

SUMMARY OF BENEFITS

Your CIGNA HealthCare Open Access Plus plan



CIGNA HealthCare

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.
- **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-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 Town of Manchester -

OAP \$5/\$10

OAP - ASO

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|--|---|--|
| Calendar Year Plan Deductible <i>Individual</i> <i>Family Maximum</i> | None None | \$250 \$750 |
| Calendar Year Out-of-Pocket Maximum <i>Individual / Family Maximum</i> | None/None | Excludes Plan Deductible \$1,500/\$4,500 |
| Coinsurance | CIGNA HealthCare pays 100% of eligible charges. You pay 0% of charges. | CIGNA HealthCare pays 80% of eligible charges. You pay 20% 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 | N/A | N A |
| Physician Services Primary Care Physician (PCP) Office Visit Specialty Physician Office Visit <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. <i>Allergy Treatment/Injections - PCP or Specialty Physician</i> <i>Allergy Serum (dispensed by physician in office)</i> <i>Second Opinion Consultations (provided on voluntary basis)</i> <i>Surgery Performed in the Physician's Office- PCP or Specialty Physician</i> | \$5 copayment per office visit \$10 copayment per office visit No charge No charge \$5 or \$10 copayment per office visit \$5 or \$10 copayment per office visit | 20% of charges** 20% of charges** 20% of charges** 20% of charges** 20% of charges** 20% of charges** |
| Preventive Care <i>Routine Preventive Care for Children through age 21 (including routine immunizations)</i> <i>Immunizations</i> <i>Routine Preventive Care for Children and Adults from age 22 (including routine immunizations)</i> Unlimited maximum per calendar year <i>Immunizations</i> | No charge No charge No charge No charge | 20% of charges** 20% of charges** 20% of charges** 20% of charges** |
| Mammograms, PSA, Pap Test Note: 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 No charge for associated wellness exam | 20% of charges** |
| Inpatient Hospital Services including: | No charge | 20% of charges* Precertification required |
| Inpatient Hospital Doctor's Visits/Consultations <i>Inpatient Hospital Professional Services</i> | No charge No charge | 20% of charges** 20% of charges** |
| Outpatient Facility Services | No charge | 20% of charges** |
| 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> | No charge No charge No charge No charge No charge | 20% of charges** 20% of charges** No charge; except if not a true emergency, then 20% of charges** 20% of charges** No charge; except if not a true emergency, then 20% of charges** |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|--|--|--|
| <p>Advanced Radiological Imaging (MRIs, MRAs, CAT Scans, PET Scans, etc.) Inpatient Facility Outpatient Facility Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit) Physician's Office</p> | <p>No charge No charge No charge No charge</p> | <p>20% of charges** 20% of charges** No charge; except if not a true emergency, then 20% of charges** 20% of charges**</p> |
| <p>Short-Term Rehabilitative Therapy (includes physical, speech, occupational, pulmonary rehab & cognitive therapy) 60 days maximum per calendar year# for all therapies combined <i>Note:</i> therapy sessions provided as part of Home Health Care accumulate to the Short-Term Rehab Therapy maximum. Outpatient Cardiac Rehabilitation Up to 36 days maximum per occurrence#</p> | <p>\$5 or \$10 copayment per office visit \$5 or \$10 copayment per office visit</p> | <p>20% of charges** 20% of charges**</p> |
| <p>Chiropractic Care Services 60 days combined with Short Term Rehabilitation Therapy maximum per calendar year#</p> | <p>\$10 copayment per office visit</p> | <p>20% of charge**</p> |
| <p>Emergency and Urgent Care Services Physician's Office – PCP or Specialty Physician Hospital Emergency Room Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician) Urgent Care Facility or Outpatient Facility Ambulance</p> | <p>\$5 or \$10 copayment per office visit \$50 copayment per visit (copay waived if admitted) No charge \$25 copayment per visit (copay waived if admitted) No charge</p> | <p>Care will be provided at in-network levels if it meets the “prudent layperson” definition of an emergency. Otherwise 20% of charges**</p> |
| <p>Maternity Care Services Initial Office Visit to Confirm Pregnancy <i>Note:</i> 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. All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (total maternity fee) Office Visits in addition to the total maternity fee performed by OB or Specialty Physician Delivery - Facility (Inpatient Hospital/Birthing Center Charges)</p> | <p>\$5 or \$10 copayment per office visit No charge \$5 or \$10 copayment per office visit No charge</p> | <p>20% of charges** 20% of charges** 20% of charges** 20% of charges* Precertification required</p> |
| <p>Inpatient Services at Other Health Care Facilities Skilled Nursing, Rehabilitation and Sub-Acute Facilities 90 days maximum per calendar year# combined for all facilities listed</p> | <p>No charge</p> | <p>20% of charges**</p> |
| <p>Home Health Services - Includes outpatient private duty nursing when approved as medically necessary, Unlimited days maximum per calendar year; 16 hour maximum per day#</p> | <p>No charge</p> | <p>20% of charges** after \$50 deductible</p> |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|--|--|---|
| <p>Family Planning Services Office Visits (lab & radiology tests, counseling) Vasectomy/Tubal Ligation (excludes reversals) Inpatient Facility Outpatient Facility Services Physician's Services – Inpatient or Outpatient Physician's Office</p> | <p>\$5 or \$10 copayment per office visit</p> <p>No charge No charge No charge \$5 or \$10 copayment per office visit</p> | <p>Covered in-network only</p> <p>Covered in-network only Covered in-network only Covered in-network only Covered in-network only</p> |
| <p>Infertility Services Office Visit (lab & radiology tests, counseling) – PCP or Specialty Physician</p> <p>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). Artificial Insemination and In-Vitro. Inpatient Facility</p> <p>Outpatient Facility Services Physician's Services \$5,000 maximum per calendar year#</p> | <p>\$5 or \$10 copayment per office visit</p> <p>No charge</p> <p>No charge No charge</p> | <p>20% of charges**</p> <p>20% of charges* Precertification required 20% of charges** 20% of charges**</p> |
| <p>TMJ – Surgical and Non-surgical</p> | <p>Not Covered</p> | <p>Not Covered</p> |
| <p>Mental Health Inpatient – Unlimited days maximum per calendar year Acute: Based on a ratio of 1:1 Partial: Based on a ratio of 2:1 Residential: Based on a ratio of 2:1 Outpatient – 40 visits maximum per calendar year# Group Therapy Mental Health – combined maximum with Outpatient Individual Mental Health services based on a ratio of 1:1 Intensive Outpatient Mental Health– 3 programs maximum per calendar year# based on a ratio of 1:1 with outpatient Mental Health visits</p> | <p>No charge</p> <p>\$10 copayment per visit \$10 copayment per session</p> <p>\$50 per program copayment</p> | <p>20% of charges* Precertification required</p> <p>20% of charges** 20% of charges**</p> <p>\$50 per program deductible, plus 20% of charges; no plan deductible</p> |
| <p>Substance Abuse Inpatient – 45 days maximum per calendar year# 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 Outpatient – 40 visits maximum per calendar year# Intensive Outpatient Substance Abuse – 3 programs maximum per calendar year# based on a ratio of 1:1 with outpatient Substance Abuse visits</p> | <p>No charge</p> <p>\$10 copayment per visit \$50 per program copayment</p> | <p>20% of charges* Precertification required</p> <p>20% of charges** \$50 per program deductible, plus 20% of charges; no plan deductible</p> |
| <p>Durable Medical Equipment \$1,000 maximum per calendar year</p> | <p>No charge</p> | <p>20% of charges**</p> |
| <p>External Prosthetic Appliances Unlimited maximum per calendar year</p> | <p>No charge</p> | <p>20% of charges**</p> |
| <p>Vision Care Eye Exam every 24 months</p> | <p>No charge</p> | <p>100% of billable of charges</p> |

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, except for Mental Health and Substance Abuse which continue to be paid at the levels specified.*

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. Treatment of TMJ disorder.
6. 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.
7. Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, including clinically severe (morbid) 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 (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.
8. 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.
9. Court ordered treatment or hospitalizations.
10. Infertility donor services and charges.
11. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction.
12. Medical and hospital care and costs for the child of a Dependent, unless this infant child is otherwise eligible under the plan.
13. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance.
14. Consumable medical supplies other than ostomy supplies and urinary catheters.
15. Private hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
16. Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets and dentures.
17. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
18. Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.

Benefit Exclusions (continued)

19. 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 the plan.
20. Routine foot care, however, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.
21. Genetic screening or pre-implantation genetic screening.
22. Fees associated with the collection or donation of blood or blood products.
23. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
24. All nutritional supplements and formulae are excluded, except infant formula needed for the treatment of inborn errors of metabolism.
25. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
26. 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.
27. 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.
28. The following services are excluded from coverage regardless of clinical indications: Massage Therapy; Macromastia or Gynecomastia Surgeries; Cosmetic Surgery and Therapies; Surgical Treatment of Varicose Veins; Rhinoplasty; Abdominoplasty/Panniculectomy; 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.

“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, 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.

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