SUMMARY OF BENEFITS

Your CIGNA HealthCare Open Access In-Network 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 Line[SM] connects you **to trained nurses** and a **library** of hundreds of recorded programs on important health topics 24 hours a day, seven days a week, from anywhere in the U.S.
- **CIGNA *Healthy Rewards*®** includes special offers on health and wellness programs and services often not covered by many traditional benefits plans. Just call 1.800.870.3470 or visit our web site at www.cigna.com.
- Prescription drug coverage is a **part of your plan**. With national and independent pharmacies participating across the country, you can have your prescription filled **wherever you go**. CIGNA 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 web site that combines helpful easy-to-use tools with personalized benefits information to help you make the most of your plan.
- **We Speak Many Languages[SM]**. We offer Language Line Services so that you can **talk with us** in 150 different languages. Just call Customer Service and ask for an interpreter to assist you.

It's Your Health

When you choose CIGNA HealthCare, you can take advantage of our **health and wellness** programs:

- We encourage you to use a **PCP** as a valuable resource and personal health advocate.
- **Preventive care services** for you and your children which are described in the Benefits Highlights.
- **CIGNA Well Informed** provides members with customized medical and wellness information to help them make healthier choices, better understand a diagnosis or treatment, and manage their health. The program includes personalized letters and other educational information to help you improve your health. Only you, your doctor and CIGNA have access to this information.
- CIGNA Well Aware for Better Health® can **help you manage** certain chronic conditions.
- 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.

NH HealthFirst Open Access In-Network Plan

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician Services		
Primary Care Physician (PCP) Office Visit	$20 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.	N/A
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; No charge after office visit copay if only x-ray and/or lab services are performed and billed.	N/A
Allergy Treatment/Injections - PCP or Specialty Physician	$20 or $50 copayment per office visit or actual charge, whichever is less	N/A
Allergy Serum (dispensed by physician in office)	No charge	
Second Opinion Consultations (provided on voluntary basis)	$20 or $50 copayment per office visit	N/A
Surgery Performed in the Physician's Office- PCP or Specialty Physician	$20 or $50 copayment per office visit	N/A
Preventive Care		
Routine Preventive Care for Children and Adults (including routine immunizations)	No charge, no plan deductible	N/A
Immunizations	No charge, no plan deductible	N/A
Colonoscopy	$250 copayment per procedure	N/A
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.*	No charge, no plan deductible	N/A
Inpatient Hospital Services including: *Semi-Private Room and Board*	No charge after the Tier 1 or Tier 2 deductible	N/A

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital Doctor's Visits/Consultations Inpatient & Outpatient Hospital Professional Services	No charge after the Tier 1 deductible	N/A
Outpatient Facility Services includes: *Operating Room, Recovery Room, Procedure Room and Treatment Room and Observation Room including:* *Lab and X-rays*	No charge after the Tier 1 or Tier 2 deductible	N/A
Laboratory and Radiology Services (includes preadmission testing) *Physician's Office* *Outpatient Hospital Facility:* *Lab Charges* *X-Ray Charges* *Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit)* *Independent X-Ray and/or Lab Facility:* *Lab Charges* *X-Ray Charges* *Independent X-Ray and/or Lab Facility (in conjunction with an Emergency Room visit)*	$20 or $50 copayment per office visit No charge No charge after the Tier 1 deductible No charge after the Tier 1 deductible No charge No charge after the Tier 1 deductible No charge	N/A N/A N/A *Covered the same as in-network except if not a true emergency, then not covered* N/A N/A *Covered the same as in-network except if not a true emergency, then not covered*
Advanced Radiological Imaging *(MRIs, MRAs, CAT Scans, PET Scans, etc.)* *Inpatient Facility* *Outpatient Facility* *Emergency Room/Urgent Care (billed by facility as part of the Emergency Room/Urgent Care visit)* *Physician's Office*	No charge after the Tier 1 or Tier 2 deductible No charge after the Tier 1 or Tier 2 deductible No charge after the Tier 1 or Tier 2 deductible No charge	N/A N/A *Covered the same as the in-network benefit except if not a true emergency, then not covered* N/A
Short-Term Rehabilitative Therapy *(Includes cardiac rehab, physical, speech, occupational, pulmonary rehab & cognitive therapy)* *20 days separate maximum per contract year for all therapies* ***Note**: Therapy sessions provided as part of Home Health Care accumulate to the Short-Term Rehab Therapy maximum.*	$50 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.	N/A
Chiropractic Services	Not covered	N/A

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Emergency and Urgent Care Services		
Physician's Office	$20 or $50 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.	*All Emergency & Urgent Care Services - Covered the same as the in-network benefit except if not a true emergency, then not covered.*
Hospital Emergency Room	$200 copayment per visit, then 100% after the Tier 1 deductible (*copay waived if admitted*)	
Urgent Care Facility or Outpatient Facility	$100 copayment per visit, then 100% after the Tier 1 or Tier 2 deductible (*copay waived if admitted)*	
Ambulance	No charge after the Tier 1 deductible	
Maternity Care Services		
Initial Office Visit to Confirm Pregnancy	No charge	N/A
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (total maternity fee)	No charge	N/A
Office Visits not included in the total maternity fee performed by OB or Specialty Physician	No charge	N/A
Delivery - Facility (Inpatient Hospital/Birthing Center Charges)	No charge after the Tier 1 or Tier 2 deductible	N/A
Inpatient Services at Other Health Care Facilities		
Skilled Nursing & Sub Acute Facilities – 100 days maximum per contract year	No charge after the Tier 1 deductible	N/A
Rehabilitation Hospital - 60 days maximum per contract year	No charge after the Tier 1 deductible	N/A
Home Health Services *(Includes outpatient private duty nursing when approved as medically necessary)*		
40 days maximum per contract year; 16 hour maximum per day	No charge after the Tier 1 deductible	N/A

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Family Planning Services		
Office Visits (lab & radiology tests, counseling)	No charge	N/A
Vasectomy/Tubal Ligation (excludes reversals)		
Inpatient Facility	No charge after the Tier 1 or Tier 2 deductible	N/A
Outpatient Facility	No charge after the Tier 1 or Tier 2 deductible	N/A
Physician's Services – Inpatient or Outpatient	No charge after the Tier 1 deductible	N/A
Physician's Office	$20 or $50 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services performed and billed.	N/A
Infertility Services *Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.*	Not covered	N/A
TMJ - Surgical and Non-Surgical	Not covered	N/A
Biologically & Non-Biologically Based Mental Health and Substance Abuse		
Inpatient – unlimited maximum per contract year	No charge after Tier 1 or Tier 2 deductible	N/A
Outpatient & Group Therapy – unlimited maximum per contract year	$20 copayment per office visit	N/A
Durable Medical Equipment *$3,000 maximum per individual per contract year*	No charge after Tier 1 deductible	N/A
External Prosthetic Appliances *Unlimited maximum per contract year*	No charge after Tier 1 deductible	N/A

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Prescription Drugs-		Covered in-network only
CIGNA Pharmacy Plus Retail Drug Program*		
*Generic*** drugs on the Prescription Drug List up to a 90-day supply*	$10 copayment per prescription/refill	
*Brand Name*** drugs designated as preferred on the Prescription Drug List with no Generic equivalent up to a 90-day supply*	$35 copayment per prescription/refill	
*Non Preferred Brand Name*** drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List up to a 90-day supply*	$50 copayment per prescription/refill	
CIGNA Tel-Drug Mail Order Drug Program*		
*Generic*** drugs on the Prescription Drug List for a 90-day supply*	$30 copayment per prescription/refill	
*Brand Name*** drugs designated as preferred on the Prescription Drug List with no Generic equivalent for a 90-day supply*	$105 copayment per prescription/refill	
*Non Preferred Brand Name*** drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List for a 90-day supply*	$150 copayment per prescription/refill	
**Includes oral contraceptives and contraceptive devices*		
****Designated as per generally-accepted industry sources and adopted by CG*		

OTHER BENEFIT INFORMATION	IN-NETWORK	OUT-OF-NETWORK
Medical Plan Contract Year Deductibles *Tier 1 Deductible* (Hospitals/Facilities**)* *Individual* *Family* *Tier 2 Deductible (Hospitals/Facilities)* *Individual* *Family* **The Tier 1 deductible is also the plan deductible for non-hospital billed services.* ***Please see the list of Tier 1 Hospitals below.*	 $2,500 $5,000 $4,000 $8,000	 N/A N/A
Medical Plan Contract Year Out-of-Pocket Maximum *Individual* *Family*	Including Deductibles $5,000 $10,000	N/A
Pharmacy Contract Year Out-of-Pocket Maximum* *Individual* *Family* **Separate from the medical plan out of pocket. Applies to retail and mail order*	 $5,000 $10,000	
Coinsurance	CIGNA HealthCare pays 100% of eligible charges. You pay 0% of charges after the plan deductible.	N/A
Precertification – ***Inpatient*** *– required for all inpatient admissions* ***Outpatient*** *- required for selected outpatient procedures and diagnostic testing or outpatient services*	 Coordinated by your physician Coordinated by your physician	 N/A N/A
Lifetime Maximum	Unlimited	N/A
Pre-existing Condition Limitation	Yes	N/A

Tier 1 Hospital's in New Hampshire:

Alice Peck Day Memorial Hospital
The Cheshire Medical Center
Cottage Hospital
Huggins Hospital
The Memorial Hospital
New London Hospital
Southern NH Medical Center
Upper Connecticut Valley Hospital
Weeks Medical Center
Androscoggin Valley Hospital
Concord Hospital
Elliot Hospital
Dartmouth-Hitchcock-Medical-Center(Effective1/1/10)
Monadnock Community Hospital
Parkland Medical Center
Speare Memorial Hospital
Franklin Regional Hospital (Effective 1/1/10)
Wentworth-Douglas Hospital

All other network Hospitals in New Hampshire and outside of New Hampshire are considered Tier 2 Hospitals.

Footnotes:

Regarding In-Network Services*:*

- *Once the out-of-pocket maximum is reached, the plan pays 100% of eligible charges for the remainder of the plan year.*
- *All inpatient hospital admissions and certain outpatient surgical and diagnostic procedures require Preadmission Certification and Continued Stay Review. Failure to obtain Preadmission Certification and/or Continued Stay Review may result in non-compliance penalties and/or reduction of benefits. Call the toll-free number on your CIGNA HealthCare ID Card to precertify.*
- *Coverage for pre-existing conditions will not be covered under this plan unless continuously insured for 9 months.*

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: *Out of network services are covered for emergencies only.*

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. 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 services, 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, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). 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. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
17. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
18. Non-prescription drugs and investigational and experimental drugs, except as provided in the plan.
19. Routine foot care, however, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.
20. Genetic screening or pre-implantation genetic screening.
21. Fees associated with the collection or donation of blood or blood products.

22. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.

23. All nutritional supplements and formulae are excluded, except infant formula needed for the treatment of inborn errors of metabolism.
24. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
25. 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.
26. 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.
27. The following services are excluded from coverage regardless of clinical indications: Massage Therapy; Cosmetic Surgery and Therapies; 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; Health Club Membership 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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