

The SelectCare POS Plan

Summary of Benefits for the Employees and Retirees of the State of Vermont

What Does “POS” Mean?

- The “SelectCare POS Plan” is a “Point-of-Service” (POS) plan. In this plan, you decide whether or not to use a network doctor or hospital at the “**point of service**”, meaning, each time you use a medical service. When you use a network provider, the plan is similar to an HMO, with no annual deductible and small copay per visit.

It’s Your Choice

- You get access to quality care at the lowest out-of-pocket costs available under your plan by having your care coordinated through your Primary Care Physician and by seeing network providers. You also get the **freedom to choose** providers who aren’t part of the network. Your copays are lowest when you see participating providers, but you’re still covered for visits to non-network providers at a higher cost share.

Important Medical Plan Features

- You choose a Primary Care Physician (PCP) – your personal doctor -- to coordinate your care. As your needs change, you can change your Primary Care Physician for any reason.
- **Preventive care services** for every covered family member.
- See a participating OB/GYN – **no referral** required.
- **Emergency and urgent care are covered** wherever you go, worldwide, **24 hours a day**.
- The plan includes a 24-hour toll-free nurse hotline to use when you need medical information. Called the CIGNA HealthCare 24-Hour Health Information LineSM, it connects you **to registered nurses** 24 hours a day, 7 days a week. You may also access a **library** of hundreds of recorded programs on important health topics 24 hours a day, 7 days a week, from anywhere in the U.S.
- The plan also offers The CIGNA HealthCare Well-Aware Program for Better Health® to **help you manage** chronic conditions like asthma and diabetes.

- Finally, the plan is also offering The CIGNA HealthCare Healthy Babies® program which provides you with education and support to help you have a **healthy pregnancy** and a **healthy baby**.

More Quality Features

- **Responsive service** – CIGNA’s Member Services representatives have the authority to **solve problems** on the phone, usually on the first call.
- **Quality comes first.** Participating providers are selected carefully to make sure you have a **wide range** of Primary Care Physician’s and specialists to choose from.
- **www.cigna.com** – Visit CIGNA’s **interactive Web site** to learn more about the SelectCare Plan and get health information, 24 hours a day. Once you are in the plan, you’ll also be able to track the status of your claims online.
- **We Speak Many LanguagesSM**. CIGNA’s Language Line Services means that you can **talk with them** in 140 different languages. Just call Customer Service, and ask for an interpreter to assist you.

Drug Plan

- The program is administered by Express Scripts, Inc. The annual deductible is \$25 per covered person per year. The plan covers 90% of the cost of generic drugs, 80% of the cost of preferred brand drugs and 60% of the cost for non-preferred brand drugs. For the 2012 Plan Year, the maximum out-of-pocket cost per individual per year is \$775 (which includes the deductible). **40% copay drugs do not contribute to the maximum out of pocket limit.** At the local pharmacy, you show your drug plan card and pay your copay; the State is automatically billed for the balance of the cost. The drug plan also features a mail order option, with the convenience of direct home delivery for long-term maintenance drugs.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Primary Care Physician (PCP) Office Visit such as: <u>Preventive Care/Well Care:</u> Periodic Physical Exams (Children and Adults) Routine Immunizations and Injections Adult/Child Medical Care for Illness or Injury Procedures performed in a Physician's Office</p> <p>Routine Mammograms</p>	<p>YOUR COST IS THE COPAY – WITH NO ANNUAL MEDICAL DEDUCTIBLE.</p> <p>\$20 Copay per office visit \$20 Copay per office visit. \$20 Copay per office visit \$20 Copay Paid at 100%</p>	<p>THE PLAN PAYS 70% AFTER THE ANNUAL MEDICAL DEDUCTIBLE.</p> <p>70% 70% 70% 70% 70%</p>
<p>Specialist Office Visits such as: Consultations and Referral Physician Services Well Care (Includes Pap Test and PSAs) Procedures performed in Physician's office</p>	<p>\$20 Copay per office visit \$20 Copay per office visit \$20 Copay per office visit</p>	<p>70% 70% 70%</p>
<p>Inpatient Hospital Services: Semi-Private Room and Board Physician Services Diagnostic/Therapeutic Lab and X-ray Drugs and Medication Operating and Recovery Room Radiation Therapy and Chemotherapy Anesthesia and Inhalation Therapy</p> <p>Inpatient Surgeon's Charges Second Surgical Opinion</p>	<p>\$250 Copay per admission</p> <p>Paid at 100%. \$20 Copay per office visit.</p>	<p>70%</p> <p>All inpatient hospital admissions require Precertification. Call the toll-free number on your CIGNA HealthCare ID Card.</p> <p>70% 70%</p>
<p>Outpatient Facility Services including: Operating Room, Recovery Room, Procedure Room and Treatment Room including: Physician Services Diagnostic/Therapeutic Lab and X-rays Anesthesia and Inhalation Therapy</p> <p>Outpatient Preadmission Testing Office Visit Outpatient Facility</p>	<p>Paid at 100%.</p> <p>Paid at 100%. Paid at 100%.</p>	<p>70%</p> <p>70% 70%</p>
<p>Laboratory and Radiology Services such as: MRIs, MRAs, CAT Scans and PET Scans Other Laboratory and Radiology Services</p>	<p>Paid at 100%.</p>	<p>70%</p>
<p>Short-Term Rehabilitative Therapy including Physical, Speech, Occupational and Chiropractic Therapies.</p>	<p>\$20 Copay per office visit – Maximum of 60 visits per year in aggregate.*</p>	<p>70% Maximum of 60 visits per year in aggregate.*</p>
<p>Prescription Drugs For both Retail and Mail Order Drugs Combined: Annual Deductible (Separate from your medical deductible)</p> <p>Plan Pays</p> <p>Your 2012 Annual Maximum Copay, excluding deductible 2012 Maximum Out-Of-Pocket expense per year</p>	<p>\$25 per individual/\$75 per family</p> <p>90% for generic drugs, 80% for preferred brand drugs, and 60% for non-preferred brand drugs \$750 per person \$775 per person (\$750 maximum copays plus \$25 annual deductible.) , then the plan pays 100% for the rest of the calendar year</p>	<p>Not Covered</p>
<p>Emergency and Urgent Care Services at: Physician's Office Emergency Room, Urgent Care or Outpatient Facility Ambulance</p>	<p>\$20 Copay \$50 Copay per visit, (waived if admitted) Paid at 100%.</p>	<p>If true emergency, benefits are the same as the in-network benefits. If not a true emergency, benefits are paid at 70%.</p>
<p>Maternity Care Services Initial Office Visit to Confirm Pregnancy All other office visits <u>Delivery</u> Hospital Charges Physician Charges</p>	<p>\$20 Copay Paid at 100%.</p> <p>\$250 Copay per admission Paid at 100%.</p>	<p>70% 70%</p> <p>70% 70%</p>
<p>Inpatient Services at Other Health Care Facilities including: Skilled Nursing, Rehabilitation and Sub-Acute Facilities</p>	<p>Paid at 100%. 60 days maximum per calendar year</p>	<p>70%. Precertification applies. 60 days maximum per calendar year</p>
<p>Home Health Services</p>	<p>Paid at 100%.</p>	<p>70% ; 40 visits per calendar yr.</p>
<p>Family Planning Services Office Visits (tests, counseling) X-ray/lab if billed by separate facility Vasectomy/Tubal Ligation (excludes reversals) Inpatient Facility Outpatient Facility Surgery in Physician's Office</p>	<p>\$20 Copay Paid at 100%.</p> <p>\$250 per admission Paid at 100%. \$20 Copay</p>	<p>70% 70%</p> <p>70% Precertification applies 70% 70%</p>
<p>Infertility Treatment – Up to \$50,000/lifetime Office Visits (tests, counseling) X-ray/lab if billed by separate facility Treatment/Surgery (includes In-vitro Fertilization, Artificial Insemination, GIFT and ZIFT) done at an inpatient or outpatient facility or physician's office.</p>	<p>\$20 Copay Paid at 100%. Paid at 100%.</p>	<p>Covered in-network only</p> <p>Covered in-network only</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<u>Mental Health and Substance Abuse Precertification Required</u>		
Inpatient Mental Health	100%	70%
Inpatient Substance Abuse	100%	70%
Inpatient Substance Abuse Detoxification	100%	70%
Inpatient Substance Abuse Rehab Facility	100%	70%
Outpatient Mental Health	100%	70%
Marital/Family Counseling	100%	Not Covered
Outpatient Substance Abuse	100%	70%
Durable Medical Equipment	Paid at 100%.	70% \$700 Calendar year maximum
External Prosthetic Appliances	Paid at 100%.	70% \$1,000 Calendar year maximum
Vision Care	\$100 every two calendar years, no deductible or coinsurance, routine exams and lenses.	
OTHER BENEFIT INFORMATION		
<u>Annual Deductible</u> Individual Family	None None	\$500 \$1,000
<u>Annual Out-of-Pocket (OOP) Maximum</u> Individual Family	None None	\$2,000 plus deductible \$6,000 plus deductible
Coinsurance	None	The plan pays 70% of eligible charges after the annual deductible is met. You pay 30% of the charges after the annual deductible is met.
Precertification (Inpatient, Outpatient, and MRI's)	Handled by your physician	Member must obtain approval
Lifetime Maximum	Unlimited	Unlimited

* Out-of-network treatment maximums are reduced by in-network services used.

If you use a CIGNA Provider (In-Network Services):

- All services must be provided by or referred by your Primary Care Physician (PCP) in order to be covered except for: emergency services, routine care provided by a participating OB/GYN, and mental health and substance abuse services authorized by CIGNA Behavioral Health, Inc.

If you use a NON-CIGNA Provider (Out-of-Network Services):

- All out-of-network hospital admissions, outpatient surgeries and MRI's must be precertified by the member. Precertification **is not required** for emergency admissions. To precertify, call the telephone number on the back of your ID card.
- Benefits which are not covered out-of-network are: Organ Transplants, Infertility Treatment and Prescription Drugs.
- Once the out-of-pocket maximum for Out-of-Network services is reached, the plan pays 100% of eligible charges for the remainder of the calendar year.

Exclusions

Your plan does not provide coverage for the following except as required by law. The following are specifically excluded services and supplies:

1. Cosmetic surgery or cosmetic therapy except as specified in the Covered Expenses section of the Certificate or Summary Plan Description.
2. Hearing aids or examinations for prescription or fitting.
3. Treatment of the teeth or peridontium unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an injury to sound natural teeth; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; or (c) charges made by a free-standing surgical facility or outpatient department of a Hospital in connection with surgery.
4. Charges for or in connection with procedures to reverse sterilization.
5. Charges for replacement of external prostheses due to loss, theft or destruction; or for any biomechanical external prosthetic devices.
6. Medical and surgical services intended primarily for the treatment or control of obesity which are not medically necessary including diet supplements and appetite suppressants.
7. Services for 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. Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
9. Therapy to improve general physical condition if not medically necessary, including, but not limited to, routine, long-term chiropractic care, and rehabilitative services which are provided to reduce potential risk factors in patients in which significant therapeutic improvement is not expected.
10. Treatment for acupuncture unless performed by an M.D., N.D., or licensed provider.
11. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, hearing aids, dentures and wigs.
12. Services for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
13. Charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected sickness or injury.
14. To the extent that payment is unlawful where the person resides when the expenses are incurred.
15. For charges which you are not obligated to pay, or for which you are not billed or for which you would not have been billed except that they were covered under this policy.
16. Charges which would not have been made if the person had no insurance.
17. To the extent that they are more than Reasonable and Customary charges.
18. Charges in connection with Custodial Services, education or training.
19. To the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
20. Infertility donor charges and services.
21. Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.
22. Charges for supplies, care, treatment or surgery which are not considered medically necessary for the care and treatment of an injury or sickness, as determined by CIGNA HealthCare.
23. For charges made for or in connection with tired, weak or strained feet for which treatment consists of routine foot care, including but not limited to, the removal of calluses and corns or the trimming of nails unless medically necessary.
24. Services in connection with speech therapy, if such therapy is (a) used to improve speech skills that have not fully developed; (b) can be considered custodial or educational, or (c) is intended to maintain speech communication; speech therapy which is not restorative in nature will not be covered.
25. Charges made by any covered provider who is a member of your family or your Dependent's family.
26. For Experimental, Investigational or Unproven treatment methods not approved by the American Medical Association or the appropriate medical specialty society.
27. Treatment of an Injury or Sickness which is due to war, declared or undeclared.
28. Expenses incurred outside of the United States or Canada, unless you or your Dependent are a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure.
29. Non-medical ancillary services, including, but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety and services, training or educational therapy for learning disabilities, developmental delays, autism or mental retardation.
30. Medical treatment when payment is denied by the Primary Plan because treatment was received from a Non-Participating provider.
31. To the extent of the exclusions imposed by any certification requirement shown in the Certificate or Summary Plan Description.
32. Services or supplies that are not medically necessary.
33. Services or supplies in excess of limitations or maximums set forth elsewhere in the plan.
34. (Whole) blood (benefits are provided for the administration, processing and storage of blood or its derivatives.)
35. Environmental modifications.
36. Cognitive retraining.
37. Charges for covered services incurred more than two years prior to the date a claim is filed.
38. Eye exercises or visual training.
39. Inpatient charges if you are inpatient on the effective date of your coverage.
40. Nutritional formula and medical food supplements taken orally.
41. Convenience and personal care or comfort items.
42. Charges for prescription drugs excluded from the plan.
43. Private room accommodations, unless medically necessary.
44. Support therapies, such as pastoral counseling, assertiveness training, dream therapy, music or art therapy, recreational therapy and smoking cessation therapy.
45. Telephone consultations between the provider and plan participant.
46. Travel (non-ambulance), even if prescribed by a physician (except as specifically stated under the Organ Transplant coverage.)