This is a summary of benefits for your Open Access Plus plan. All deductibles and plan out-of-pocket maximums accumulate in one direction toward in-network unless otherwise noted. Plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between in- and out-of-network unless otherwise noted.

CIGNA HealthCare Benefit Summary
Vernon Board of Education
Supervisors 046, Librarians 038, Teachers 014
Sec's/Cust/Ma 018, Cafeteria 040, VSAA Admin. 015, Cert Non-Affil 045, Non-Aff Sec's 047, Para's - 037
Open Access Plus Copay Plan – Option 1

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	$1,000,000
Coinsurance Levels	100%	70%
Maximum Reimbursable Charge *determined based on the lesser of the provider's normal charge for a similar service or supply;* ***or*** A percentage of a fee schedule developed by CIGNA that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market. **Note**: In some cases, a Medicare based fee schedule will not be used and the Maximum Reimbursable charge for covered services is determined based on the lesser of: • the provider's normal charge for a similar service or supply; or • the charges made by 80% of the providers of such service or supply in the geographic area where it is received as compiled in a database selected by CIGNA. **Note:** The provider may bill the member the difference between the provider's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles, copayments and coinsurance.	Not applicable	200%
Deductible Accumulators	One way accumulation	
Calendar Year Deductible		
Individual	None	$2,000 per person
Two Person	None	$4,000 two person
Family Maximum	None	$4,000 per family
Family Maximum Deductible Calculation	Individual Deductible	Individual Deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Out-of-Pocket Maximum Accumulators		
Accumulation Between In-network and Out-of-Network OOP Maximum: One way accumulation		
Includes Deductible	N/A	No
Includes Copays	No	No
Does not apply to Benefits for accident or sickness are paid at 100% of charges once an individual's out-of-pocket has been reached.	Non-compliance penalties and copays	Non-compliance penalties, deductibles, charges in excess of Reasonable and Customary
Out-of-Pocket Maximum		
Individual	None	$25,000 per person
Two Person	None	$25,000 two person
Family Maximum	None	$25,000 per family
Family Maximum OOP Calculation	Individual OOP	Individual OOP
Automated Annual Reinstatement	Not Applicable	
Physician's Services		
Primary Care Physician's Office visit	No charge after $20 PCP per office visit copay	70% after plan deductible
Specialty Care Physician's Office Visit *Office Visits* *Consultant and Referral Physician's Services*	No charge after $20 Specialist per office visit copay	70% after plan deductible
Surgery Performed In the Physician's Office	$20 per office visit copay	70% after plan deductible
Second Opinion Consultations (services will be provided on a voluntary basis)	$20 per office visit copay	70% after plan deductible
Allergy Office Visit/Testing	$20 per office visit copay	70% after plan deductible
Allergy Treatment/Injections/Serum (dispensed by the physician in the office)	No charge	70% after plan deductible
Hearing Exams – One per two calendar years	$20 per office visit copay	70% after plan deductible
Preventive Care *Routine Preventive Care for children through age 6 (including immunization)*	No charge	70% after plan deductible
Immunizations (includes travel immunizations)	No charge	70% after plan deductible
Routine Preventive Care for children and adults from age 7; subject to an unlimited maximum per calendar year (including routine immunization)	No charge	70% after plan deductible
Immunizations (includes travel immunizations)	No charge	70% after plan deductible
Well Woman Exam	No charge	70% after plan deductible
Mammograms, PSA, Pap Smear	No charge	70% after plan deductible

Confidential, unpublished property of CIGNA. Do not duplicate or distribute. Use and distribution limited solely to authorized personnel.
© Copyright 2010 CIGNA

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital - Facility Services	$200 copay per admission	70% after plan deductible
Semi Private Room and Board	Limited to semi-private room negotiated rate	Limited to semi-private room rate
Private Room	Limited to semi-private room negotiated rate	Limited to semi-private room rate
Special Care Units (ICU/CCU)	Limited to negotiated rate	Limited ICU/CCU daily room rate
Outpatient Facility Services *Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room* **Note:** Non-surgical treatment procedures are not subject to the facility copay.	$100 copay per visit	70% after plan deductible
Inpatient Hospital Physician's Visits/Consultations	No charge	70% after plan deductible
Inpatient Hospital Professional Services *Surgeon* *Radiologist* *Pathologist* *Anesthesiologist*	No charge	70% after plan deductible
Multiple Surgical Reduction	Multiple surgeries performed during one operating session result in payment reduction of 50% of charges to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.	
Outpatient Professional Services *Surgeon* *Radiologist* *Pathologist* *Anesthesiologist*	No charge	70% after plan deductible
Emergency and Urgent Care Services *Physician's Office*	$20 per office visit copay	$20 per office visit copay (except if not a true emergency, then 70% after plan deductible).
Hospital Emergency Room	$50 per visit copay*	$50 per visit copay* (except if not a true emergency, then 70% after plan deductible)
Outpatient Professional services (radiology, pathology and ER Physician)	No charge	No charge (except if not a true emergency, then 70% after plan deductible)
Urgent Care Facility or Outpatient Facility	$20 per visit copay*	$20 per visit copay* (except if not a true emergency, then 70% after plan deductible)
Ambulance	No charge	No charge (except if not a true emergency, then 70% after plan deductible)
	*waived if admitted	*waived if admitted

Confidential, unpublished property of CIGNA. Do not duplicate or distribute. Use and distribution limited solely to authorized personnel.
© Copyright 2010 CIGNA

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Services at Other Health Care Facilities *Includes Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities and Specialty Hospitals* 180 days combined maximum per calendar year	No charge	70% after plan deductible
Laboratory and Radiology Services (includes pre-admission testing)		
Physician's Office	No charge	70% after plan deductible
Outpatient Hospital Facility	No charge	70% after plan deductible
Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	No charge	No charge (except if not a true emergency, then 70% after plan deductible)
Independent X-ray and/or Lab facility	No charge	70% after plan deductible
Independent X-ray and/or Lab Facility in conjunction with an ER visit	No charge	No charge (except if not a true emergency, then 70% after plan deductible)
Advanced Radiological Imaging (i.e. MRI's, MRAs, CAT Scans and PET Scans, etc.)		
Inpatient Facility	No charge	70% after plan deductible
Outpatient Facility	No charge	70% after plan deductible
Emergency Room/Urgent Care Facility (billed by the facility as part of the ER visit)	No charge	No charge (unless not a true emergency then 70% after plan deductible)
Physician's Office	No charge	70% after plan deductible
Outpatient Short-Term Rehabilitative Therapy and Chiropractic Care Services Unlimited days combined maximum per calendar year Includes: Physical Therapy Speech Therapy Occupational Therapy Chiropractic Therapy (includes Chiropractors) Pulmonary Rehab Cognitive Therapy	$20 per visit copay	70% after plan deductible
Outpatient Cardiac Rehabilitation Maximum: Up to 36 days per calendar year (maximum may vary based on individual member needs, not to exceed 36 days)	No charge	70% after plan deductible

Confidential, unpublished property of CIGNA. Do not duplicate or distribute. Use and distribution limited solely to authorized personnel.
© Copyright 2010 CIGNA

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	If these services occur in an office setting a $20 copay will apply per visit. If they occur within a facility setting, then No charge.	70% after plan deductible
Home Health Care 200 days maximum per calendar year (includes outpatient private duty nursing when approved as medically necessary) **Note:** The maximum number of hours per day is limited to 16 hours. Multiple visits can occur in one day; with a visit defined as a period of 2 hours or less (e.g. maximum of 8 visits per day).	No charge	80% after $50 deductible
Hospice *Inpatient Services* *Unlimited maximum*	No charge	70% after plan deductible
Bereavement Counseling		
Services provided as part of Hospice Care *Inpatient (same coinsurance level as Inpatient Hospice Facility)* *Outpatient*	No charge No charge	70% after plan deductible 70% after plan deductible
Services provided by Mental Health Professional	Covered under Mental Health benefit	Covered under Mental health benefit
Maternity Care Services *Initial Visit to Confirm Pregnancy*	$20 per office visit copay	70% after plan deductible
All Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges (i.e. global maternity fee)	No charge	70% after plan deductible
Office Visits in addition to the global maternity fee when performed by an OB or Specialist	$20 per office visit copay	70% after plan deductible
Delivery – Facility (Inpatient Hospital, Birthing Center)	$200 copay per admission	70% after plan deductible
Abortion *Includes elective and non-elective procedures*		
Inpatient Facility	$200 copay per admission	70% after plan deductible
Outpatient Surgical Facility	$100 copay per visit	70% after plan deductible
Physician's Office	$20 per office visit copay	70% after plan deductible
Outpatient Professional Services	No charge	70% after plan deductible
Inpatient Professional Services	No charge	70% after plan deductible

Confidential, unpublished property of CIGNA. Do not duplicate or distribute. Use and distribution limited solely to authorized personnel.
© Copyright 2010 CIGNA

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Family Planning Services *Office Visits, Lab and Radiology Tests and Counseling* **Note:** The standard benefit will include coverage for contraceptive devices (e.g. Depo-Provera and Intrauterine Devices (IUDs). Diaphragms will also be covered when services are provided in the physician's office.	$20 per office visit copay	70% after plan deductible
Surgical Sterilization Procedure *for Vasectomy/Tubal Ligation (excludes reversals)* *Inpatient Facility*	 $200 copay per admission	 70% after plan deductible
Outpatient Facility	$100 copay per visit	70% after plan deductible
Inpatient Physician's Services	No charge	70% after plan deductible
Outpatient Physician's Services	No charge	70% after plan deductible
Physician's Office	$20 per office visit copay	70% after plan deductible
Infertility Treatment Coverage will be provided for the following services: ❖ Testing and treatment services performed in connection with an underlying medical condition. ❖ Testing performed specifically to determine the cause of infertility. ❖ Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). ❖ Infertility injectibles ❖ Artificial Insemination, In-vitro, GIFT, ZIFT, etc).		

CIGNA HealthCare

Confidential, unpublished property of CIGNA. Do not duplicate or distribute. Use and distribution limited solely to authorized personnel.
© Copyright 2010 CIGNA

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Office Visit (Lab and Radiology Test, Counseling)	$20 per office visit copay	70% after plan deductible
Inpatient Facility	$200 copay per admission	70% after plan deductible
Outpatient Facility	$100 copay per visit	70% after plan deductible
Physician Services	$20 per office visit copay	70% after plan deductible
Unlimited lifetime maximum per member Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility).		
Organ Transplant *Includes all medically appropriate, non-experimental transplants*		
Inpatient Facility	$200 copay per admission	70% after plan deductible
Physician's Services	No charge	70% after plan deductible
Travel Services Maximum- only available for Lifesource facilities	$10,000	In-network only
Durable Medical Equipment	No charge	70% after plan deductible
Unlimited maximum per calendar year Includes Diabetic Equipment		
External Prosthetic Appliances	No charge	70% after plan deductible
Unlimited maximum per calendar year		
Ostomy Related Services	No charge	70% after plan deductible
Hearing Aids For Children age 12 years and under with a maximum of $1,000 per member every 2 calendar years	No charge	70% after plan deductible
Wigs Up to $350 maximum per member per calendar year	No charge	No charge
Specialized Formula Dietary Supplements and Nutritional formulas are limited to infant formula needed for the treatment of inborn errors of metabolism, including PKU and Maple Syrup Disease	No charge	70% after plan deductible

Confidential, unpublished property of CIGNA. Do not duplicate or distribute. Use and distribution limited solely to authorized personnel.
© Copyright 2010 CIGNA

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Bariatric Surgery		
Physician's Office	$20 per office visit copay	70% after plan deductible
Inpatient Facility	$200 copay per admission	70% after plan deductible
Outpatient Surgical Facility	$100 copay per visit	70% after plan deductible
Physician's Services *Unlimited Maximum*	No charge	70% after plan deductible
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth. Includes coverage for impacted wisdom teeth in a hospital setting.		
Physician's Office	$20 per office visit copay	70% after plan deductible
Inpatient Facility	$200 copay per admission	70% after plan deductible
Outpatient Surgical Facility	$100 copay per visit	70% after plan deductible
Physician's Services	No charge	70% after plan deductible
TMJ - Surgical and Non-surgical	Not Covered	Not Covered
Routine Foot Disorders	Not covered, except for services associated with foot care for diabetes and peripheral vascular disease, when medically necessary.	Not covered, except for services associated with foot care for diabetes and peripheral vascular disease, when medically necessary.

CIGNA HealthCare

Confidential, unpublished property of CIGNA. Do not duplicate or distribute. Use and distribution limited solely to authorized personnel.
© Copyright 2010 CIGNA

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Mental Health/Substance Abuse	***Please note the following regarding Mental Health (MH) and Substance Abuse (SA) benefit administration:*** • Substance Abuse includes Alcohol and Drug Abuse services. Transition of Care benefits are provided for a 90-day time period.	
Mental Health		
Inpatient	$200 copay per admission; Unlimited day maximum	70% after plan deductible; Unlimited day maximum per calendar year
Outpatient (Includes Individual, Group, and Intensive Outpatient)	No charge after $20 per visit copay; Unlimited visit maximum per calendar year	70% after plan deductible; Unlimited visit maximum per calendar year
Substance Abuse		
Inpatient	$200 copay per admission; Unlimited day maximum	70% after plan deductible; Unlimited day maximum per calendar year
Outpatient (Includes Individual, Group, and Intensive Outpatient)	No charge after $20 per visit copay; Unlimited visit maximum per calendar year	70% after plan deductible; Unlimited day maximum per calendar year
MH/SA Utilization Review & Case Management	Inpatient and Outpatient Management (CAP): • CHS provides utilization review and case management for In-network and Out-of-network Inpatient Services and In-network Outpatient Management services. • Includes Lifestyle Management Program (Stress Management, Tobacco Cessation and Weight Management)	
Pre-existing Condition Limitation (PCL)	Does not apply	
Pre-Admission Certification - Continued Stay Review Personal Health Solutions *CIGNA's PAC/CSR is not necessary for Medicare Primary individuals *Inpatient Pre-Admission Certification* - Continued Stay Review (required for all inpatient admissions)	Coordinated by Provider/PCP	**Mandatory**: Employee is responsible for contacting CIGNA Healthcare. Penalties for non-compliance: • $500 penalty applied to hospital inpatient charges for failure to contact CIGNA Healthcare to precertify admission. • Benefits are reduced by 50% for any admission reviewed by CIGNA Healthcare and not certified. • Benefits are reduced by 50% for any additional days not certified by CIGNA Healthcare.

CIGNA HealthCare

Confidential, unpublished property of CIGNA. Do not duplicate or distribute. Use and distribution limited solely to authorized personnel.
© Copyright 2010 CIGNA

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Case Management	Coordinated by CIGNA Healthcare. This is a service designated 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.	

Confidential, unpublished property of CIGNA. Do not duplicate or distribute. Use and distribution limited solely to authorized personnel.
© Copyright 2010 CIGNA

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" and except tier three cancer drugs as per state mandate.
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. Treatment of TMJ disorder.
11. 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.
12. 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.
13. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under "Covered Services and Supplies."
14. Reversal of male and female voluntary sterilization procedures.
15. Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
16. 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.
17. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
18. 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.
19. 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.
20. Private hospital rooms and/or private duty nursing 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,

Confidential, unpublished property of CIGNA. Do not duplicate or distribute. Use and distribution limited solely to authorized personnel.
© Copyright 2010 CIGNA

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 corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures.
23. 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.
24. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
25. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
26. Treatment by acupuncture.
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. Fees associated with the collection or donation of blood or blood products, except for autologous donation.
33. Cost of biologicals that are immunizations or medications to protect against occupational hazards and risks.
34. Cosmetics, dietary supplements and health and beauty aids.
35. All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
36. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
37. Telephone, e-mail & Internet consultations and telemedicine.
38. Massage Therapy

This Benefit Summary highlights some of the benefits available under your plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your Group Service Agreement or Certificate.

Benefits are insured and/or administered by Connecticut General Life Insurance Company.

"CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, CIGNA Vision Care, Inc., Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc. "CIGNA Tel-Drug" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C., which are also operating subsidiaries of CIGNA Corporation.

Updated 4/29/2010

CIGNA HealthCare

Confidential, unpublished property of CIGNA. Do not duplicate or distribute. Use and distribution limited solely to authorized personnel.
© Copyright 2010 CIGNA