i>Inpatient Facility</i></p> <p><i>Outpatient Facility Services</i></p> <p><i>Physician's Services – Inpatient or Outpatient</i> <i>Physician's Office</i></p>	<p>\$30 or \$50 copayment per office visit</p> <p>\$150 copayment per admission, plus 20% of charges*</p> <p>\$75 copayment per facility visit, plus 20% of charges* 20% of charges* \$30 or \$50 copayment per office visit</p>	<p>Covered in-network only</p> <p>\$150 deductible per admission, plus 40% of charges* Precertification required \$75 deductible per facility visit, plus 40% of charges** 40% of charges** 40% of charges**</p>
<p>Infertility Services <i>Office Visit (lab & radiology tests, counseling) – PCP or Specialty Physician</i></p> <p><i>Treatment/Surgery (excludes artificial insemination)</i> <i>(excludes in-vitro fertilization, GIFT, ZIFT, etc.)</i> <i>Inpatient Facility</i></p> <p><i>Outpatient Facility Services</i></p> <p><i>Physician's Services – Inpatient or Outpatient</i></p>	<p>\$30 or \$50 copayment per office visit</p> <p>\$150 copayment per admission, plus 20% of charges* \$75 copayment per facility visit, plus 20% of charges* 20% of charges*</p>	<p>Covered in-network only</p> <p>Covered in-network only</p> <p>Covered in-network only</p> <p>Covered in-network only</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Clinically Severe Obesity/Bariatric Surgery <i>Physician's Office</i></p> <p><i>Inpatient Facility</i></p> <p><i>Outpatient Facility</i></p> <p><i>Physician's Services – Inpatient or Outpatient</i></p>	<p>\$30 or \$50 copayment per office visit</p> <p>\$150 copayment per admission, plus 20% of charges*</p> <p>\$75 copayment per facility visit, plus 20% of charges*</p> <p>20% of charges*</p>	<p>40% of charges**</p> <p>\$150 deductible per admission, plus 40% of charges** Precertification required</p> <p>\$75 deductible per facility visit, plus 40% of charges** 40% of charges**</p>
<p>TMJ – Surgical and Non-surgical: case-by-case basis. Subject to medical necessity, including appliances & orthodontic treatment. <i>Physician's Office</i></p> <p><i>Inpatient Facility</i></p> <p><i>Outpatient Facility Services</i></p> <p><i>Physician's Services – Inpatient or Outpatient</i></p>	<p>\$30 or \$50 copayment per office visit</p> <p>\$150 copayment per admission, plus 20% of charges*</p> <p>\$75 copayment per facility visit, plus 20% of charges*</p> <p>20% of charges*</p>	<p>40% of charges**</p> <p>\$150 deductible per admission, plus 40% of charges* Precertification required</p> <p>\$75 deductible per facility visit, plus 40% of charges** 40% 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><i>Physician's Office</i></p> <p><i>Outpatient Facility services</i></p> <p>Note: Non-surgical treatment procedures (including Intensive Outpatient) are not subject to the Outpatient Facility copay or Outpatient Facility deductible.</p>	<p>\$150 copayment per admission, plus 20% of charges*</p> <p>\$30 or \$50 copayment per office visit</p> <p>\$75 copayment per facility visit, plus 20% of charges*</p>	<p>\$150 deductible per admission, plus 40% of charges* Precertification required</p> <p>40% of charges**</p> <p>\$75 deductible per facility visit, plus 40% 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><i>Physician's Office</i></p> <p><i>Outpatient Facility services</i></p> <p>Note: Non-surgical treatment procedures (including Intensive Outpatient) are not subject to the Outpatient Facility copay or Outpatient Facility deductible.</p>	<p>\$150 copayment per admission, plus 20% of charges*</p> <p>\$30 or \$50 copayment per office visit</p> <p>\$75 copayment per facility visit, plus 20% of charges*</p>	<p>\$150 deductible per admission, plus 40% of charges* Precertification required</p> <p>40% of charges**</p> <p>\$75 deductible per facility visit, plus 40% of charges**</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
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 <i>Eye Exam every 24 months</i> <i>Reimbursement toward purchase of a pair of lenses or contact lenses every 24 months</i> <i>Reimbursement toward purchase of frames every 24 months</i>	\$20 allowance per exam 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 Frames \$15	Covered in-network only
Prescription Drugs CIGNA Pharmacy Retail Drug Program Mandatory Generic <i>Generic Drugs</i> <i>Brand Name Drugs</i> CIGNA Tel-Drug Mail Order Drug Program <i>Generic Drugs</i> <i>Brand Name Drugs</i> Pharmacy Out of Pocket Maximum (Individual/Family)(Mail Order included)	\$3 per 30-day supply for generic drugs 50% of charges per prescription/refill \$9 per 90-day supply for generic drugs 50% of charges per prescription/refill \$2,500 per individual/\$5,000 per family	Covered in-network only Covered in-network only Covered in-network only Covered in-network only
<u>Applies to Vermont Residents only:</u> For prescription drug copayment plans that include a mail order drug plan, the copayment for a 90-day supply at retail or mail order pharmacies will be equal to three times the copayment for a 30-day supply. The copayment for a 90-day supply when obtained from either a retail or mail order drug pharmacy will be equal. Each prescription order or refill will be limited to up to a consecutive 90-day supply at a mail order or retail participating pharmacy, unless limited by the drug manufacturer's packaging or other applicable law.		

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, including Mental Health and Substance Abuse services.*

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 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.
9. 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. 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.

Benefit Exclusions (continued)

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. (Note: This limitation will not apply to Members of employer groups who are not required by law to provide workers' compensation benefits.)
24. 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.
25. 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.
26. 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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