

**AGREEMENT  
BETWEEN  
THE MANCHESTER BOARD OF EDUCATION  
AND  
AFSCME COUNCIL 4  
LOCAL 818-49  
MANCHESTER BOARD OF EDUCATION  
BUILDING AND GROUNDS SUPERVISORS  
COVERING THE PERIOD  
JULY 1, 2014 THROUGH JUNE 30, 2017**

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**WORKING AGREEMENT  
BETWEEN  
THE MANCHESTER BOARD OF EDUCATION  
AND  
AFSCME COUNCIL 4, LOCAL 818-49**

This Agreement is entered into by and between the Manchester Board of Education, hereinafter referred to as the "Board," and AFSCME Council 4 Local 818-49, hereinafter referred to as the "Union."

**ARTICLE 1  
RECOGNITION**

Section 1.0 The Board, acting through its Superintendent of Schools, recognizes the Union as the sole and exclusive bargaining agent for the purpose of collective bargaining on matters of wages, hours of employment, working conditions, grievances, and other conditions of employment for all Supervisors of Buildings and Grounds Department of the Manchester Board of Education, as more fully described in the certification in Case No. ME-18,030, dated June 21, 1996.

**ARTICLE 2  
HOURS OF WORK, OVERTIME AND HOLIDAY PREMIUM PAY**

Section 2.0 Normal work days, normal work week, and work scheduling shall continue as currently practiced. Changes in current practices as to normal work days, normal work week, and work scheduling shall require negotiations between the parties as provided in the Municipal Employee Relations Act.

Section 2.1 Employees are subject to being called in for work outside of their normal work hours based upon emergency and other business necessity. Employees will not be required to remain at work for any minimum number of hours when they are called in and will be permitted to return home when their duties have been completed.

All employees will rotate on-call service on a regular, weekly basis. On-call service is from Monday at 6:00 a.m. through the following Monday at 6:00 a.m. If a change in rotation is required, it is the responsibility of the employee to work out replacement with notification to the Facilities Manager. Employees will receive on-call pay of two hundred dollars (\$ 200) per week of on-call service. Employees receiving on-call pay must be within reach at all times and must respond to all calls received. Employees may not travel out of the range of the cell phone provided. Failure to respond while on-call will subject the employee to disciplinary action. On-call service will not count towards compensatory time; however, if called in for work sections 2.1 and 2.2 will apply.

Section 2.2 The current practice of utilization of compensatory time will continue for the life of the agreement.

**ARTICLE 3**  
**WAGES**

Section 3.0 The final salary schedule and individual rates as negotiated and adopted by the Board shall be a supplement to this Agreement.

Section 3.1 Wage scales and job classifications shall be negotiated and made part of this Agreement. A complete list of job descriptions shall be furnished to the Union.

Section 3.2 The Board agrees to cover the employees under the provisions of the Workers' Compensation Laws of Connecticut. Employee will not suffer loss of income if injured or absent because of job-related injury while they are receiving Workers' Compensation for up to nine (9) months from the date of the injury. They will continue to receive their regular payroll checks, and in the event that compensation checks are sent directly to them, these checks will be signed over to the Board of Education.

Section 3.3 The Union President shall be informed in writing of all wage increases within the bargaining unit.

Section 3.4 Employees shall receive longevity payments in recognition of their length of service on the following basis. Prior service as a regular, full-time Board of Education employee shall be included.

| <u>YEARS OF SERVICE</u> | <u>AMOUNT ANNUALLY</u> |
|-------------------------|------------------------|
| 5 to 10 years           | \$300                  |
| 10 to 15 years          | \$400                  |
| 15 to 20 years          | \$600                  |
| 20 or more years        | \$800                  |

Longevity service increments will be paid as a lump sum on the payroll following employee's anniversary of hire. Employees hired on or after July 1, 2011, will not be eligible for longevity payments.

Section 3.5

Effective the first of the month following the signing of this Agreement, all employees shall be paid by direct deposit.

**ARTICLE 4**

**SENIORITY, PROBATION, PROMOTIONS, TRANSFERS**

Section 4.0 Effective July 1, 2011, seniority shall commence upon the date that the employee begins as a full-time paid employee of this bargaining unit. The employee's earned seniority shall not be lost because of absence due to illness, pregnancy, maternity leave, bereavement, jury duty, personal leave, or other authorized leave, or while eligible for recall. Seniority and seniority rights will not be accrued during unpaid leaves of absence or layoff, but such rights will not be lost by the employee because of such leave or, if recalled, because of such layoff.

Section 4.1 An employee's seniority and his employment shall terminate upon any of the following:

1. Resignation
2. Discharge for Just Cause
3. Retirement
4. Death
5. Expiration of Recall Rights

Section 4.2 Seniority will be used to determine vacation preference and layoffs in the event of a reduction in force. An employee whose position has been abolished may assume the position of a less senior employee provided he/she is qualified to perform the duties of that position.

Section 4.3 Probationary Period: Employees shall be considered probationary during their first ninety (90) calendar days of employment, provided the employee works at least sixty (60) days within said probationary period. Otherwise a new probationary period shall commence. During such probationary period, the employee shall not attain seniority rights under this Agreement, and such probationary employee will be subject to discharge by the Board, in its discretion, without access to the Grievance Procedure. At the successful completion of the probationary period, seniority shall be retroactive to the commencement of employment.

Section 4.4 In the event an employee is recalled within eighteen (18) months of being laid off, the employee's seniority shall be reinstated, except that no credit shall be given for the period of non-employment. An employee on layoff wishing to remain on the recall list shall apply in writing by certified mail to the office of the Assistant to the Superintendent Finance and Management for retention of his/her name on or before June

of each year subsequent to his/her layoff. Failure to comply with these recall provisions will signify the termination of all said employee's recall rights. Once the recall period expires, the employee shall have no rights and shall be considered terminated.

#### Section 4.5

- A. Notice of all bargaining unit vacancies to be filled and new positions shall be electronically mailed on a separate bulletin to employees. The posting shall remain open five (5) work days prior to any action taken by the Board to fill such vacancies and/or new positions. Employees wishing to fill such vacancies or new positions may personally, or through a Union official, submit their written request to the Personnel Office. Employees expressing a desire to fill the vacancy or new position and who were not selected for such assignment, in accordance with the provisions of this Agreement, may appeal the action through the Grievance Procedure. Qualified Board employees will receive first consideration over applicants outside of Board employment. For internal candidates, the appointment will be made to the applicant determined by the Superintendent or his/her designee to be best qualified on an overall basis to perform the job. If the internal candidates have relatively equal qualifications, seniority shall govern.
- B. Copies of the job posting, a list of persons bidding for the job and the name of the person appointed shall be sent to the Union President no later than seven (7) calendar days from appointment, unless there have been no bids submitted.
- C. All vacancies shall be filled within ninety (90) calendar days from the date of an employee vacating a position or of the establishment of a new position. Management and Union shall negotiate salaries and working conditions within the jurisdiction of the Union to the extent required under MERA.
- D. If the employee who bid into a bargaining unit position during the first fifteen (15) calendar days of his/her probationary period, wished to voluntarily return to the position held prior to his/her promotion, he/she may do so provided the position has not been filled and the Superintendent/designee is notified in writing.

Section 4.6 In the event of a layoff, the Union President shall be notified at least thirty (30) working days in advance of the effective date of the layoff. Notification shall include all details of the proposed layoff and shall allow an opportunity to negotiate the impact of the layoff.

**ARTICLE 5**  
**LEAVE PROVISIONS**

Section 5.0 Each employee shall have credited to their account sick leave at current base pay of twelve (12) working days during each fiscal year, with a maximum accumulation of one hundred eighty-four (184) days. Employees hired prior to June 28, 1999 shall receive fifteen (15) days of sick leave per fiscal year. Each employee shall be entitled to use such sick leave with full pay as has accrued to his/her credit. Each employee shall be notified of his/her accumulated sick leave on each payroll check.

Section 5.1

- A. In exceptional cases, the Superintendent or designee may grant additional sick leave with or without pay, provided that the Superintendent's or his designee's decision in one case shall not establish or be claimed as a precedent in any other case(s). Requests for such additional sick leave shall be in writing and be signed by the employee, if possible.
- B. After all sick leave has been exhausted, an expectant employee shall be permitted to use three (3) personal leave days pursuant to FMLA provisions, during or shortly after the pregnancy or adoption.
- C. Employees are permitted to donate earned vacation days to a designated member of the bargaining group. Such donation must be in writing.

Section 5.2 Employees hired prior to July 1, 1997 with ten (10) years or more of service with the Board of Education, upon retirement shall receive on the basis of his/her current wages, full compensation for any of unused accumulated sick leave, up to a maximum of one hundred and twenty (120) days.

Employees hired prior to July 1, 1997 with less than ten (10) years of service with the Board of Education, upon retirement shall receive one-half of his/her accumulated sick leave. Accumulated sick leave shall not exceed one hundred and twenty (120) days.

Employees hired after June 30, 1997, shall receive a maximum of seventy (70) days at a rate based on the average per diem of their last year's salary.

Employees hired after June 30, 2001 will receive no pay out of accumulated sick leave upon retirement.

For each eligible employee who has reached the age of fifty-five (55) during the calendar year of the employee's retirement, the Board shall contribute the applicable compensation amount under the provisions of this Article into a 401 (a) plan established by the Board in the employee's name. Such contributions into the 401 (a) plan shall be mandatory for each eligible retiring employee. The Board shall make such contributions within sixty

(60) days after the effective date of retirement. For any eligible retiree who has not reached the age of fifty-five (55) as of the date of retirement, the board shall pay directly to the employee the dollar amount applicable to such employee for the payment of unused sick leave, with such amount to be determined in accordance with the provisions of this Article. Such payments shall be made within the same time period applicable to 401 (a) contributions under the provisions of this Article.

Section 5.3 Each employee shall be granted leave with full pay for the following reasons:

- A. In the event of death in the immediate family of an employee, or the immediate family of his/her spouse, up to three (3) days of leave with pay shall be granted. Immediate family for purposes of this clause is defined as parents, grandparents, spouse, brother, sister, child, stepchild, grandchild, son-in-law, daughter-in-law, brother-in-law, sister-in-law, and any relative who is domiciled in the employee's household.
- B. Each employee shall be granted necessary travel time, with approval of his/her Supervisor, not to exceed in the aggregate a total of three (3) days per contract year to fulfill the obligation of going to, attending, and returning from funerals of persons other than those covered under Section 5.3A.
- C. To attend previously approved professional conferences or take courses of study which will contribute to, or increase the employee's knowledge with regard to betterment of the public service. Such approvals will be granted only where budgetary provisions have been made for the above-mentioned purposes.
- D. Any employee called to jury duty shall be paid the difference between the employee's regular rate of pay and the fee received from serving as a juror. No employee shall receive more compensation than normally would have been received had he not served jury duty. An employee called to jury duty shall furnish the Board with a Notice to Serve immediately upon receipt. The employee shall return to work on the following day he/she is released from jury duty.
- E. A maximum of five (5) personal days per year may be used for the following reasons:
  - a. For attendance at weddings in the employee's immediate family or immediate circle of friends, with at least 48 hours advance notice and the permission of the employee's supervisor.
  - b. For attendance at the graduation of someone in the employee's immediate family with at least 48 hours advance notice and the permission of the Superintendent or his/her designee.

- c. Any personal emergency reason which cannot be conducted outside working hours.

#### Section 5.4 Union Leave

- A. One (1) Union official may be designated on behalf of the bargaining unit to process grievances and other labor relations issues, and such member and grievant(s) shall be granted leave of duty with full pay for a reasonable period while engaged in processing said grievance, at each step of the procedure through arbitration.
- B. Two (2) members of the Union may be granted a reasonable leave of absence from duty with pay not to exceed a total of ten (10) days a year to attend conventions or other Union business, but said employee shall not be granted or entitled to reimbursement by the Board for any expenses incurred in travel or otherwise. At least three (3) days written notice shall be required. This leave shall be non-cumulative. At no time shall two (2) members be on leave during the same time period.
- C. During contract negotiations, the Union shall have the right to have two (2) bargaining unit members of its negotiating committee present for all meetings. When such meetings take place during scheduled work hours, the member shall suffer no loss of pay.

Section 5.5 Leave of absence without pay may be granted by the Superintendent for not longer than one (1) year. Requests for such leave shall be made in writing and shall include a statement of the reasons therefore and of the length of leave requested. Following such leave, the employee shall return to the position held at the time of said leave. Action by the Superintendent with respect to one leave request will neither establish nor be claimed as a precedent or practice for other request. Seniority shall not continue to accrue during any unpaid leave of absence.

#### Section 5.6

- A. No employee shall lose any seniority standing because of any military service including service in the National Guard or organized reserves.
- B. On return from military service, an employee shall be reinstated in his/her former job or one of like rank and pay including any increase granted during his/her absence on military service provided that he/she reports for duty within ninety (90) calendar days of his/her discharge from military service.

Section 5.7 The employee's accumulation of sick leave, upon leaving for military service or leave without pay, shall be retained to his/her credit when he/she returns.

Section 5.8 Any employee who becomes pregnant is requested to notify the administration in writing at least four (4) months prior to the expected date of delivery and shall thereafter provide a doctor's certificate indicating continued fitness for work as often as the school administration may require. Leave shall begin when, in the opinion of her doctor, the employee is no longer physically able to work and will end when, in the opinion of her doctor, the employee is physically able to return to work. Any disability resulting from pregnancy shall be considered sickness for the purpose of this Agreement. Except in the case of unusual medical difficulties, leave is not expected to continue more than six (6) to eight (8) weeks after delivery. It is understood that employees disabled under the provisions of this Article shall return to the school system at the end of said disability. The Board of Education will comply with all Family Medical Leave Act (F.M.L.A.) provisions.

An employee absent on pregnancy leave who wishes to return to her same position must so notify the Superintendent or designee in writing, prior to the last scheduled work day. Such employee shall have up to ninety (90) unpaid calendar days from the date of the end of the six (6) to eight (8) weeks disability leave to return to work, which unpaid leave shall constitute child rearing leave. At least one month's written notice of intention to take unpaid child rearing leave must be given to the Superintendent or designee. Maternity/child rearing leave cannot exceed 12 (twelve) weeks. NOTE: Accrued paid vacation time may be credited towards the 90 days.

Section 5.9 During periods of leave without pay, except for military leave and FMLA leave, the employee shall not continue to accrue seniority credit and shall not be credited with time for the purpose of accruing sick leave or vacation leave.

- A. Any Employee who is on a leave of absence without pay shall not be paid for any leave benefits during the period of absence and shall not accumulate vacation time or other leave benefits during the leave period. Any vacation time due an employee at the time of taking a leave of absence without pay may be paid at that time. Authorized leaves of absence for one month or less will not be used as a basis for reducing employees' benefits.

Section 5.10 Accumulated sick time of employees will be listed on the employee's pay check.

Section 5.11 Sick Leave Bank

- A. Each member of the Union shall be permitted to contribute any two (2) days from his/her sick leave accumulation reserve each school year to a "Sick Leave Bank" which shall be established to aid members who suffer prolonged illness and whose sick leave accumulation has been exhausted. The bank shall be build up to a maximum of two hundred fifty (250) days. No more days shall be added until the bank is depleted to approximately one hundred twenty-five

(125) days. Then the bank will be built up again using the same process. Generally an employee must be a contributing member for at least one year before being permitted to apply for benefits.

- B. When an employee has exhausted all available sick leave, application for additional sick leave time from the Emergency Sick Leave Bank may be submitted, accompanied by a physician's statement describing the illness and offering a prognosis for a date of return to work.

The Sick Bank Committee may grant up to thirty (30) days from the Emergency Sick Bank. If the thirty (30) days are exhausted, the employee may request an additional grant of up to twenty (20) days. These may be granted following a five-day waiting period. An up-to-date physician's statement is required. An additional twenty (20) half-days may be granted in extreme cases and must be accompanied by an up-to-date physician's statement. All fees required by a physician are to be borne by the employee.

In determining a grant of sick days, the Committee will consider such criteria as: the employee's statement of illness, the physician or medical professional's submitted statement(s), employment records, history of the use of sick time, the results of Committee investigations and such additional materials as are available to the Committee.

The Committee has the right to require a second physician's opinion, chosen by the Board of Education members of the Committee, and a third physician's opinion chosen by the Union members of the Committee.

- C. The following conditions shall apply:

1. Additions to the bank shall be made at the beginning of the school year.
2. A person withdrawing membership in the bank will not be able to withdraw the contributed days.
3. Persons withdrawing sick leave days from the bank will not have to replace these days except as a regular contributing member of the bank.
4. Sick leave shall mean the leave a staff member has for that year plus his/her accumulation.

- D. The Committee will be composed of three (3) members selected by the Union leadership (one of whom will be the President) and three (3) members selected by the Superintendent (one of whom will be the Assistant Superintendent for Administration).

Decisions of the Committee are final and not subject to arbitration.

The Committee may promulgate further guidelines assuming that such guidelines are in concert with the conditions of the contract and the policies of the Manchester Board of Education.

**ARTICLE 6**  
**HOLIDAYS**

Section 6.0 The following holidays shall be observed as days off with full pay:

|                        |                            |   |
|------------------------|----------------------------|---|
| New Year's Day         | Independence Day           | Veteran's Day                                   |
| Martin Luther King Day | Labor Day (if schools have | Thanksgiving Day                                |
| President's Day        | been made ready            | Day after Thanksgiving                          |
| Good Friday            | for the opening of school) | Christmas Day                                   |
| Memorial Day           | Columbus Day               | Employee's Birthday (with<br>one week's notice) |

Section 6.1

- A. Holidays occurring on Saturday will be observed on the preceding Friday if there is no school on said Friday. If school is in session, the employees shall be granted a day off at a time mutually agreeable.
- B. Holidays occurring on Sunday will be observed on the following day if there is no school on said Monday. If school is in session, the employees shall be granted a day off at a time mutually agreeable.

Section 6.2 Whenever any of these holidays shall occur during the paid vacation of an employee, he/she shall be entitled to that holiday with pay and shall not have a vacation day charged to vacation records.

Section 6.3 Whenever any of these holidays shall occur while an employee is out on paid sick leave, the employee shall be granted an additional day off at a time mutually agreeable provided that a doctor's note verifying the sickness has been presented.

**ARTICLE 7**  
**VACATIONS**

Section 7.0 Employees shall be entitled to vacation with full pay on the following basis:

- A. An employee with less than one (1) year of service shall be entitled to one (1) vacation day for each month of service, except that they shall not be entitled to any vacation until after two (2) complete months of service.
- B. Employees who have completed one (1) year of service shall be entitled to a vacation with pay of ten (10) working days annually.
- C. Employees who have completed five (5) years of service shall be entitled to a vacation with pay of twenty (20) working days annually.
- D. Any employee receiving benefits over and above those described herein shall continue to receive said benefits.

Section 7.1 The employee's anniversary date of employment will be used to determine the amount of vacation time due. Employees must take all vacation time earned or two (2) weeks, whichever is less, during the year following the anniversary date on which it is earned. Any additional earned vacation time may be carried over from one vacation year to the next, up to a maximum accumulation of not more than six (6) weeks. For the purposes of computing vacation time, the school year (July 1 through June 30) will be used.

Section 7.2

- A. Vacation days may be taken consecutively or otherwise.
- B. Employees shall submit written vacation requests as far in advance of the vacation as possible. Whenever there shall be a conflict in requested vacation dates, preference shall be given to the employees according to their seniority within this bargaining unit. All vacations must be approved in advance by the Facilities Manager.

Section 7.3 Any additional vacation due an employee the first year after qualifying for such additional vacation may be taken, subject to the provisions of Section 7.0C, any time two (2) months prior to or two (2) months after qualifying.

Section 7.4 An employee, upon termination of his/her services with the Board, shall be entitled to full pay for any vacation time due him/her including pro-rata time to date of termination. In the event of an employee's death, such payment shall be made to his/her dependent survivor, beneficiary, or estate if there is no dependent survivor.

Section 7.5 In the event of illness during an employee's vacation period, the employee shall be given an option of charging the sick days to his/her sick leave, provided that a doctor's certificate verifies the illness.

**ARTICLE 8**  
**INSURANCE AND PENSION**

Section 8.0

A. The Board shall provide and pay for the following insurance for each employee hired on or before June 30, 2005 and their dependents. Employees hired on or after July 1, 2005, shall not be eligible to enroll in the PPO plan. The following plans will be offered to each employee, at the following premium cost shares:

1. Open Access \$30

15.0% of the annual premiums effective July 1, 2013.  
Effective upon signing, the Board shall offer Open Access \$30 and employees shall contribute 16.0% of the annual premiums. Effective July 1, 2015, the employee contribution shall be 17% and effective July 1, 2016, the employee contribution shall be 17.5%.

2. Open Access \$20

13.0% of the annual premiums effective July 1, 2013.  
Effective upon signing, the Board shall offer Open Access \$20 and employees shall contribute 13.5% of the annual premiums. Effective July 1, 2015, the employees contribution shall be 14.0% and effective July 1, 2016 the employee contribution shall be 14.5%.

3. H.S.A. (Health Savings Account)

11.0% of the annual premiums effective July 1, 2011- June 30, 2014.  
Effective upon signing the employee shall contribute 11.5% of the annual premiums. Effective July 1, 2015 the employee contribution shall be 12% and effective July 1, 2016 the employee contribution shall be 12.5.

The Board of Education will fund 50% of the Deductible.

For a description of these plans, see Appendix II.

B. The Board shall provide a prescription plan that is the same or similar to that currently provided by Medco, with same or similar being defined as the benefits arrangements provided by an alternative health insurance benefit carrier being such that the size of the service network offered must be 80% of that currently offered.

C. The Board shall provide a Full Service Dental Plan, including rider for unmarried children, with Plan same or similar to that provided by Delta Dental, with same or similar being defined as the benefits arrangements provided by an

alternative health insurance benefit carrier being such that the size of the service network offered must be 80% of that currently offered. Dental riders A, B and C will be provided to employees at the group rate, provided the employee pays the full costs of such riders.

- D. The Board reserves the right to change health insurance plans to a plan that is the same or similar to the plans currently provided, with same or similar being defined as the benefits arrangements provided by an alternative health insurance benefit carrier being such that the size of the network offered must be 80% of that currently offered with similar geographic patterns. The following will be excluded in determining whether a plan is similar or not: out-of-state reciprocal arrangements for routine care (non-emergencies), except that at least one plan option shall include such out-of-state reciprocal arrangements; claims processing; payment methods and plan documents definitions and language. The Superintendent shall give notice to the Union of the intention to make a change, simultaneous to his/her receipt of notice from the Town of Manchester but in no event shall the notice be less than 15 days.

If the Union disapproves of any change pursuant to the written statement noted above, it may submit the issue to arbitration within fifteen (15) calendar days of receipt of notice from the Superintendent that the Board intends to implement the new plan. Arbitration in accordance with the rules of the American Arbitration Association will be the exclusive method for deciding the above issue.

- E. Life Insurance and an ADD policy in the amount of one times the employee's salary, rounded up to the nearest thousand.

Section 8.1 Bargaining unit members will be covered by applicable provisions of the Town of Manchester Defined Benefit Pension Plan in accordance with its terms. The percent of contribution is 6.4%. This shall also be inclusive of the combo "rule of 80" (combination of age years and years of service) retirement provisions which will enable employees to retire without reduction and will count as a normal retirement under the plan.

Employees hired on/after July 1, 2011 will only be eligible for the Town of Manchester Defined Contribution Plan. The percent of contribution is 6%.

Section 8.2 Pursuant to Connecticut State Board of Labor Relations decisions, the Union shall be entitled to give notice to the Town to negotiate concerning pension issues.

Section 8.3 Retiree Insurance

- A. Employees initially hired by the Board on or before June 30, 1998, and who retire on or after July 1, 1998, under the Town pension plan and their spouses shall be provided with the prevailing health, prescription and dental, insurance

benefits granted to active bargaining unit employees for themselves and spouses. Employees shall contribute 25% of the respective coverage costs (single or couple) until the retiree, or the retiree's spouse, reach Medicare Eligibility age. At that time, the individual who has reached that age must leave the Board's insurance program and enroll in Medicare. The remaining individual will be responsible for 25% of the single coverage premium costs.

- B. Employees hired by the Board on or after July 1, 1998, and who retire under the Town pension plan shall be provided the same health insurance benefits as active employees and shall pay the full cost of these benefits.
- C. In order to receive health insurance benefits after retirement as provided above, the employees must have a minimum of fifteen (15) years of service in the Manchester Public Schools as an employee of the Board prior to their retirement under the Town pension plan. For employees who receive a disability retirement, the minimum years of service provision shall be waived. Supervisors hired in or prior to the 1995-1996 school year must have served a minimum of ten (10) years for these benefits.
- D. When a Supervisor retires under paragraph "A" above and they become eligible for Medicare, they shall be provided the "Medicare supplement plan" for which the retiree must pay 100% of the premium.

Section 8.4 Upon the death of an employee, the Board shall afford the surviving spouse (and any dependent children under the age of 25) the opportunity to purchase insurance at the same rate as active employees through June 30<sup>th</sup> of the fiscal year in which the employee became deceased. Thereafter, the surviving spouse (and any dependent children under the age of 25) will be entitled to benefits under COBRA for the statutory period.

## **ARTICLE 9**

### **SAFETY & HEALTH**

Section 9.0 The President of the Union shall designate an employee to serve on the Board Safety Committee.

Section 9.1 The Board will provide employees who work outside in inclement weather foul weather gear, i.e, rain coats or rain suits, rain hats, boots, gloves, etc., for their care and maintenance. These items are not for personal use.

Section 9.2 The Board shall provide, free of charge to employees, medical injections for the prevention and treatment of contagious diseases such as flu, tetanus, and hepatitis, etc., as may be approved by the Board's medical advisor.

Section 9.3 The Board shall supply safety shoes, or supply a payment therefore, and safety glasses, including prescription glasses when required, for all members of the Bargaining Unit whose duties require them to wear such safety equipment.

Section 9.4 The Board shall furnish each employee, at no cost to the employee, with eleven (11) sets of uniforms provided & maintained by a uniform service. Employees are required to be in a Board provided uniform at all times while on duty during normal working hours.

## **ARTICLE 10**

### **DISCIPLINARY PROCEDURE**

#### Section 10.0

A. All disciplinary actions shall be for just cause.

B. Disciplinary action shall include:

1. A verbal warning;
2. Written warning;
3. Suspension without pay (1 – 5 days); and
4. Discharge,

and shall normally follow this order. The Superintendent or his/her designee reserves the right to deviate from the above procedure in appropriate cases.

C. Whenever any such action is taken, the Superintendent shall, at the time of suspension or discharge, furnish the President of the Union, in writing, a statement of the reasons for such action and the period of time for which any such suspension is to be effective.

D. Any disciplinary action or measure imposed upon an employee may be processed as a grievance through the grievance procedure.

E. The service record of any employee disciplined under Article 10.0A and/or B shall be cleared after eighteen (18) months. Matters involving absenteeism shall be retained in the employee's permanent service record for a period up to eighteen (18) months.

F. If the employer has reason to reprimand an employee, it shall be done in a manner that will not embarrass the employee before other employees or in public.

**ARTICLE 11**  
**PRIOR PRACTICE**

Section 11.0 Nothing in this Agreement shall be construed as abridging any right, benefit, or condition of employment that employees and/or the Board have enjoyed heretofore unless it is specifically stated that said practice has been superseded by a provision of this Agreement.

**ARTICLE 12**  
**UNION SECURITY**

Section 12.0 The Board agrees to deduct from the pay of all its employees, who authorize in writing such deductions from their wages, such membership dues, agency fees, initiation fees and reinstatement fees as may be fixed by the Union. Such deductions shall continue for the duration of this Agreement or any extension thereof.

Section 12.1 The deduction for any month will be made during each pay period of said month and shall be remitted to the Financial Officer of the Union not later than the last day of said month. The monthly remittances to the Union will be accompanied with a list of names of employees from whose wages such deductions have been made and the amount deducted from each employee.

Section 12.2 All full-time permanent employees shall, within thirty (30) days of the signing of this Agreement or within thirty (30) days of the date of hire, as a condition of employment, remain or become and remain a member of the Union and shall pay to the Union monthly Union dues in an amount uniformly required of its members. In lieu thereof, any current employees, or any employee hired after the effective date of this Agreement may choose not to become a member of the Union, in which case such employee shall, as a condition of employment, pay a monthly service fee to the Union which shall be in an amount determined by the Union in accordance with law. Should an employee not comply with the conditions of this section, his/her employment will be terminated within thirty (30) days after notice by the Union to the Supervisor or his/her designee.

Section 12.3 During the term of this Agreement, the Board shall furnish the Union upon request with an up-to-date list of bargaining unit employees. When a new employee is hired, the Board shall notify the Union and furnish the Union with the name, date of employment, position and rate of pay of the new employee. When the employment of an employee terminates, the Board shall notify the Union and furnish the name and date of termination of the employee.

**ARTICLE 13**  
**MANAGEMENT RIGHTS**

Except where such rights, powers and authority are specifically relinquished, abridged, or limited by the provisions of this Agreement, the Board has and will continue to retain, whether exercised or not, all of the rights, power and authority held by the Board before the negotiating and signing of this contract, and except where such rights, powers, and authority are specifically relinquished, abridged, or limited by the provisions of this Agreement, it shall have the sole and unquestioned right, responsibility, and prerogative of management of the affairs of the Board and direction of the working force:

- A. To determine the care, maintenance, and operation of equipment and property used for and on behalf of the purposes of the Board.
- B. To establish or continue policies, practices, and procedures for the conduct of Board business and, from time to time, to change or abolish such policies, practices, or procedures. However, where such policies, practices, or procedures impact wages, hours or conditions of employment, the Board shall notify the Union and offer to negotiate regarding such changes to the extent required by the MERA.
- C. To establish or discontinue positions, classifications, processes or operations.
- D. To select and to determine the number and types of employees required.
- E. To employ, transfer, promote, or demote employees, or to lay-off, terminate, or otherwise relieve employees from duty for lack of work or other legitimate reasons when it shall be in the best interest of the Board or the Department.
- F. To prescribe and enforce rules and regulations for the maintenance of discipline and for the performance of work in accordance with the requirements of the Board, provided such rules and regulations which impact wages, hours or conditions of employment have been furnished to the Union and the Union has been given an opportunity to negotiate such rules and regulations to the extent required by MERA.
- G. To ensure that incidental duties connected with any department operations shall be performed by employees.

**ARTICLE 14**  
**SAVINGS CLAUSE**

Section 14.0 Should any Article, Section, or portion thereof of this Agreement be held unlawful and unenforceable by any court of competent jurisdiction, such decision of the

court shall apply only to the specific Article, Section, or portion thereof directly specified in the decision. Upon the issuance of such a decision, the parties agree immediately to negotiate a substitute for the invalidated Article, Section or portion thereof.

## **ARTICLE 15**

### **GRIEVANCE PROCEDURE**

Section 15.0 The Superintendent or his/her designee and the Union shall meet periodically at a time mutually convenient for the purpose of discussing matters of mutual interest, performance of work, employee behavior, and working conditions with the intent to avoid the necessity of individual recourse to the formal grievance procedure and to generally promote a satisfactory relationship.

Section 15.1 The purpose of this procedure is to provide an orderly method for adjusting grievances. Grievances arising out of matters covered by this Agreement and disputes and consultations on any questions arising out of employer-employee relationships will be processed in the following manner:

Step 1 – The aggrieved employee and/or his/her Union Steward shall take up the grievance or dispute with the employee’s immediate superior. The immediate superior shall adjust the matter at once, or notify the employee and his/her Steward of his/her decision within five (5) days from the date the matter is presented. If the grievance is presented in writing at Step 1, the response shall be written.

Step 2 – If the matter has not been settled, it may be presented in writing (such presentation must be made within fifteen (15) days of receipt of the Step 1 response) by the Steward and/or the President of the Union to the Superintendent. The Superintendent shall, within ten (10) days from the date the matter is submitted to him/her, arrange a meeting with all those concerned to review the facts, and notify the employee, the President of the Union, and AFSCME Council 4 of his decision in writing, within ten (10) days after the date of the meeting.

Step 3 – If the matter is still unsettled, the parties may present the grievance in writing (such presentation must be made within fifteen (15) days of receipt of the Step 2 response) to the Board of Education. Each party reserves the right, however, to waive this step of the grievance procedure and proceed to Arbitration. The Board of Education or designated committee of the Board of Education shall review the grievance within thirty (30) days after its submission to the Board, and shall afford the parties an opportunity to present their positions on the grievance. The Board of Education or its designated committee, as the case may be, shall issue a decision concerning the grievance in writing within ten (10) days after the date it was presented to the Board of Education.

Arbitration – If the matter is still unsettled, the Union may submit the matter to arbitration by the State Board of Mediation and Arbitration (such presentation must be

made within thirty (30) days of Step 2). The decision of the Arbitrator(s) shall be final and binding on both parties. Termination (discharge) cases may be referred by the Board in its discretion to the American Arbitration Association for arbitration in accordance with its Voluntary Labor Arbitration rules, provided the Board pays all costs of the arbitration charged by the AAA and the Arbitrator. The decision of the arbitrator shall be final and binding upon both parties as provided by law.

Section 15.2 Failure of the employee, the Board or the Union to insist upon compliance with any provision of this Agreement at any given time or times under any given set or sets of circumstance shall not operate to waive or modify such provision, or in any manner whatsoever to render it unenforceable, as to any other time or times or as to any other occurrence or occurrences, whether the circumstances are, or are not, the same.

Section 15.3 No grievance may be initiated more than twenty (20) calendar days after the occurrence of one or both of the following events:

- A. The knowledge of the occurrence of the condition giving rise to the grievance;
- B. Written notice of said condition to the employee or employees involved.

## **ARTICLE 16**

### **GENERAL PROVISIONS**

Section 16.0 Employees are allowed a meal allowance of ten dollars (\$10.00) when required by the Board to work at least three (3) hours beyond their normal quitting time.

Section 16.1 It is understood that the supervisor shall continue to serve under the direction of the Superintendent of Schools or his/her designee(s) and in accordance with Board and administrative policies, rules and regulations, provided that the provisions of this agreement shall supersede and prevail over any conflicting provisions.

Section 16.2

- A. Board may require evidence that medical attention was obtained by employees who are absent for five (5) or more consecutive work days or who exhibit a pattern of habitual absenteeism. Employees should be prepared to present such medical documentation. The Board of Education may require an employee to undergo a physical examination at Board expense.
- B. The Board of Education will require newly hired employees to undergo a physical examination prior to or at a time of initial employment.

Section 16.3 There shall be no alteration, variation or amendment of the terms and conditions of this Agreement, unless made and agreed to in writing by both parties. Any

agreement must be approved by the Union membership and the Board of Education in order to become effective.

Section 16.4 If there is any previously adopted policy, rule, or regulation of the Board which is in conflict with any provision of the Agreement, said Agreement provision shall prevail during the term of this Agreement.

Section 16.5 When an employee is required by the Board to use his/her own vehicle to perform Board business, he/she shall be reimbursed at the IRS rate.

Section 16.6 The Union's business representative shall be permitted to visit specific job sites where bargaining unit members are employed. Notice is first given to the Superintendent or his/her designee, and such visits are to be at normal business hours and not interfere with the operation of the department.

Section 16.7 Any employee who is required by law or the Board to attend any training or conferences shall be reimbursed for enrollment fees, meals (where applicable), travel, and lodging (where applicable) in accordance with current Board policy.

Section 16.8 Credit Union payroll deductions shall be made for those employees who desire to be members of an available Credit Union.

Section 16.9 At least one (1) bulletin board or space on a bulletin board shall be placed, in an accessible place for the use of the Union for the posting of official Union notices or announcements.

Section 16.10 The Board will provide each employee with a copy of this Agreement within thirty (30) days after the date of the signing of this Agreement. New employees will be provided with a copy of this Agreement at the time of hire.

Section 16.11 Second shift employees may attend Union meetings with the stipulation that such meetings occur within Town limits after first arranging for any necessary coverage.

Section 16.12 All members of this bargaining unit who supervise one or more employees shall be provided with training concerning supervisory responsibilities and human rights and opportunities law.

Section 16.13 Any complaint made against a supervisor or person from whom he is administratively responsible for, shall promptly be called to the attention of the supervisor. In no case shall any anonymous complaint be formalized. No unsubstantiated complaint shall be placed in the employee's file. Employees shall be given copies of any complaint.

Section 16.14 Bargaining unit work should be performed by members of the unit. The board may accept volunteer work and/or workfare work under the following conditions.

- A. That there be no reduction in the work force of the unit because of the volunteer and/or workfare efforts.
- B. That the President of the Union have prior knowledge.
- C. That the Union staff monitors the volunteer work.

Section 16.15 Evaluations: Employees of the bargaining unit shall be subject to annual evaluations. Employees may grieve such evaluations if they do not agree with any or all of their evaluations. The evaluation form to be used is attached as Appendix III.

Section 16.16 Vehicle Usage:

- A. Members of this bargaining unit recognize that at times they will be Emergency Responders and, as such, will be allowed to use a Board of Education vehicle to and from school and during school days.
- B. Under no circumstances will a Buildings and Grounds supervisor be paid both an automatic monthly stipend and be permitted to use Board of Education vehicles for the same mileage.

## **ARTICLE 17**

### **WEARING APPAREL/REPLACEMENT**

Section 17.0 The Board will pay for glasses broken or damaged on the job due to job conditions and not due to the employee's negligence.

Section 17.1 The Board of Education shall replace or reimburse the employee for personal items damaged or lost in the course of employment. The sum of such claims for the bargaining unit shall not exceed \$2,000 annually.

**ARTICLE 18**  
**EDUCATION REIMBURSEMENT**

Section 18.0 The Board of Education will reimburse employees for 85% of the tuition and lab fees for courses taken to enhance job skills. These courses must have prior administrative approval and be limited to one (1) per semester.

**ARTICLE 19**  
**DURATION**

Section 19.0 This agreement shall be effective as of the date of ratification, and shall remain in full force and effect through the 30<sup>th</sup> day of June, 2017, except for wages which shall be retroactive as per Appendix I. The parties shall provide notice to re-negotiate the terms of this Agreement pursuant to the Municipal Employee Relations Act (MERA).

IN WITNESS WHEREOF, the parties hereto have set their hands this 9<sup>th</sup> day of January, 2014.

FOR MANCHESTER  
BOARD OF EDUCATION



Patricia F. Brooks  
Assistant to the Superintendent  
Finance and Management

FOR LOCAL 818-49 OF COUNCIL 4  
AFSCME, AFL-CIO



Charles Cadman  
Union President Local 818-49



Patricia Johnson Cardin  
Council 4 AFSCME

APPENDIX I  
WAGES

Salary Schedule

| <u>Position</u>        | 2014-2015 | 2015-2016 | 2016-2017 |
|------------------------|-----------|-----------|-----------|
| Projects Supervisor    | 77,564    | \$79,115  | \$80,697  |
| Maintenance Supervisor | \$77,564  | \$79,115  | \$80,697  |
| Custodial Supervisor   | \$77,564  | \$79,115  | \$80,697  |

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- A. Employees hired after the signing of this contract into any on of the bargaining unit positions will receive the stated salary, less six percent (6%), for the probationary period. At the end of the probationary period, the employee will receive the stated salary, less five percent (5%), until the completion of one-year of service. Upon completion of one-year of service, the employee will receive the stated salary.
- B. There is currently only one pay grade. Any changes to this structure will be negotiated with the Union.

## CLIENT SUMMARY OF BENEFITS

**Cigna Health and Life Insurance Co.**  
**For - Manchester Town and Board of Education**  
**Open Access Plus Plan - BOE \$20 Cafeteria, Custodians, Nurses, Secretaries, Teachers, Paraeducators, B&G Supervisors**



| Plan Highlights  | In-Network                       | Out-of-Network                     |
|--|----------------------------------|------------------------------------|
| <b>Lifetime Maximum</b>  | Unlimited                        | Unlimited                          |
| <b>Coinsurance</b>   | Plan pays 100% coinsurance       | Plan pays 80% coinsurance          |
| <b>Maximum Reimbursable Charge</b><br>Out-of-network services are subject to a Calendar Year deductible and maximum reimbursable charge limitations. Payments made to health care professionals not participating in Cigna's network are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a percentage (300%) of a fee schedule developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule is not used, and the maximum reimbursable charge for covered services is determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or the amount charged for that service by 80% of the health care professionals in the geographic area where it is received. The health care professional may bill the customer the difference between the health care professional's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles, co-payments and coinsurance. | Not Applicable                   | 300%                               |
| <b>Calendar Year Deductible</b> <ul style="list-style-type: none"> <li>• Only the amount you pay for in-network covered expenses counts toward your in-network deductible. Only the amount you pay for out-of-network covered expenses only counts toward your out-of-network deductible.</li> <li>• After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan.</li> </ul>   | Individual: None<br>Family: None | Individual: \$200<br>Family: \$500 |

7/1/2014

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Open Access Plus - Copay - Manchester Board of Education OAP Preferred \$20 Cafeteria, Custodians, Nurses, Secretaries, Teachers Copay, Paraeducators, B&G Supervi:

| Plan Highlights   | In-Network                                 | Out-of-Network  |
|---|--|---|
| <b>Calendar Year Out-of-Pocket Maximum</b> <ul style="list-style-type: none"> <li>Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. Only the amount you pay for out-of-network covered expenses counts toward your out-of-network out-of-pocket maximum.</li> <li>Plan deductible contributes towards your out-of-pocket maximum.</li> <li>All copays and benefit deductibles contribute towards your out-of-pocket maximum.</li> <li>Mental Health and Substance Abuse covered expenses contribute towards your out-of-pocket maximum.</li> <li>After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.</li> <li>Non-compliance penalties contribute towards your out-of-pocket maximum.</li> </ul> | Individual: \$6,350<br>Family: \$12,700    | Individual: \$1,200<br>Family: \$2,500  |
| <b>Pre-Existing Condition Limitation (PCL)</b>  | Not Applicable                             | Not Applicable  |
| <b>Pre-certification - Continued Stay Review - PHS Inpatient</b> - required for all inpatient admissions  | Coordinated by your physician              | Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance. <ul style="list-style-type: none"> <li>\$250 penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.</li> <li>Benefits are reduced by 50% for any admission reviewed by Cigna Healthcare and not certified.</li> <li>Benefits are reduced by 50% for any additional days not certified by Cigna Healthcare.</li> </ul> |
| Benefit   | In-Network                                 | Out-of-Network  |
| Physician Services  |  |   |
| <b>Primary Care Physician (PCP) Office Visit</b>  | \$20 PCP copay; then Plan pays 100%        | Plan pays 80% coinsurance after plan deductible is met  |
| <b>Specialty Care Physician Office Visit</b>  | \$20 Specialist copay; then Plan pays 100% | Plan pays 80% coinsurance after plan deductible is met  |

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| Benefit   | In-Network   | Out-of-Network   |
|---|--|--|
| <b>Physician Services</b>   |  |  |
| <b>Surgery Performed in Physician's Office</b>  | Plan pays 100% coinsurance                                 | Plan pays 80% coinsurance after plan deductible is met |
| <b>Allergy Treatment/Injections</b>   | Plan pays 100%   | Plan pays 80% coinsurance after plan deductible is met |
| <b>Allergy Serum</b><br>Dispensed by the physician in the office  | Plan pays 100%   | Plan pays 80% coinsurance after plan deductible is met |
| Benefit   | In-Network   | Out-of-Network   |
| <b>Preventive Care</b>  |  |  |
| <b>Routine Preventive Care - All Ages</b> <ul style="list-style-type: none"> <li>Includes well-baby, well-child, well-woman and adult preventive care</li> <li>Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.</li> </ul>  | Plan pays 100%   | Plan pays 80% coinsurance after plan deductible is met |
| <b>Immunizations - All Ages</b> <ul style="list-style-type: none"> <li>Includes travel related immunizations</li> </ul>   | Plan pays 100%   | Plan pays 80% coinsurance after plan deductible is met |
| <b>Mammogram, PAP, PSA Tests</b> <ul style="list-style-type: none"> <li>Coverage includes the associated Preventive Outpatient Professional Services.</li> <li>Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.</li> </ul>   | Plan pays 100%   | Plan pays 80% coinsurance after plan deductible is met |
| Benefit   | In-Network   | Out-of-Network   |
| <b>Inpatient</b>  |  |  |
| <b>Inpatient Hospital Facility</b>  |  |  |
| <b>Semi-Private Room:</b> In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate<br><b>Private Room:</b> In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate<br><b>Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):</b> In-Network: Limited to the negotiated rate / Out-of-Network: Limited to ICU/CCU daily room rate | \$200 per admission copay, then Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met |
| <b>Inpatient Hospital Physician's Visit/Consultation</b>  | Plan pays 100% coinsurance                                 | Plan pays 80% coinsurance after plan deductible is met |

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| Benefit   | In-Network   | Out-of-Network   |
|---|--|--|
| <b>Inpatient</b>  |  |  |
| <b>Inpatient Professional Services</b> <ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>   | Plan pays 100% coinsurance   | Plan pays 80% coinsurance after plan deductible is met |
| <b>Multiple Surgical Reduction</b>  | Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery. |  |
| Benefit   | In-Network   | Out-of-Network   |
| <b>Outpatient</b>   |  |  |
| <b>Outpatient Facility Services</b> <ul style="list-style-type: none"> <li>Non-surgical treatment procedures are not subject to the facility per visit copay/benefit deductible</li> </ul>  | \$100 per facility visit copay, then Plan pays 100% coinsurance  | Plan pays 80% coinsurance after plan deductible is met |
| <b>Outpatient Professional Services</b> <ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>  | Plan pays 100% coinsurance   | Plan pays 80% coinsurance after plan deductible is met |
| <b>Cardiac Rehabilitation</b> <ul style="list-style-type: none"> <li>36 days maximum per occurrence</li> </ul>  | \$20 PCP or \$20 Specialist copay; then Plan pays 100%   | Plan pays 80% coinsurance after plan deductible is met |
| <b>Short-Term Rehabilitation</b> <ul style="list-style-type: none"> <li>Includes physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation and cognitive therapy</li> <li>60 days maximum per Calendar Year (all therapies combined and reduced by any days used for chiropractic care)</li> <li>Therapy days, provided as part of an approved Home Health Care plan, accumulate to the outpatient short term rehab therapy maximum</li> </ul> | Plan pays 100%   | Plan pays 80% coinsurance after plan deductible is met |
| <b>Chiropractic Care</b> <ul style="list-style-type: none"> <li>60 days maximum per Calendar Year (reduced by any days used for physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation and cognitive therapy)</li> <li>Includes maintenance and massage therapy when in conjunction with chiropractic care</li> </ul>   | \$20 PCP or \$20 Specialist copay; then Plan pays 100%   | Plan pays 80% coinsurance after plan deductible is met |

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| Benefit   | In-Network  | Out-of-Network  |
|---|---|---|
| <b>Other Health Care Facilities/Services</b>  |   |   |
| <b>Home Health Care</b><br>(includes outpatient private duty nursing days when approved as medically necessary) <ul style="list-style-type: none"> <li>• Unlimited days maximum per Calendar Year</li> <li>• 16 hour maximum per day</li> </ul> | Plan pays 100% coinsurance  | Plan pays 80% coinsurance after plan deductible is met  |
| <b>Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility</b> <ul style="list-style-type: none"> <li>• 180 days maximum per Calendar Year</li> </ul>   | Plan pays 100% coinsurance  | Plan pays 80% coinsurance after plan deductible is met  |
| <b>Durable Medical Equipment</b> <ul style="list-style-type: none"> <li>• Unlimited maximum per Calendar Year</li> </ul>  | Plan pays 100% coinsurance  | Plan pays 80% coinsurance after plan deductible is met  |
| <b>Breast Feeding Equipment and Supplies</b> <ul style="list-style-type: none"> <li>• Limited to the rental of one breast pump per birth as ordered or prescribed by a physician.</li> <li>• Includes related supplies</li> </ul>               | Plan pays 100%  | Plan pays 80% coinsurance after plan deductible is met  |
| <b>External Prosthetic Appliances (EPA)</b> <ul style="list-style-type: none"> <li>• Unlimited maximum per Calendar Year</li> </ul>   | Plan pays 100% coinsurance  | Plan pays 80% coinsurance after plan deductible is met  |
| <b>Nutritional Formula</b> <ul style="list-style-type: none"> <li>• Birth through 12 years of age</li> </ul>  | Plan pays 100% coinsurance  | Plan pays 100% of billable charges  |
| <b>Osteopaths</b>   | \$20 Specialist copay; then Plan pays 100%  | \$20 per visit deductible, then plan pays 100% of billable charges  |
| <b>Naturopath</b>   | \$20 Specialist copay; then Plan pays 100%  | \$20 per visit deductible, then plan pays 100% of billable charges  |
| <b>Wigs</b> <ul style="list-style-type: none"> <li>• \$350 maximum per calendar year</li> </ul>   | Plan pays 100% coinsurance  | Plan pays 100% of billable charges  |
| <b>Hearing Aids</b> <ul style="list-style-type: none"> <li>• \$1,000 maximum per calendar year for ages 12 years and younger</li> </ul>   | Plan pays 100% coinsurance  | Plan pays 80% coinsurance after plan deductible is met  |
| <b>Hearing Exams</b><br><br>1 exam every 24 months  | \$20 PCP or \$20 Specialist copay; then Plan pays 100%  | Plan pays 80% coinsurance after plan deductible is met  |
| <b>Routine Foot Disorders</b>   | 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. |
| <b>Vision care</b> <ul style="list-style-type: none"> <li>• Eye exam once every 24 months</li> </ul>  | \$20 PCP or \$20 Specialist copay; then Plan pays 100%  | \$20 per visit deductible, then plan pays 100% of billable charges  |
| <b>Oral Surgery - Impacted Wisdom Teeth Inpatient Facility</b>  | \$200 per admission copay, then Plan pays 100% coinsurance  | Plan pays 80% coinsurance after plan deductible is met  |

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| Place of Service - You pay based on where you receive services. |                    |  |                            |  |                                      |                |                 |  |   |   |
|---|--------------------|--|----------------------------|--|--------------------------------------|----------------|-----------------|--|---|---|
| Benefit   | Physician's Office |  | Outpatient Facility        |  | Emergency Room/ Urgent Care Facility |                | Independent Lab |  | Inpatient Hospital                              |   |
|   | In-Network         | Out-of-Network   | In-Network                 | Out-of-Network   | In-Network                           | Out-of-Network | In-Network      | Out-of-Network   | In-Network                                      | Out-of-Network                                  |
| Lab and X-ray   | Plan pays 100%     | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100%             | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100%                       |                | Plan pays 100%  | Plan pays 80% coinsurance after plan deductible is met | Covered under plan's Inpatient Hospital benefit | Covered under plan's Inpatient Hospital benefit |
| Advanced Radiology Imaging (MRI, MRA, CAT Scan, PET Scan, etc.) | Plan pays 100%     | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100%                       |                | Not Applicable  | Not Applicable   | Covered under plan's Inpatient Hospital benefit | Covered under plan's Inpatient Hospital benefit |

| Place of Service - You pay based on where you receive services. |  |                |  |                |   |                |                            |                |                |
|---|--|----------------|--|----------------|---|----------------|----------------------------|----------------|----------------|
| Benefit   | Physician's Office                                     |                | Emergency Room   |                | Outpatient Professional Services (Radiologist, Pathologist, ER Physician) |                | *Ambulance                 |                |                |
|   | In-Network   | Out-of-Network | In-Network   | Out-of-Network | In-Network  | Out-of-Network | In-Network                 | Out-of-Network | Out-of-Network |
| Emergency Care  | \$20 PCP or \$20 Specialist copay; then Plan pays 100% |                | \$75 per visit (copay waived if admitted); then Plan pays 100% |                | Plan pays 100%  |                | Plan pays 100% coinsurance |                |                |

\* Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.

| Place of Service - You pay based on where you receive services. |  |                |  |                |                                  |                |                            |                |                |
|---|--|----------------|--|----------------|----------------------------------|----------------|----------------------------|----------------|----------------|
| Benefit   | Physician's Office                                     |                | Urgent Care Facility   |                | Outpatient Professional Services |                | *Ambulance                 |                |                |
|   | In-Network   | Out-of-Network | In-Network   | Out-of-Network | In-Network                       | Out-of-Network | In-Network                 | Out-of-Network | Out-of-Network |
| Urgent Care   | \$20 PCP or \$20 Specialist copay; then Plan pays 100% |                | \$50 per visit (copay waived if admitted); then Plan pays 100% |                | Plan pays 100%                   |                | Plan pays 100% coinsurance |                |                |

\* Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.

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**Place of Service - You pay based on where you receive services.**

| Benefit          | Initial Visit to Confirm Pregnancy                     |  | All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges |  | Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist) |  | Delivery - Facility (Inpatient Hospital, Birthing Center) |   |
|------------------|--|--|---|--|---|--|---|---|
|                  | In-Network   | Out-of-Network   | In-Network  | Out-of-Network   | In-Network  | Out-of-Network   | In-Network  | Out-of-Network                                    |
| <b>Maternity</b> | \$20 PCP or \$20 Specialist copay; then Plan pays 100% | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance  | Plan pays 80% coinsurance after plan deductible is met | \$20 PCP or \$20 Specialist copay; then Plan pays 100%                                | Plan pays 80% coinsurance after plan deductible is met | Covered same as plan's Inpatient Hospital benefit         | Covered same as plan's Inpatient Hospital benefit |

**Place of Service - You pay based on where you receive services.**

| Benefit   | Inpatient Hospital and Other Health Care Facilities |  | Outpatient Services        |  |
|---|---|--|----------------------------|--|
|   | In-Network  | Out-of-Network   | In-Network                 | Out-of-Network   |
| <b>Hospice (provided as part of Hospice Care Program)</b>                         | Plan pays 100% coinsurance                          | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met |
| <b>Bereavement Counseling (Services provided as part of Hospice Care Program)</b> | Plan pays 100% coinsurance                          | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met |

**Place of Service - You pay based on where you receive services.**

| Benefit  | Physician's Office                                     |  | Inpatient Facility   |  | Outpatient Facility   |  | Inpatient Professional Services |  | Outpatient Professional Services |  |
|--|--|--|--|--|---|--|---------------------------------|--|----------------------------------|--|
|  | In-Network   | Out-of-Network   | In-Network   | Out-of-Network   | In-Network  | Out-of-Network   | In-Network                      | Out-of-Network   | In-Network                       | Out-of-Network   |
| <b>Abortion (Elective and non-elective procedures)</b> | \$20 PCP or \$20 Specialist copay; then Plan pays 100% | Plan pays 80% coinsurance after plan deductible is met | \$200 per admission copay, then Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | \$100 per facility visit copay, then Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance      | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance       | Plan pays 80% coinsurance after plan deductible is met |

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**Place of Service - You pay based on where you receive services.**

| Benefit  | Physician's Services - Office Visit                    |  | Inpatient Hospital Facility                                |  | Outpatient Facility Services                                    |  | Inpatient Professional Services |  | Outpatient Professional Services |  |
|--|--|--|--|--|---|--|---------------------------------|--|----------------------------------|--|
|  | In-Network   | Out-of-Network   | In-Network   | Out-of-Network   | In-Network  | Out-of-Network   | In-Network                      | Out-of-Network   | In-Network                       | Out-of-Network   |
| <b>Family Planning - Men's Services</b>  | \$20 PCP or \$20 Specialist copay; then Plan pays 100% | Plan pays 80% coinsurance after plan deductible is met | \$200 per admission copay, then Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | \$100 per facility visit copay, then Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance      | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance       | Plan pays 80% coinsurance after plan deductible is met |
| Includes surgical services, such as vasectomy (excludes reversals)   |  |  |  |  |   |  |                                 |  |                                  |  |
| <b>Family Planning - Women's Services</b>  | Plan pays 100%   | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100%   | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100%  | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100%                  | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100%                   | Plan pays 80% coinsurance after plan deductible is met |
| Includes surgical services, such as tubal ligation (excludes reversals)  |  |  |  |  |   |  |                                 |  |                                  |  |
| Contraceptive devices as ordered or prescribed by a physician.   |  |  |  |  |   |  |                                 |  |                                  |  |
| <b>Infertility</b>   | \$20 PCP or \$20 Specialist copay; then Plan pays 100% | Plan pays 80% coinsurance after plan deductible is met | \$200 per admission copay, then Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | \$100 per facility visit copay, then Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance      | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance       | Plan pays 80% coinsurance after plan deductible is met |
| Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc. |  |  |  |  |   |  |                                 |  |                                  |  |
| Unlimited lifetime maximum   |  |  |  |  |   |  |                                 |  |                                  |  |

**Place of Service - You pay based on where you receive services.**

| Benefit   | Inpatient Hospital Facility                    |  |  | Inpatient Professional Services |                                    |  |
|---|--|--|--|---------------------------------|------------------------------------|--|
|   | Lifesource Facility In-Network                 | Non-Lifesource Facility In-Network                         | Out-of-Network   | Lifesource Facility In-Network  | Non-Lifesource Facility In-Network | Out-of-Network   |
| <b>Organ Transplants</b>  | \$200 per admission copay, then Plan pays 100% | \$200 per admission copay, then Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100%                  | Plan pays 100% coinsurance         | Plan pays 80% coinsurance after plan deductible is met |
| Travel Maximum - Lifesource Facility: In-Network: \$10,000 maximum per Transplant |  |  |  |                                 |                                    |  |

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| Place of Service - You pay based on where you receive services.   |  |  |  |  |   |  |                                 |  |                                  |  |
|---|--|--|--|--|---|--|---------------------------------|--|----------------------------------|--|
| Benefit   | Physician's Services - Office Visit                    |  | Inpatient Hospital Facility                                |  | Outpatient Facility Services                                    |  | Inpatient Professional Services |  | Outpatient Professional Services |  |
|   | In-Network   | Out-of-Network   | In-Network   | Out-of-Network   | In-Network  | Out-of-Network   | In-Network                      | Out-of-Network   | In-Network                       | Out-of-Network   |
| Dental Care   | \$20 PCP or \$20 Specialist copay; then Plan pays 100% | Plan pays 80% coinsurance after plan deductible is met | \$200 per admission copay, then Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | \$100 per facility visit copay, then Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance      | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance       | Plan pays 80% coinsurance after plan deductible is met |
| Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth. |  |  |  |  |   |  |                                 |  |                                  |  |

| Place of Service - You pay based on where you receive services. |                    |                |                    |                |                     |                |                                 |                |                                  |                |
|---|--------------------|----------------|--------------------|----------------|---------------------|----------------|---------------------------------|----------------|----------------------------------|----------------|
| Benefit   | Physician's Office |                | Inpatient Facility |                | Outpatient Facility |                | Inpatient Professional Services |                | Outpatient Professional Services |                |
|   | In-Network         | Out-of-Network | In-Network         | Out-of-Network | In-Network          | Out-of-Network | In-Network                      | Out-of-Network | In-Network                       | Out-of-Network |
| TMJ, Surgical and Non-Surgical                                  | Not covered        | Not covered    | Not covered        | Not covered    | Not covered         | Not covered    | Not covered                     | Not covered    | Not covered                      | Not covered    |

| Place of Service - You pay based on where you receive services. |  |  |  |  |   |  |                                 |  |                                  |  |
|---|--|--|--|--|---|--|---------------------------------|--|----------------------------------|--|
| Benefit   | Physician's Services - Office Visit                    |  | Inpatient Hospital Facility                                |  | Outpatient Facility Services                                    |  | Inpatient Professional Services |  | Outpatient Professional Services |  |
|   | In-Network   | Out-of-Network   | In-Network   | Out-of-Network   | In-Network  | Out-of-Network   | In-Network                      | Out-of-Network   | In-Network                       | Out-of-Network   |
| Bariatric Surgery   | \$20 PCP or \$20 Specialist copay; then Plan pays 100% | Plan pays 80% coinsurance after plan deductible is met | \$200 per admission copay, then Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | \$100 per facility visit copay, then Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance      | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance       | Plan pays 80% coinsurance after plan deductible is met |

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**Place of Service - You pay based on where you receive services.**

| Benefit              | Inpatient  |  | Outpatient - Physician's Office<br>(includes individual, group therapy mental health and intensive outpatient mental health) |  | Outpatient Facility<br>(includes individual, group therapy mental health and intensive outpatient mental health) |  |
|----------------------|--|--|--|--|--|--|
|                      | In-Network   | Out-of-Network   | In-Network   | Out-of-Network   | In-Network   | Out-of-Network   |
| <b>Mental Health</b> | \$200 per admission copay, then Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | \$20 copay, then Plan pays 100%  | Plan pays 80% coinsurance after plan deductible is met | \$20 copay, then Plan pays 100%  | Plan pays 80% coinsurance after plan deductible is met |

- Unlimited maximum per Calendar Year
- Mental Health services are paid at 100% after you reach your out-of-pocket maximum.

**Place of Service - You pay based on where you receive services.**

| Benefit                | Inpatient  |  | Outpatient - Physician's Office<br>(includes individual and intensive outpatient substance abuse) |  | Outpatient Facility<br>(includes individual and intensive outpatient substance abuse) |  |
|------------------------|--|--|---|--|---|--|
|                        | In-Network   | Out-of-Network   | In-Network  | Out-of-Network   | In-Network  | Out-of-Network   |
| <b>Substance Abuse</b> | \$200 per admission copay, then Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | \$20 copay, then Plan pays 100%   | Plan pays 80% coinsurance after plan deductible is met | \$20 copay, then Plan pays 100%   | Plan pays 80% coinsurance after plan deductible is met |

**Note:** Detox is covered under medical

- Unlimited maximum per Calendar Year
- Substance Abuse services are paid at 100% after you reach your out-of-pocket maximum.

**Mental Health and Substance Abuse services**

**MH/SA Service Specific Administration**

Partial Hospitalization, Residential Treatment and Intensive Outpatient Programs:

- Partial Hospitalization: The coinsurance level for Partial Hospitalization services is the same as the coinsurance level for inpatient MH/SA services.
- Standard for Residential Treatment: Subject to the plan's inpatient MH/SA benefit. Coverage only if approved through Cigna Behavioral Health Case Management.
- Intensive Outpatient Program (IOP): Benefit is the same as outpatient visits. Coverage only if approved through Cigna Behavioral Health Case Management.

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## Mental Health and Substance Abuse services

### Mental Health/Substance Abuse Utilization Review, Case Management and Programs

Cigna Behavioral Advantage - Inpatient and Outpatient Management

- Inpatient utilization review and case management
- Outpatient utilization review and case management
- Partial Hospitalization
- Intensive outpatient programs
- Changing Lives by Integrating Mind and Body Program
- Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management.
- Narcotic Therapy Management
- Complex Psychiatric Case Management

## Pharmacy

Pharmacy benefits not provided by Cigna

## Health and Wellness Programs

### Your Health First - 200

Individuals with one or more of the chronic conditions, identified on the right, receive the following support:

- Health and Wellness Coaching
- Cigna Well Informed Program
- Preference Sensitive Care
- 24 hour Health Information Line
- Pre/Post Discharge Outreach

Holistic health support for the following chronic health conditions:

- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- Peripheral Arterial Disease
- Asthma
- Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)
- Diabetes Type 1
- Diabetes Type 2
- Metabolic Syndrome/Weight Complications
- Osteoarthritis
- Low Back Pain
- Anxiety
- Bipolar Disorder
- Depression

### 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.

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## Definitions

**Coinsurance** - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called coinsurance.

**Copay** - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.

**Deductible** - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.

**Out-of-Pocket Maximum** - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "maximum reimbursable charges" or negotiated fees for covered services.

**Prescription Drug List** - The list of prescription brand and generic drugs covered by your pharmacy plan.

**Transition of Care** - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

## Dollars & Sense

**DOLLARS & SENSE:** Easy ways to decrease your out-of-pocket health care expenses.

### **In-network care**

Using doctors, hospitals and facilities that participate in the Cigna network can save you money. In addition, choosing Cigna Care designated specialists - doctors in 19 specialties who have been identified for their superior performance in quality and cost efficiency - may save you even more. You can verify that a doctor or facility is in Cigna's network and learn more about the Cigna Care designation by checking the directory on myCigna.com or Cigna.com, or by calling the customer service number on the back of your Cigna ID card. Cigna is open 24/7.

### **Urgent care**

**(Average urgent care center cost \$131 / Average hospital ER cost \$1,523)**

Many people use the emergency room (ER) for conditions that are not serious or life-threatening. Using an urgent care center or your doctor's office instead of an ER can save you hundreds of dollars and provides the same quality of care as an ER. If you need care and are not sure if you need to go to the ER, speak with your doctor or call Cigna's 24-hour nurse line at the number on the back your Cigna ID card to determine the most appropriate location for urgent care.

### **Convenience care or retail clinics**

**(Average convenience care clinic cost \$61 / Average hospital ER cost \$1,523)**

Convenience care clinics provide quick and easy access to high quality treatment for common medical conditions when your doctor is not available. These clinics are located in department stores, grocery stores and pharmacies. To locate convenience care clinics, you can check the Directory on myCigna.com or Cigna.com, or call the customer service number on the back of your Cigna ID card. Cigna is open 24/7.

### **Laboratory and pathology tests**

**(Average LabCorp/Quest cost \$9 / Average other lab cost \$24 / Average outpatient hospital lab cost \$48)**

Two of the nation's largest and most prominent laboratories, Quest Diagnostics, Inc. (Quest) and Laboratory Corporation of America (LabCorp), participate in the Cigna network. Services at these labs can cost 70-75% less and offer the same or better quality than hospital laboratories. When you need lab services, discuss these options with your doctor. To find the nearest Quest and LabCorp locations, check the directory on myCigna.com or Cigna.com.

### **Radiology services (MRI or CT scan)**

**(Average independent radiology facility cost \$591 / Average outpatient hospital cost \$1,198)**

If you need to have an MRI or CT scan, you can save hundreds of dollars by using an independent radiology center. While Cigna contracts with all types of facilities that provide radiology services, using independent radiology centers will save you money, without any difference in quality. Discuss location options with your doctor. For help locating the most cost effective facility in which to have an MRI or CT scan, you can use the cost comparison tools on myCigna.com or call the customer service number on the back of your Cigna ID card.

### **Colonoscopy, endoscopy or arthroscopy**

**(Average freestanding surgery center cost \$1,438 / Average outpatient hospital cost \$2,821)**

When a doctor recommends a colonoscopy, GI endoscopy or arthroscopy, make sure you know your options. Using a freestanding outpatient surgery center for

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## Dollars & Sense

these procedures instead of a hospital can often save hundreds of dollars, while maintaining the same high quality as a hospital. Talk with your doctor about options. For help locating the most appropriate facility, you can use our cost comparison tools on myCigna.com or call the customer service number on the back of your Cigna ID card.

### Cigna Home Delivery Pharmacy

You can save money and enjoy convenient home delivery by using Cigna Home Delivery Pharmacy for your prescription medications. You can get up to a 90-day supply of your medication.

## Exclusions

### What's Not Covered (not all-inclusive):

Your plan provides for most medically necessary services. 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. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- 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 plan.
- 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.
- For or in connection with experimental, investigational or unproven services.
- Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services do not include routine patient care costs related to qualified clinical trials as described in your plan document. 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.
- 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.
- The following services are excluded from coverage regardless of clinical indications: Abdominoplasty; Panniculectomy; Rhinoplasty; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Surgical or nonsurgical treatment of TMJ disorders.
- 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. 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 six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as

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## Exclusions

shown in Covered Expenses, including: medical and surgical services to alter appearance 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.

- Unless otherwise covered in this plan, 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.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- Any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasm, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Nonmedical 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 nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
- 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.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, and dentures.
- Aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- 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.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations 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.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.

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## Exclusions

- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- Medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- Medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Telephone, e-mail, and Internet consultations, and telemedicine.
- Reversal of male and female voluntary sterilization.

### These are only the highlights

This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence. This summary provides additional information not provided in the Summary of Benefits and Coverage document required by the Federal Government.

*"Cigna," the "Tree of Life" logo, "Cigna Care Network," "Cigna Behavioral Health," "Cigna Choice Fund," "Cigna Well Aware for Better Health" and "Your Health First" are registered service marks, and "Cigna Healthcare," "Cigna Pharmacy," "Cigna Home Delivery Pharmacy," "Cigna Well Informed," and "Cigna Behavioral Advantage" are service marks, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company (CGLIC), Cigna Health and Life Insurance Company (CHLIC), Cigna Behavioral Health, Inc., Tel-Drug, Inc., Tel-Drug of Pennsylvania, L.L.C. and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc. In Arizona, HMO plans are offered by Cigna HealthCare of Arizona, Inc. In Connecticut, HMO plans are offered by Cigna HealthCare of Connecticut, Inc. In North Carolina, HMO plans are offered by Cigna HealthCare of North Carolina, Inc. In California, HMO and Network plans are offered by Cigna HealthCare of California, Inc. All other medical plans in these states are insured or administered by CGLIC or CHLIC. "Cigna Home Delivery Pharmacy" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C.*

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## CLIENT SUMMARY OF BENEFITS

**Cigna Health and Life Insurance Co.**  
**For - Manchester Town and Board of Education**  
**Open Access Plus 32 Plan - BOE \$30 Cafeteria, Custodians, Nurses, Secretaries, Teachers, Paraeducators, B&G Supervisors**



| Plan Highlights  | In-Network                 | Out-of-Network            |
|--|----------------------------|---------------------------|
| <b>Lifetime Maximum</b>  | Unlimited                  | Unlimited                 |
| <b>Coinsurance</b>   | Plan pays 100% coinsurance | Plan pays 80% coinsurance |
| <b>Maximum Reimbursable Charge</b><br>Out-of-network services are subject to a Calendar Year deductible and maximum reimbursable charge limitations. Payments made to health care professionals not participating in Cigna's network are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a percentage (300%) of a fee schedule developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule is not used, and the maximum reimbursable charge for covered services is determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or the amount charged for that service by 80% of the health care professionals in the geographic area where it is received. The health care professional may bill the customer the difference between the health care professional's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles, co-payments and coinsurance. | Not Applicable             | 300%                      |

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| Plan Highlights  | In-Network                                      | Out-of-Network                                 |
|--|---|--|
| <p><b>Calendar Year Deductible</b></p> <ul style="list-style-type: none"> <li>• Only the amount you pay for in-network covered expenses counts toward your in-network deductible. Only the amount you pay for out-of-network covered expenses only counts toward your out-of-network deductible.</li> <li>• After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan.</li> <li>• This plan includes a combined Medical/Pharmacy plan deductible.</li> <li>• Retail Pharmacy costs contribute to the combined Medical/Pharmacy plan deductible and home delivery costs do not contribute to the combined Medical/Pharmacy plan deductible.</li> </ul>  | <p>Individual: None<br/>Family: None</p>        | <p>Individual: \$250<br/>Family: \$750</p>     |
| <p><b>Calendar Year Out-of-Pocket Maximum</b></p> <ul style="list-style-type: none"> <li>• Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. Only the amount you pay for out-of-network covered expenses counts toward your out-of-network out-of-pocket maximum.</li> <li>• Plan deductible contributes towards your out-of-pocket maximum.</li> <li>• All copays and benefit deductibles contribute towards your out-of-pocket maximum.</li> <li>• Mental Health and Substance Abuse covered expenses contribute towards your out-of-pocket maximum.</li> <li>• After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.</li> <li>• This plan includes a combined Medical/Pharmacy out-of-pocket maximum.</li> <li>• Retail Pharmacy costs contribute to the combined Medical/Pharmacy out-of-pocket maximum and home delivery costs do not contribute to the combined Medical/Pharmacy out-of-pocket maximum.</li> <li>• Non-compliance penalties contribute towards your out-of-pocket maximum.</li> </ul> | <p>Individual: \$6,350<br/>Family: \$12,700</p> | <p>Individual: \$1,250<br/>Family: \$3,250</p> |
| <p><b>Pre-Existing Condition Limitation (PCL)</b></p>  | <p>Not Applicable</p>                           | <p>Not Applicable</p>                          |

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| Plan Highlights   | In-Network                    | Out-of-Network   |
|---|-------------------------------|--|
| Pre-certification - Continued Stay Review - PHS Inpatient - required for all inpatient admissions | Coordinated by your physician | <p>Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.</p> <ul style="list-style-type: none"> <li>\$250 penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.</li> <li>Benefits are reduced by 50% for any admission reviewed by Cigna Healthcare and not certified.</li> <li>Benefits are reduced by 50% for any additional days not certified by Cigna Healthcare.</li> </ul> |

| Benefit   | In-Network                                 | Out-of-Network   |
|---|--|--|
| <b>Physician Services</b>                                 |  |  |
| Primary Care Physician (PCP) Office Visit                 | \$30 PCP copay; then Plan pays 100%        | Plan pays 80% coinsurance after plan deductible is met |
| Specialty Care Physician Office Visit                     | \$30 Specialist copay; then Plan pays 100% | Plan pays 80% coinsurance after plan deductible is met |
| Surgery Performed in Physician's Office                   | Plan pays 100% coinsurance                 | Plan pays 80% coinsurance after plan deductible is met |
| Allergy Treatment/Injections                              | Plan pays 100%                             | Plan pays 80% coinsurance after plan deductible is met |
| Allergy Serum<br>Dispensed by the physician in the office | Plan pays 100%                             | Plan pays 80% coinsurance after plan deductible is met |

| Benefit  | In-Network     | Out-of-Network   |
|--|----------------|--|
| <b>Preventive Care</b>   |                |  |
| <b>Routine Preventive Care - All Ages</b> <ul style="list-style-type: none"> <li>Includes well-baby, well-child, well-woman and adult preventive care</li> <li>Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.</li> </ul> | Plan pays 100% | Plan pays 80% coinsurance after plan deductible is met |
| <b>Immunizations - All Ages</b> <ul style="list-style-type: none"> <li>Includes travel related immunizations</li> </ul>  | Plan pays 100% | Plan pays 80% coinsurance after plan deductible is met |

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| Benefit   | In-Network   | Out-of-Network   |
|---|--|--|
| <b>Preventive Care</b>  |  |  |
| <b>Mammogram, PAP, PSA Tests</b> <ul style="list-style-type: none"> <li>Coverage includes the associated Preventive Outpatient Professional Services.</li> <li>Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.</li> </ul>   | Plan pays 100%   | Plan pays 80% coinsurance after plan deductible is met |
| Benefit   | In-Network   | Out-of-Network   |
| <b>Inpatient</b>  |  |  |
| <b>Inpatient Hospital Facility</b><br><br><b>Semi-Private Room:</b> In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate<br><b>Private Room:</b> In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate<br><b>Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):</b> In-Network: Limited to the negotiated rate / Out-of-Network: Limited to ICU/CCU daily room rate | \$400 per admission copay, then Plan pays 100% coinsurance   | Plan pays 80% coinsurance after plan deductible is met |
| <b>Inpatient Hospital Physician's Visit/Consultation</b>  | Plan pays 100% coinsurance   | Plan pays 80% coinsurance after plan deductible is met |
| <b>Inpatient Professional Services</b> <ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>   | Plan pays 100% coinsurance   | Plan pays 80% coinsurance after plan deductible is met |
| <b>Multiple Surgical Reduction</b>  | Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery. |  |
| Benefit   | In-Network   | Out-of-Network   |
| <b>Outpatient</b>   |  |  |
| <b>Outpatient Facility Services</b> <ul style="list-style-type: none"> <li>Non-surgical treatment procedures are not subject to the facility per visit copay/benefit deductible</li> </ul>  | \$200 per facility visit copay, then Plan pays 100% coinsurance  | Plan pays 80% coinsurance after plan deductible is met |
| <b>Outpatient Professional Services</b> <ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>  | Plan pays 100% coinsurance   | Plan pays 80% coinsurance after plan deductible is met |

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| Benefit   | In-Network   | Out-of-Network   |
|---|--|--|
| <b>Outpatient</b>   |  |  |
| <b>Short-Term Rehabilitation</b> <ul style="list-style-type: none"> <li>Includes physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation and cognitive therapy</li> <li>60 days maximum per Calendar Year (all therapies combined and reduced by any days used for chiropractic care)</li> <li>Therapy days, provided as part of an approved Home Health Care plan, accumulate to the outpatient short term rehab therapy maximum</li> </ul> | Plan pays 100%   | Plan pays 80% coinsurance after plan deductible is met             |
| <b>Cardiac Rehabilitation</b> <ul style="list-style-type: none"> <li>36 days maximum per occurrence</li> </ul>  | \$30 PCP or \$30 Specialist copay; then Plan pays 100% | Plan pays 80% coinsurance after plan deductible is met             |
| <b>Chiropractic Care</b> <ul style="list-style-type: none"> <li>60 days maximum per Calendar Year (reduced by any days used for physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation and cognitive therapy)</li> <li>Includes maintenance and massage therapy when in conjunction with chiropractic care</li> </ul>   | \$30 PCP or \$30 Specialist copay; then Plan pays 100% | Plan pays 80% coinsurance after plan deductible is met             |
| <b>Other Health Care Facilities/Services</b>  |  |  |
| <b>Home Health Care</b><br>(includes outpatient private duty nursing days when approved as medically necessary) <ul style="list-style-type: none"> <li>200 days maximum per Calendar Year</li> <li>16 hour maximum per day</li> </ul>   | Plan pays 100% coinsurance                             | Plan pays 80% coinsurance after plan deductible is met             |
| <b>Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility</b> <ul style="list-style-type: none"> <li>180 days maximum per Calendar Year</li> </ul>   | Plan pays 100% coinsurance                             | Plan pays 80% coinsurance after plan deductible is met             |
| <b>Durable Medical Equipment</b> <ul style="list-style-type: none"> <li>Unlimited maximum per Calendar Year</li> </ul>  | Plan pays 100% coinsurance                             | Plan pays 80% coinsurance after plan deductible is met             |
| <b>Breast Feeding Equipment and Supplies</b> <ul style="list-style-type: none"> <li>Limited to the rental of one breast pump per birth as ordered or prescribed by a physician.</li> <li>Includes related supplies</li> </ul>   | Plan pays 100%   | Plan pays 80% coinsurance after plan deductible is met             |
| <b>External Prosthetic Appliances (EPA)</b> <ul style="list-style-type: none"> <li>Unlimited maximum per Calendar Year</li> </ul>   | Plan pays 100% coinsurance                             | Plan pays 80% coinsurance after plan deductible is met             |
| <b>Nutritional Formula</b> <ul style="list-style-type: none"> <li>Birth through 12 years of age</li> </ul>  | Plan pays 100% coinsurance                             | Plan pays 100% of billable charges                                 |
| <b>Osteopaths</b>   | \$30 Specialist copay; then Plan pays 100%             | \$30 per visit deductible, then plan pays 100% of billable charges |

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| Benefit  | In-Network  | Out-of-Network  |
|--|---|---|
| <b>Other Health Care Facilities/Services</b>   |   |   |
| <b>Naturopath</b>  | \$30 Specialist copay; then Plan pays 100%  | \$30 per visit deductible, then plan pays 100% of billable charges  |
| <b>Wigs</b><br>• \$350 maximum per calendar year   | Plan pays 100% coinsurance  | Plan pays 100% of billable charges  |
| <b>Hearing Aids</b><br>• \$1,000 maximum per calendar year for ages 12 years and younger | Plan pays 100% coinsurance  | Plan pays 80% coinsurance after plan deductible is met  |
| <b>Hearing Exams</b><br>1 exam every 24 months   | \$30 PCP or \$30 Specialist copay; then Plan pays 100%  | Plan pays 80% coinsurance after plan deductible is met  |
| <b>Routine Foot Disorders</b>  | 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. |
| <b>Vision care</b><br>• Eye exam once every 24 months                                    | \$30 PCP or \$30 Specialist copay; then Plan pays 100%  | \$30 per visit deductible, then plan pays 100% of billable charges  |
| <b>Oral Surgery - Impacted Wisdom Teeth Inpatient Facility</b>                           | \$400 per admission copay, then Plan pays 100% coinsurance  | Plan pays 80% coinsurance after plan deductible is met  |

**Place of Service - You pay based on where you receive services.**

| Benefit  | Physician's Office |  | Outpatient Facility        |  | Emergency Room/ Urgent Care Facility |                | Independent Lab |  | Inpatient Hospital                              |   |
|--|--------------------|--|----------------------------|--|--------------------------------------|----------------|-----------------|--|---|---|
|  | In-Network         | Out-of-Network   | In-Network                 | Out-of-Network   | In-Network                           | Out-of-Network | In-Network      | Out-of-Network   | In-Network                                      | Out-of-Network                                  |
| <b>Lab and X-ray</b>   | Plan pays 100%     | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100%             | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100%                       |                | Plan pays 100%  | Plan pays 80% coinsurance after plan deductible is met | Covered under plan's Inpatient Hospital benefit | Covered under plan's Inpatient Hospital benefit |
| <b>Advanced Radiology Imaging (MRI, MRA, CAT Scan, PET Scan, etc.)</b> | Plan pays 100%     | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100%                       |                | Not Applicable  | Not Applicable   | Covered under plan's Inpatient Hospital benefit | Covered under plan's Inpatient Hospital benefit |

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| Place of Service - You pay based on where you receive services  |  |  |   |  |   |  |   |   |
|---|--|--|---|--|---|--|---|---|
| Benefit   | Physician's Office                                     |  | Emergency Room  |  | Outpatient Professional Services<br>(Radiologist, Pathologist, ER Physician)          |  | *Ambulance  |   |
|   | In-Network   | Out-of-Network   | In-Network  | Out-of-Network   | In-Network  | Out-of-Network   | In-Network  | Out-of-Network                                    |
| <b>Emergency Care</b>   | \$30 PCP or \$30 Specialist copay; then Plan pays 100% |  | \$75 per visit (copay waived if admitted); then Plan pays 100%                    |  | Plan pays 100%  |  | Plan pays 100% coinsurance                                |   |
| * Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered. |  |  |   |  |   |  |   |   |
| Place of Service - You pay based on where you receive services  |  |  |   |  |   |  |   |   |
| Benefit   | Physician's Office                                     |  | Urgent Care Facility  |  | Outpatient Professional Services  |  | *Ambulance  |   |
|   | In-Network   | Out-of-Network   | In-Network  | Out-of-Network   | In-Network  | Out-of-Network   | In-Network  | Out-of-Network                                    |
| <b>Urgent Care</b>  | \$30 PCP or \$30 Specialist copay; then Plan pays 100% |  | \$75 per visit (copay waived if admitted); then Plan pays 100%                    |  | Plan pays 100%  |  | Plan pays 100% coinsurance                                |   |
| * Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered. |  |  |   |  |   |  |   |   |
| Place of Service - You pay based on where you receive services  |  |  |   |  |   |  |   |   |
| Benefit   | Initial Visit to Confirm Pregnancy                     |  | All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges |  | Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist) |  | Delivery - Facility (Inpatient Hospital, Birthing Center) |   |
|   | In-Network   | Out-of-Network   | In-Network  | Out-of-Network   | In-Network  | Out-of-Network   | In-Network  | Out-of-Network                                    |
| <b>Maternity</b>  | \$30 PCP or \$30 Specialist copay; then Plan pays 100% | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance  | Plan pays 80% coinsurance after plan deductible is met | \$30 PCP or \$30 Specialist copay; then Plan pays 100%                                | Plan pays 80% coinsurance after plan deductible is met | Covered same as plan's Inpatient Hospital benefit         | Covered same as plan's Inpatient Hospital benefit |
| Place of Service - You pay based on where you receive services  |  |  |   |  |   |  |   |   |
| Benefit   | Inpatient Hospital and Other Health Care Facilities    |  |   |  | Outpatient Services   |  |   |   |
|   | In-Network   |  | Out-of-Network  |  | In-Network  |  | Out-of-Network  |   |
| <b>Hospice (provided as part of Hospice Care Program)</b>   | Plan pays 100% coinsurance                             |  | Plan pays 80% coinsurance after plan deductible is met                            |  | Plan pays 100% coinsurance  |  | Plan pays 80% coinsurance after plan deductible is met    |   |
| <b>Bereavement Counseling (Services provided as part of Hospice Care Program)</b>   | Plan pays 100% coinsurance                             |  | Plan pays 80% coinsurance after plan deductible is met                            |  | Plan pays 100% coinsurance  |  | Plan pays 80% coinsurance after plan deductible is met    |   |

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| Place of Service - You pay based on where you receive services   |  |  |  |  |   |  |                                 |  |                                  |  |
|--|--|--|--|--|---|--|---------------------------------|--|----------------------------------|--|
| Benefit  | Physician's Office                                     |  | Inpatient Facility   |  | Outpatient Facility   |  | Inpatient Professional Services |  | Outpatient Professional Services |  |
|  | In-Network   | Out-of-Network   | In-Network   | Out-of-Network   | In-Network  | Out-of-Network   | In-Network                      | Out-of-Network   | In-Network                       | Out-of-Network   |
| <b>Abortion</b><br>(Elective and non-elective procedures)  | \$30 PCP or \$30 Specialist copay; then Plan pays 100% | Plan pays 80% coinsurance after plan deductible is met | \$400 per admission copay, then Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | \$200 per facility visit copay, then Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance      | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance       | Plan pays 80% coinsurance after plan deductible is met |
| Place of Service - You pay based on where you receive services   |  |  |  |  |   |  |                                 |  |                                  |  |
| Benefit  | Physician's Services - Office Visit                    |  | Inpatient Hospital Facility                                |  | Outpatient Facility Services                                    |  | Inpatient Professional Services |  | Outpatient Professional Services |  |
|  | In-Network   | Out-of-Network   | In-Network   | Out-of-Network   | In-Network  | Out-of-Network   | In-Network                      | Out-of-Network   | In-Network                       | Out-of-Network   |
| <b>Family Planning - Men's Services</b>  | \$30 PCP or \$30 Specialist copay; then Plan pays 100% | Plan pays 80% coinsurance after plan deductible is met | \$400 per admission copay, then Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | \$200 per facility visit copay, then Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance      | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance       | Plan pays 80% coinsurance after plan deductible is met |
| Includes surgical services, such as vasectomy (excludes reversals)   |  |  |  |  |   |  |                                 |  |                                  |  |
| <b>Family Planning - Women's Services</b>  | Plan pays 100%   | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100%   | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100%  | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100%                  | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100%                   | Plan pays 80% coinsurance after plan deductible is met |
| Includes surgical services, such as tubal ligation (excludes reversals)  |  |  |  |  |   |  |                                 |  |                                  |  |
| Contraceptive devices as ordered or prescribed by a physician.   |  |  |  |  |   |  |                                 |  |                                  |  |
| <b>Infertility</b>   | \$30 PCP or \$30 Specialist copay; then Plan pays 100% | Plan pays 80% coinsurance after plan deductible is met | \$400 per admission copay, then Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | \$200 per facility visit copay, then Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance      | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance       | Plan pays 80% coinsurance after plan deductible is met |
| Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc. |  |  |  |  |   |  |                                 |  |                                  |  |
| Unlimited lifetime maximum   |  |  |  |  |   |  |                                 |  |                                  |  |

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**Place of Service - You pay based on where you receive services.**

| Benefit                  | Inpatient Hospital Facility                    |  |  | Inpatient Professional Services |                                    |  |
|--------------------------|--|--|--|---------------------------------|------------------------------------|--|
|                          | Lifesource Facility In-Network                 | Non-Lifesource Facility In-Network                         | Out-of-Network   | Lifesource Facility In-Network  | Non-Lifesource Facility In-Network | Out-of-Network   |
| <b>Organ Transplants</b> | \$400 per admission copay, then Plan pays 100% | \$400 per admission copay, then Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100%                  | Plan pays 100% coinsurance         | Plan pays 80% coinsurance after plan deductible is met |

Travel Maximum - Lifesource Facility: In-Network: \$10,000 maximum per Transplant

**Place of Service - You pay based on where you receive services.**

| Benefit            | Physician's Services - Office Visit                    |  | Inpatient Hospital Facility                                |  | Outpatient Facility Services                                    |  | Inpatient Professional Services |  | Outpatient Professional Services |  |
|--------------------|--|--|--|--|---|--|---------------------------------|--|----------------------------------|--|
|                    | In-Network   | Out-of-Network   | In-Network   | Out-of-Network   | In-Network  | Out-of-Network   | In-Network                      | Out-of-Network   | In-Network                       | Out-of-Network   |
| <b>Dental Care</b> | \$30 PCP or \$30 Specialist copay; then Plan pays 100% | Plan pays 80% coinsurance after plan deductible is met | \$400 per admission copay, then Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | \$200 per facility visit copay, then Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance      | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance       | Plan pays 80% coinsurance after plan deductible is met |

Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.

**Place of Service - You pay based on where you receive services.**

| Benefit                               | Physician's Office |                | Inpatient Facility |                | Outpatient Facility |                | Inpatient Professional Services |                | Outpatient Professional Services |                |
|---------------------------------------|--------------------|----------------|--------------------|----------------|---------------------|----------------|---------------------------------|----------------|----------------------------------|----------------|
|                                       | In-Network         | Out-of-Network | In-Network         | Out-of-Network | In-Network          | Out-of-Network | In-Network                      | Out-of-Network | In-Network                       | Out-of-Network |
| <b>TMJ, Surgical and Non-Surgical</b> | Not covered        | Not covered    | Not covered        | Not covered    | Not covered         | Not covered    | Not covered                     | Not covered    | Not covered                      | Not covered    |

| Place of Service - You pay based on where you receive services |  |  |  |  |   |  |                                 |  |                                  |  |
|--|--|--|--|--|---|--|---------------------------------|--|----------------------------------|--|
| Benefit  | Physician's Services - Office Visit                    |  | Inpatient Hospital Facility                                |  | Outpatient Facility Services                                    |  | Inpatient Professional Services |  | Outpatient Professional Services |  |
|  | In-Network   | Out-of-Network   | In-Network   | Out-of-Network   | In-Network  | Out-of-Network   | In-Network                      | Out-of-Network   | In-Network                       | Out-of-Network   |
| <b>Bariatric Surgery</b>                                       | \$30 PCP or \$30 Specialist copay; then Plan pays 100% | Plan pays 80% coinsurance after plan deductible is met | \$400 per admission copay, then Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | \$200 per facility visit copay, then Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance      | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance       | Plan pays 80% coinsurance after plan deductible is met |

| Place of Service - You pay based on where you receive services   |  |  |  |  |  |  |
|--|--|--|--|--|--|--|
| Benefit  | Inpatient  |  | Outpatient - Physician's Office<br>(includes individual, group therapy mental health and intensive outpatient mental health) |  | Outpatient Facility<br>(includes individual, group therapy mental health and intensive outpatient mental health) |  |
|  | In-Network   | Out-of-Network   | In-Network   | Out-of-Network   | In-Network   | Out-of-Network   |
| <b>Mental Health</b>   | \$400 per admission copay, then Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | \$30 copay, then Plan pays 100%  | Plan pays 80% coinsurance after plan deductible is met | \$30 copay, then Plan pays 100%  | Plan pays 80% coinsurance after plan deductible is met |
| <ul style="list-style-type: none"> <li>• Unlimited maximum per Calendar Year</li> <li>• Mental Health services are paid at 100% after you reach your out-of-pocket maximum.</li> </ul> |  |  |  |  |  |  |

| Place of Service - You pay based on where you receive services   |  |  |   |  |   |  |
|--|--|--|---|--|---|--|
| Benefit  | Inpatient  |  | Outpatient - Physician's Office<br>(includes individual and intensive outpatient substance abuse) |  | Outpatient Facility<br>(includes individual and intensive outpatient substance abuse) |  |
|  | In-Network   | Out-of-Network   | In-Network  | Out-of-Network   | In-Network  | Out-of-Network   |
| <b>Substance Abuse</b>   | \$400 per admission copay, then Plan pays 100% coinsurance | Plan pays 80% coinsurance after plan deductible is met | \$30 copay, then Plan pays 100%   | Plan pays 80% coinsurance after plan deductible is met | \$30 copay, then Plan pays 100%   | Plan pays 80% coinsurance after plan deductible is met |
| <b>Note:</b> Detox is covered under medical <ul style="list-style-type: none"> <li>• Unlimited maximum per Calendar Year</li> <li>• Substance Abuse services are paid at 100% after you reach your out-of-pocket maximum.</li> </ul> |  |  |   |  |   |  |

**Mental Health and Substance Abuse services**

**MH/SA Service Specific Administration**  
 Partial Hospitalization, Residential Treatment and Intensive Outpatient Programs:

- Partial Hospitalization: The coinsurance level for Partial Hospitalization services is the same as the coinsurance level for inpatient MH/SA services.
- Standard for Residential Treatment: Subject to the plan's inpatient MH/SA benefit. Coverage only if approved through Cigna Behavioral Health Case Management.
- Intensive Outpatient Program (IOP): Benefit is the same as outpatient visits. Coverage only if approved through Cigna Behavioral Health Case Management.

**Mental Health/Substance Abuse Utilization Review, Case Management and Programs**  
 Cigna Behavioral Advantage - Inpatient and Outpatient Management

- Inpatient utilization review and case management
- Outpatient utilization review and case management
- Partial Hospitalization
- Intensive outpatient programs
- Changing Lives by Integrating Mind and Body Program
- Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management.
- Narcotic Therapy Management
- Complex Psychiatric Case Management

| <b>Pharmacy</b> | <b>In-Network</b> | <b>Out-of-Network</b> |
|-----------------|-------------------|-----------------------|
|-----------------|-------------------|-----------------------|

|  |   |  |
|--|---|--|
| <p><b>Cigna Pharmacy one-tier coinsurance plan</b></p> <ul style="list-style-type: none"> <li>• No Mandatory Generics</li> <li>• Self Administered injectable and optional injectable drugs - includes infertility drugs</li> <li>• Includes Oral Contraceptives - with specific products covered 100%</li> <li>• Lifestyle drugs included - limited to sexual dysfunction</li> <li>• Prescription diet drugs included</li> <li>• Prescription smoking cessation drugs included</li> <li>• Prescription vitamins included</li> <li>• Oral Fertility drugs included</li> <li>• Insulin, glucose test strips, lancets, insulin needles &amp; syringes, insulin pens and cartridges included</li> </ul> | <p><b>Retail - 90 day supply</b><br/>                     You pay 20%<br/>                     Plan pays 80%</p> <p><b>Home delivery</b><br/>                     Not covered</p> | <p><b>Retail</b><br/>                     You pay 20%<br/>                     Plan pays 80%<br/>                     after the deductible is met</p> <p><b>Home Delivery</b><br/>                     Not covered</p> |
|--|---|--|

**Pharmacy Clinical Management and Prior Authorization**

- Your plan is subject to certain clinical edits and prior authorization requirements.
- Refill-too-soon and plan exclusion edits are always included.
- Additional clinical management - Basic package - provides a limited set of clinical edits such as prior authorization, age edits and quantity limits for a specific list of prescription medications.

**Pharmacy****In-Network****Out-of-Network****Specialty Pharmacy Management:**

- Clinical Programs
  - o Prior authorization is not required on specialty medications but quantity limits may apply.
  - o Theracare® Program
- Medication Access Option
  - o Retail and/or Home Delivery

**Additional Information****Prescription Drug List:**

- Cigna Standard Prescription Drug List

**Health and Wellness Programs****Your Health First - 200**

Individuals with one or more of the chronic conditions, identified on the right, receive the following support:

- Health and Wellness Coaching
- Cigna Well Informed Program
- Preference Sensitive Care
- 24 hour Health Information Line
- Pre/Post Discharge Outreach

Holistic health support for the following chronic health conditions:

- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- Peripheral Arterial Disease
- Asthma
- Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)
- Diabetes Type 1
- Diabetes Type 2
- Metabolic Syndrome/Weight Complications
- Osteoarthritis
- Low Back Pain
- Anxiety
- Bipolar Disorder
- Depression

**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.

## Definitions

**Coinsurance** - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called coinsurance.

**Copay** - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.

**Deductible** - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.

**Out-of-Pocket Maximum** - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "maximum reimbursable charges" or negotiated fees for covered services.

**Prescription Drug List** - The list of prescription brand and generic drugs covered by your pharmacy plan.

**Transition of Care** - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

## Dollars & Sense

**DOLLARS & SENSE:** Easy ways to decrease your out-of-pocket health care expenses.

### In-network care

Using doctors, hospitals and facilities that participate in the Cigna network can save you money. In addition, choosing Cigna Care designated specialists - doctors in 19 specialties who have been identified for their superior performance in quality and cost efficiency - may save you even more. You can verify that a doctor or facility is in Cigna's network and learn more about the Cigna Care designation by checking the directory on myCigna.com or Cigna.com, or by calling the customer service number on the back of your Cigna ID card. Cigna is open 24/7.

### Urgent care

**(Average urgent care center cost \$131 / Average hospital ER cost \$1,523)**

Many people use the emergency room (ER) for conditions that are not serious or life-threatening. Using an urgent care center or your doctor's office instead of an ER can save you hundreds of dollars and provides the same quality of care as an ER. If you need care and are not sure if you need to go to the ER, speak with your doctor or call Cigna's 24-hour nurse line at the number on the back your Cigna ID card to determine the most appropriate location for urgent care.

### Convenience care or retail clinics

**(Average convenience care clinic cost \$61 / Average hospital ER cost \$1,523)**

Convenience care clinics provide quick and easy access to high quality treatment for common medical conditions when your doctor is not available. These clinics are located in department stores, grocery stores and pharmacies. To locate convenience care clinics, you can check the Directory on myCigna.com or Cigna.com, or call the customer service number on the back of your Cigna ID card. Cigna is open 24/7.

### Laboratory and pathology tests

**(Average LabCorp/Quest cost \$9 / Average other lab cost \$24 / Average outpatient hospital lab cost \$48)**

Two of the nation's largest and most prominent laboratories, Quest Diagnostics, Inc. (Quest) and Laboratory Corporation of America (LabCorp), participate in the Cigna network. Services at these labs can cost 70-75% less and offer the same or better quality than hospital laboratories. When you need lab services, discuss these options with your doctor. To find the nearest Quest and LabCorp locations, check the directory on myCigna.com or Cigna.com.

### Radiology services (MRI or CT scan)

**(Average independent radiology facility cost \$591 / Average outpatient hospital cost \$1,198)**

If you need to have an MRI or CT scan, you can save hundreds of dollars by using an independent radiology center. While Cigna contracts with all types of facilities that provide radiology services, using independent radiology centers will save you money, without any difference in quality. Discuss location options with your doctor. For help locating the most cost effective facility in which to have an MRI or CT scan, you can use the cost comparison tools on myCigna.com or call the customer service number on the back of your Cigna ID card.

### Colonoscopy, endoscopy or arthroscopy

**(Average freestanding surgery center cost \$1,438 / Average outpatient hospital cost \$2,821)**

When a doctor recommends a colonoscopy, GI endoscopy or arthroscopy, make sure you know your options. Using a freestanding outpatient surgery center for these procedures instead of a hospital can often save hundreds of dollars, while maintaining the same high quality as a hospital. Talk with your doctor about options.

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## Dollars & Sense

For help locating the most appropriate facility, you can use our cost comparison tools on myCigna.com or call the customer service number on the back of your Cigna ID card.

### Cigna Home Delivery Pharmacy

You can save money and enjoy convenient home delivery by using Cigna Home Delivery Pharmacy for your prescription medications. You can get up to a 90-day supply of your medication.

## Exclusions

### What's Not Covered (not all-inclusive):

Your plan provides for most medically necessary services. 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. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- 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 plan.
- 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.
- For or in connection with experimental, investigational or unproven services.
- Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services do not include routine patient care costs related to qualified clinical trials as described in your plan document. 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.
- The following services are excluded from coverage regardless of clinical indications: Abdominoplasty; Panniculectomy; Rhinoplasty; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Surgical or nonsurgical treatment of TMJ disorders.
- 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. 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 six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance 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.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not

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## Exclusions

limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.

- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Nonmedical 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 nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
- 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.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, and dentures.
- Aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- 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.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations 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.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- Medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.

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## EXCLUSIONS

- Medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Telephone, e-mail, and Internet consultations, and telemedicine.
- Reversal of male and female voluntary sterilization.

### **These are only the highlights**

This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description – the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence. This summary provides additional information not provided in the Summary of Benefits and Coverage document required by the Federal Government.

*"Cigna," the "Tree of Life" logo, "Cigna Care Network," "Cigna Behavioral Health," "Cigna Choice Fund," "Cigna Well Aware for Better Health" and "Your Health First" are registered service marks, and "Cigna Healthcare," "Cigna Pharmacy," "Cigna Home Delivery Pharmacy," "Cigna Well Informed," and "Cigna Behavioral Advantage" are service marks, of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company (CGLIC), Cigna Health and Life Insurance Company (CHLIC), Cigna Behavioral Health, Inc., Tel-Drug, Inc., Tel-Drug of Pennsylvania, L.L.C. and HMO or service company subsidiaries of Cigna Health Corporation and Cigna Dental Health, Inc. In Arizona, HMO plans are offered by Cigna HealthCare of Arizona, Inc. In Connecticut, HMO plans are offered by Cigna HealthCare of Connecticut, Inc. In North Carolina, HMO plans are offered by Cigna HealthCare of North Carolina, Inc. In California, HMO and Network plans are offered by Cigna HealthCare of California, Inc. All other medical plans in these states are insured or administered by CGLIC or CHLIC. "Cigna Home Delivery Pharmacy" refers to Tel-Drug, Inc. and Tel-Drug of Pennsylvania, L.L.C.*

## CLIENT SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.  
 For - Manchester Town and Board of Education  
 Choice Fund Open Access Plus HSA Plan



**Your coverage includes a health savings account that you can use to pay for eligible out-of-pocket expenses.**

**Employer Contribution**

Employee - Varies base on bargaining agreement  
 Employee + 1 - Varies base on bargaining agreement  
 Family - Varies base on bargaining agreement

| Plan Highlights   | In-Network                 | Out-of-Network            |
|---|----------------------------|---------------------------|
| <b>Lifetime Maximum</b>   | Unlimited                  | Unlimited                 |
| <b>Coinsurance</b>  | Plan pays 100% coinsurance | Plan pays 80% coinsurance |
| <p><b>Maximum Reimbursable Charge</b><br/>                     Out-of-network services are subject to a Contract Year deductible and maximum reimbursable charge limitations. Payments made to health care professionals not participating in Cigna's network are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a percentage (300%) of a fee schedule developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule is not used, and the maximum reimbursable charge for covered services is determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or the amount charged for that service by 80% of the health care professionals in the geographic area where it is received. The health care professional may bill the customer the difference between the health care professional's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles, co-payments and coinsurance.</p> | Not Applicable             | 300%                      |

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| Plan Highlights   | In-Network                             | Out-of-Network  |
|---|--|---|
| <b>Contract Year Deductible</b> <ul style="list-style-type: none"> <li>The amount you pay for all covered expenses counts toward both your in-network and out-of-network deductibles.</li> <li>All eligible family members contribute towards the family plan deductible. Once the family deductible has been met, the plan will pay each eligible family member's covered expenses based on the coinsurance level specified by the plan.</li> <li>This plan includes a combined Medical/Pharmacy plan deductible.</li> <li>Retail and home delivery Pharmacy costs contribute to the combined Medical/Pharmacy deductible.</li> </ul>  | Individual: \$1,500<br>Family: \$3,000 | Individual: \$1,500<br>Family: \$3,000  |
| <b>Contract Year Out-of-Pocket Maximum</b> <ul style="list-style-type: none"> <li>The amount you pay for all covered expenses counts toward both your in-network and out-of-network out-of-pocket maximums.</li> <li>Plan deductible contributes towards your out-of-pocket maximum.</li> <li>Mental Health and Substance Abuse covered expenses contribute towards your out-of-pocket maximum.</li> <li>All eligible family members contribute towards the family out-of-pocket maximum. Once the family out-of-pocket maximum has been met, the plan will pay each eligible family member's covered expenses at 100%.</li> <li>This plan includes a combined Medical/Pharmacy out-of-pocket maximum.</li> <li>Retail and home delivery Pharmacy costs contribute to the combined Medical/Pharmacy out-of-pocket maximum.</li> </ul> | Individual: \$1,500<br>Family: \$3,000 | Individual: \$3,000<br>Family: \$6,000  |
| <b>Pre-Existing Condition Limitation (PCL)</b>  | Not Applicable                         | Not Applicable  |
| <b>Pre-certification - Continued Stay Review - PHS</b>  | Coordinated by your physician          | Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance. <ul style="list-style-type: none"> <li>\$250 penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.</li> <li>Benefits are reduced by 50% for any admission reviewed by Cigna Healthcare and not certified.</li> <li>Benefits are reduced by 50% for any additional days not certified by Cigna Healthcare.</li> </ul> |

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| Benefit   | In-Network  | Out-of-Network   |
|---|---|--|
| <b>Physician Services</b>   |   |  |
| Primary Care Physician (PCP) Office Visit   | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met |
| Specialty Care Physician Office Visit   | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met |
| Surgery Performed in Physician's Office   | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met |
| Allergy Treatment/Injections  | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met |
| Allergy Serum<br>Dispensed by the physician in the office   | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met |
| Benefit   | In-Network  | Out-of-Network   |
| <b>Preventive Care</b>  |   |  |
| <b>Routine Preventive Care - All Ages</b> <ul style="list-style-type: none"> <li>Includes well-baby, well-child, well-woman and adult preventive care</li> <li>Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.</li> </ul>  | Plan pays 100%, no plan deductible                      | Plan pays 80% coinsurance after plan deductible is met |
| <b>Immunizations - All Ages</b> <ul style="list-style-type: none"> <li>Includes travel related immunizations</li> </ul>   | Plan pays 100%, no plan deductible                      | Plan pays 80% coinsurance after plan deductible is met |
| <b>Mammogram, PAP, PSA Tests</b> <ul style="list-style-type: none"> <li>Coverage includes the associated Preventive Outpatient Professional Services.</li> <li>Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.</li> </ul>   | Plan pays 100%, no plan deductible                      | Plan pays 80% coinsurance after plan deductible is met |
| Benefit   | In-Network  | Out-of-Network   |
| <b>Inpatient</b>  |   |  |
| <b>Inpatient Hospital Facility</b><br><br><b>Semi-Private Room:</b> In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate<br><b>Private Room:</b> In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate<br><b>Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):</b> In-Network: Limited to the negotiated rate / Out-of-Network: Limited to ICU/CCU daily room rate | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met |

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| Benefit   | In-Network   | Out-of-Network   |
|---|--|--|
| <b>Inpatient</b>  |  |  |
| <b>Inpatient Hospital Physician's Visit/Consultation</b>  | Plan pays 100% coinsurance after plan deductible is met  | Plan pays 80% coinsurance after plan deductible is met |
| <b>Inpatient Professional Services</b> <ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>   | Plan pays 100% coinsurance after plan deductible is met  | Plan pays 80% coinsurance after plan deductible is met |
| <b>Multiple Surgical Reduction</b>  | Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery. |  |
| Benefit   | In-Network   | Out-of-Network   |
| <b>Outpatient</b>   |  |  |
| <b>Outpatient Facility Services</b>   | Plan pays 100% coinsurance after plan deductible is met  | Plan pays 80% coinsurance after plan deductible is met |
| <b>Outpatient Professional Services</b> <ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>  | Plan pays 100% coinsurance after plan deductible is met  | Plan pays 80% coinsurance after plan deductible is met |
| <b>Short-Term Rehabilitation</b> <ul style="list-style-type: none"> <li>Includes physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation and cognitive therapy</li> <li>60 days maximum per Contract Year for all therapies combined</li> <li>Includes chiropractic therapy (Includes chiropractors)</li> <li>Therapy days, provided as part of an approved Home Health Care plan, accumulate to the outpatient short term rehab therapy maximum.</li> </ul> | Plan pays 100% coinsurance after plan deductible is met  | Plan pays 80% coinsurance after plan deductible is met |
| <b>Cardiac Rehabilitation</b> <ul style="list-style-type: none"> <li>36 days maximum per Contract Year</li> </ul>   | Plan pays 100% coinsurance after plan deductible is met  | Plan pays 80% coinsurance after plan deductible is met |
| Benefit   | In-Network   | Out-of-Network   |
| <b>Other Health Care Facilities/Services</b>  |  |  |
| <b>Home Health Care</b><br>(includes outpatient private duty nursing days when approved as medically necessary) <ul style="list-style-type: none"> <li>Unlimited days maximum per Contract Year</li> <li>16 hour maximum per day</li> </ul>   | Plan pays 100% coinsurance after plan deductible is met  | Plan pays 80% coinsurance after plan deductible is met |
| <b>Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility</b> <ul style="list-style-type: none"> <li>180 days maximum per Contract Year</li> </ul>   | Plan pays 100% coinsurance after plan deductible is met  | Plan pays 80% coinsurance after plan deductible is met |

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| Benefit   | In-Network  | Out-of-Network  |
|---|---|---|
| <b>Other Health Care Facilities/Services</b>  |   |   |
| <b>Durable Medical Equipment</b> <ul style="list-style-type: none"> <li>Unlimited maximum per Contract Year</li> </ul>  | Plan pays 100% coinsurance after plan deductible is met   | Plan pays 80% coinsurance after plan deductible is met  |
| <b>Breast Feeding Equipment and Supplies</b> <ul style="list-style-type: none"> <li>Limited to the rental of one breast pump per birth as ordered or prescribed by a physician.</li> <li>Includes related supplies</li> </ul> | Plan pays 100%  | Plan pays 80% coinsurance after plan deductible is met  |
| <b>External Prosthetic Appliances (EPA)</b> <ul style="list-style-type: none"> <li>Unlimited maximum per Contract Year</li> </ul>   | Plan pays 100% coinsurance after plan deductible is met   | Plan pays 80% coinsurance after plan deductible is met  |
| <b>Nutritional Formula</b> <ul style="list-style-type: none"> <li>Birth through 12 years of age</li> </ul>  | Plan pays 100% coinsurance  | Plan pays 100% of billable charges  |
| <b>Osteopaths</b>   | Plan pays 100% coinsurance after plan deductible is met   | Plan pays 80% coinsurance after plan deductible is met  |
| <b>Naturopaths</b>  | Plan pays 100% coinsurance after plan deductible is met   | Plan pays 80% coinsurance after plan deductible is met  |
| <b>Wigs</b> <ul style="list-style-type: none"> <li>\$350 maximum per calendar year</li> </ul>   | Plan pays 100% coinsurance after plan deductible is met   | Plan pays 80% coinsurance after plan deductible is met  |
| <b>Hearing Aids</b> <ul style="list-style-type: none"> <li>\$1,000 maximum per calendar year for ages 12 years and younger</li> </ul>   | Plan pays 100% coinsurance  | Plan pays 80% coinsurance after plan deductible is met  |
| <b>Hearing Exams</b> <ul style="list-style-type: none"> <li>1 exam every 2 contract years</li> </ul>  | Plan pays 100% coinsurance after plan deductible is met   | Plan pays 80% coinsurance after plan deductible is met  |
| <b>Routine Foot Disorders</b>   | 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. |
| <b>Vision care</b> <ul style="list-style-type: none"> <li>Eye exam once every 24 months</li> </ul>  | Plan pays 100% after the medical plan deductible is met   | Plan pays 80% after the medical plan deductible is met  |
| <b>Oral Surgery - Impacted Wisdom Teeth Inpatient Facility</b>  | Plan pays 100% coinsurance after plan deductible is met   | Plan pays 80% coinsurance after plan deductible is met  |

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| Place of Service - You pay based on where you receive services. |   |  |   |  |   |                |   |  |   |   |
|---|---|--|---|--|---|----------------|---|--|---|---|
| Benefit   | Physician's Office                                      |  | Outpatient Facility                                     |  | Emergency Room/ Urgent Care Facility                    |                | Independent Lab   |  | Inpatient Hospital                              |   |
|   | In-Network  | Out-of-Network   | In-Network  | Out-of-Network   | In-Network  | Out-of-Network | In-Network  | Out-of-Network   | In-Network                                      | Out-of-Network                                  |
| Lab and X-ray   | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met |                | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Covered under plan's Inpatient Hospital benefit | Covered under plan's Inpatient Hospital benefit |
| Advanced Radiology Imaging (MRI, MRA, CAT Scan, PET Scan, etc.) | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met |                | Not Applicable  | Not Applicable   | Covered under plan's Inpatient Hospital benefit | Covered under plan's Inpatient Hospital benefit |

| Place of Service - You pay based on where you receive services.   |   |   |   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|---|---|---|
| Benefit   | Physician's Office                                      |   | Emergency Room  |   | Outpatient Professional Services (Radiologist, Pathologist, ER Physician) |   | *Ambulance  |   |   |   |
|   | In-Network  | Out-of-Network  | In-Network  | Out-of-Network  | In-Network  | Out-of-Network  | In-Network  | Out-of-Network  | Out-of-Network  |   |
| Emergency Care  | Plan pays 100% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met                   | Plan pays 100% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met |
| * Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered. |   |   |   |   |   |   |   |   |   |   |

| Place of Service - You pay based on where you receive services.   |   |   |   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|---|---|---|
| Benefit   | Physician's Office                                      |   | Urgent Care Facility                                    |   | Outpatient Professional Services                        |   | *Ambulance  |   |   |   |
|   | In-Network  | Out-of-Network  | In-Network  | Out-of-Network  | In-Network  | Out-of-Network  | In-Network  | Out-of-Network  | Out-of-Network  |   |
| Urgent Care   | Plan pays 100% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met |
| * Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered. |   |   |   |   |   |   |   |   |   |   |

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| Place of Service - You pay based on where you receive services. |   |  |   |  |   |  |   |   |
|---|---|--|---|--|---|--|---|---|
| Benefit   | Initial Visit to Confirm Pregnancy                      |  | All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges |  | Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist) |  | Delivery - Facility (Inpatient Hospital, Birthing Center) |   |
|   | In-Network  | Out-of-Network   | In-Network  | Out-of-Network   | In-Network  | Out-of-Network   | In-Network  | Out-of-Network                                    |
| Maternity   | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met                           | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met                               | Plan pays 80% coinsurance after plan deductible is met | Covered same as plan's Inpatient Hospital benefit         | Covered same as plan's Inpatient Hospital benefit |

| Place of Service - You pay based on where you receive services.            |   |  |   |  |
|--|---|--|---|--|
| Benefit  | Inpatient Hospital and Other Health Care Facilities     |  | Outpatient Services                                     |  |
|  | In-Network  | Out-of-Network   | In-Network  | Out-of-Network   |
| Hospice (provided as part of Hospice Care Program)                         | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met |
| Bereavement Counseling (Services provided as part of Hospice Care Program) | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met |

| Place of Service - You pay based on where you receive services. |   |  |   |  |   |  |   |  |   |  |
|---|---|--|---|--|---|--|---|--|---|--|
| Benefit   | Physician's Office                                      |  | Inpatient Facility                                      |  | Outpatient Facility                                     |  | Inpatient Professional Services                         |  | Outpatient Professional Services                        |  |
|   | In-Network  | Out-of-Network   |
| Abortion (Elective and non-elective procedures)                 | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met |

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**Place of Service - You pay based on where you receive services.**

| Benefit   | Physician's Services - Office Visit                     |  | Inpatient Hospital Facility                             |  | Outpatient Facility Services                            |  | Inpatient Professional Services                         |  | Outpatient Professional Services                        |  |
|---|---|--|---|--|---|--|---|--|---|--|
|   | In-Network  | Out-of-Network   |
| <b>Family Planning - Men's Services</b>   | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met |
| Includes surgical services, such as vasectomy (excludes reversals)  |   |  |   |  |   |  |   |  |   |  |
| <b>Family Planning - Women's Services</b>   | Plan pays 100%  | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100%  | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100%  | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100%  | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100%  | Plan pays 80% coinsurance after plan deductible is met |
| Includes surgical services, such as tubal ligation (excludes reversals).<br>Contraceptive devices as ordered or prescribed by a physician.  |   |  |   |  |   |  |   |  |   |  |
| <b>Infertility</b>  | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met |
| Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.<br>\$25,000 lifetime maximum |   |  |   |  |   |  |   |  |   |  |

**Place of Service - You pay based on where you receive services.**

| Benefit   | Inpatient Hospital Facility                 |   |  | Inpatient Professional Services             |   |  |
|---|---|---|--|---|---|--|
|   | Lifesource Facility In-Network              | Non-Lifesource Facility In-Network                      | Out-of-Network   | Lifesource Facility In-Network              | Non-Lifesource Facility In-Network                      | Out-of-Network   |
| <b>Organ Transplants</b>  | Plan pays 100% after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met |
| Travel Lifetime Maximum - Lifesource Facility: In-Network: \$10,000 maximum per Transplant per Lifetime |   |   |  |   |   |  |

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| Place of Service - You pay based on where you receive services.   |   |  |   |  |   |  |   |  |   |  |
|---|---|--|---|--|---|--|---|--|---|--|
| Benefit   | Physician's Services - Office Visit                     |  | Inpatient Hospital Facility                             |  | Outpatient Facility Services                            |  | Inpatient Professional Services                         |  | Outpatient Professional Services                        |  |
|   | In-Network  | Out-of-Network   |
| Dental Care   | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met |
| Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth. |   |  |   |  |   |  |   |  |   |  |

| Place of Service - You pay based on where you receive services. |                    |                |                    |                |                     |                |                                 |                |                                  |                |
|---|--------------------|----------------|--------------------|----------------|---------------------|----------------|---------------------------------|----------------|----------------------------------|----------------|
| Benefit   | Physician's Office |                | Inpatient Facility |                | Outpatient Facility |                | Inpatient Professional Services |                | Outpatient Professional Services |                |
|   | In-Network         | Out-of-Network | In-Network         | Out-of-Network | In-Network          | Out-of-Network | In-Network                      | Out-of-Network | In-Network                       | Out-of-Network |
| TMJ, Surgical and Non-Surgical                                  | Not covered        | Not covered    | Not covered        | Not covered    | Not covered         | Not covered    | Not covered                     | Not covered    | Not covered                      | Not covered    |

| Place of Service - You pay based on where you receive services. |   |  |   |  |   |  |   |  |   |  |
|---|---|--|---|--|---|--|---|--|---|--|
| Benefit   | Physician's Services - Office Visit                     |  | Inpatient Hospital Facility                             |  | Outpatient Facility Services                            |  | Inpatient Professional Services                         |  | Outpatient Professional Services                        |  |
|   | In-Network  | Out-of-Network   |
| Bariatric Surgery   | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met |

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**Place of Service - You pay based on where you receive services.**

| Benefit              | Inpatient   |  | Outpatient - Physician's Office<br>(includes individual, group therapy mental health and intensive outpatient mental health) |  | Outpatient Facility<br>(includes individual, group therapy mental health and intensive outpatient mental health) |  |
|----------------------|---|--|--|--|--|--|
|                      | In-Network  | Out-of-Network   | In-Network   | Out-of-Network   | In-Network   | Out-of-Network   |
| <b>Mental Health</b> | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met  | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met  | Plan pays 80% coinsurance after plan deductible is met |

- Unlimited maximum per Contract Year
- Mental Health services are paid at 100% after you reach your out-of-pocket maximum

**Place of Service - You pay based on where you receive services.**

| Benefit                | Inpatient   |  | Outpatient - Physician's Office<br>(includes individual and intensive outpatient substance abuse) |  | Outpatient Facility<br>(includes individual and intensive outpatient substance abuse) |  |
|------------------------|---|--|---|--|---|--|
|                        | In-Network  | Out-of-Network   | In-Network  | Out-of-Network   | In-Network  | Out-of-Network   |
| <b>Substance Abuse</b> | Plan pays 100% coinsurance after plan deductible is met | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met   | Plan pays 80% coinsurance after plan deductible is met | Plan pays 100% coinsurance after plan deductible is met                               | Plan pays 80% coinsurance after plan deductible is met |

**Note:** Detox is covered under medical

- Unlimited maximum per Contract Year
- Substance Abuse services are paid at 100% after you reach your out-of-pocket maximum

**Mental Health and Substance Abuse Services**

**MH/SA Service Specific Administration**

Partial Hospitalization, Residential Treatment and Intensive Outpatient Programs:

- Partial Hospitalization: The coinsurance level for Partial Hospitalization services is the same as the coinsurance level for inpatient MH/SA services.
- Standard for Residential Treatment: Subject to the plan's inpatient MH/SA benefit. Coverage only if approved through Cigna Behavioral Health Case Management.
- Intensive Outpatient Program (IOP): Benefit is the same as outpatient visits. Coverage only if approved through Cigna Behavioral Health Case Management.

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## Mental Health and Substance Abuse Services

### Mental Health/Substance Abuse Utilization Review, Case Management and Programs

Cigna Behavioral Advantage - Inpatient and Outpatient Management

- Inpatient utilization review and case management
- Outpatient utilization review and case management
- Partial Hospitalization
- Intensive outpatient programs
- Changing Lives by Integrating Mind and Body Program
- Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management.
- Narcotic Therapy Management
- Complex Psychiatric Case Management

| Pharmacy   | In-Network   | Out-of-Network  |
|--|--|---|
| <p><b>Cigna Pharmacy three-tier coinsurance plan</b></p> <ul style="list-style-type: none"> <li>• No Mandatory Generics</li> <li>• Self Administered injectable and optional injectable drugs - includes infertility drugs</li> <li>• Includes Oral Contraceptives - with specific products covered 100%</li> <li>• Lifestyle drugs included - limited to sexual dysfunction</li> <li>• Prescription diet drugs included</li> <li>• Prescription smoking cessation drugs included</li> <li>• Prescription vitamins included</li> <li>• Oral Fertility drugs included</li> <li>• Insulin, glucose test strips, lancets, insulin needles &amp; syringes, insulin pens and cartridges included</li> </ul> | <p><b>Retail - 30 day supply</b><br/>                     Generic: You pay 0% after the deductible<br/>                     Preferred Brand: You pay 0% after the deductible<br/>                     Non-Preferred Brand: You pay 0% after the deductible</p> <p><b>Home delivery - 90 day supply</b><br/>                     Generic: You pay 0% after the deductible<br/>                     Preferred Brand: You pay 0% after the deductible<br/>                     Non-Preferred Brand: You pay 0% after the deductible</p> | <p><b>Retail</b><br/>                     You pay 20%<br/>                     Plan pays 80%</p> <p><b>Home Delivery</b><br/>                     Not covered</p> |
| <p><b>Pharmacy Clinical Management and Prior Authorization</b></p> <ul style="list-style-type: none"> <li>• Your plan is subject to certain clinical edits and prior authorization requirements.</li> <li>• Refill-too-soon and plan exclusion edits are always included.</li> <li>• Additional clinical management - Basic package - provides a limited set of clinical edits such as prior authorization, age edits and quantity limits for a specific list of prescription medications.</li> </ul>  |  |   |
| <p><b>Specialty Pharmacy Management:</b></p> <ul style="list-style-type: none"> <li>• Clinical Programs                             <ul style="list-style-type: none"> <li>o Prior authorization is not required on specialty medications but quantity limits may apply.</li> <li>o Theracare® Program</li> </ul> </li> <li>• Medication Access Option                             <ul style="list-style-type: none"> <li>o Retail and/or Home Delivery</li> </ul> </li> </ul>   |  |   |
| <p><b>Additional Information</b></p> <p><b>Prescription Drug List:</b></p> <ul style="list-style-type: none"> <li>• Cigna Standard Prescription Drug List</li> </ul>   |  |   |

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## Health and Wellness Programs

|  |   |
|--|---|
| <p><b>Your Health First - 200</b><br/>Individuals with one or more of the chronic conditions, identified on the right, receive the following support:</p> <ul style="list-style-type: none"> <li>• Health and Wellness Coaching</li> <li>• Cigna Well Informed Program</li> <li>• Preference Sensitive Care</li> <li>• 24 hour Health Information Line</li> <li>• Pre/Post Discharge Outreach</li> </ul>   | <p>Holistic health support for the following chronic health conditions:</p> <ul style="list-style-type: none"> <li>• Heart Disease</li> <li>• Coronary Artery Disease</li> <li>• Angina</li> <li>• Congestive Heart Failure</li> <li>• Acute Myocardial Infarction</li> <li>• Peripheral Arterial Disease</li> <li>• Asthma</li> <li>• Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)</li> <li>• Diabetes Type 1</li> <li>• Diabetes Type 2</li> <li>• Metabolic Syndrome/Weight Complications</li> <li>• Osteoarthritis</li> <li>• Low Back Pain</li> <li>• Anxiety</li> <li>• Bipolar Disorder</li> <li>• Depression</li> </ul> |
| <p><b>Health Advisor - A</b><br/>Support for healthy and at-risk individuals to help them stay healthy</p> <ul style="list-style-type: none"> <li>• Health and Wellness Coaching</li> <li>• Gaps in Care coaching for select conditions</li> <li>• Preference Sensitive Care/Treatment</li> <li>• Decision Support Coaching</li> </ul>   | <p>Included</p>   |
| <p><b>Case Management</b><br/>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.</p>   |   |
| <p><b>Definitions</b></p>  |   |
| <p><b>Coinsurance</b> - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called coinsurance.</p> <p><b>Copay</b> - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.</p> <p><b>Deductible</b> - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.</p> <p><b>Out-of-Pocket Maximum</b> - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "maximum reimbursable charges" or negotiated fees for covered services.</p> <p><b>Prescription Drug List</b> - The list of prescription brand and generic drugs covered by your pharmacy plan.</p> <p><b>Transition of Care</b> - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.</p> |   |

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## Dollars & Sense

**DOLLARS & SENSE:** Easy ways to decrease your out-of-pocket health care expenses.

### **In-network care**

Using doctors, hospitals and facilities that participate in the Cigna network can save you money. In addition, choosing Cigna Care designated specialists - doctors in 19 specialties who have been identified for their superior performance in quality and cost efficiency - may save you even more. You can verify that a doctor or facility is in Cigna's network and learn more about the Cigna Care designation by checking the directory on myCigna.com or Cigna.com, or by calling the customer service number on the back of your Cigna ID card. Cigna is open 24/7.

### **Urgent care**

**(Average urgent care center cost \$131 / Average hospital ER cost \$1,523)**

Many people use the emergency room (ER) for conditions that are not serious or life-threatening. Using an urgent care center or your doctor's office instead of an ER can save you hundreds of dollars and provides the same quality of care as an ER. If you need care and are not sure if you need to go to the ER, speak with your doctor or call Cigna's 24-hour nurse line at the number on the back your Cigna ID card to determine the most appropriate location for urgent care.

### **Convenience care or retail clinics**

**(Average convenience care clinic cost \$61 / Average hospital ER cost \$1,523)**

Convenience care clinics provide quick and easy access to high quality treatment for common medical conditions when your doctor is not available. These clinics are located in department stores, grocery stores and pharmacies. To locate convenience care clinics, you can check the Directory on myCigna.com or Cigna.com, or call the customer service number on the back of your Cigna ID card. Cigna is open 24/7.

### **Laboratory and pathology tests**

**(Average LabCorp/Quest cost \$9 / Average other lab cost \$24 / Average outpatient hospital lab cost \$48)**

Two of the nation's largest and most prominent laboratories, Quest Diagnostics, Inc. (Quest) and Laboratory Corporation of America (LabCorp), participate in the Cigna network. Services at these labs can cost 70-75% less and offer the same or better quality than hospital laboratories. When you need lab services, discuss these options with your doctor. To find the nearest Quest and LabCorp locations, check the directory on myCigna.com or Cigna.com.

### **Radiology services (MRI or CT scan)**

**(Average independent radiology facility cost \$591 / Average outpatient hospital cost \$1,198)**

If you need to have an MRI or CT scan, you can save hundreds of dollars by using an independent radiology center. While Cigna contracts with all types of facilities that provide radiology services, using independent radiology centers will save you money, without any difference in quality. Discuss location options with your doctor. For help locating the most cost effective facility in which to have an MRI or CT scan, you can use the cost comparison tools on myCigna.com or call the customer service number on the back of your Cigna ID card.

### **Colonoscopy, endoscopy or arthroscopy**

**(Average freestanding surgery center cost \$1,438 / Average outpatient hospital cost \$2,821)**

When a doctor recommends a colonoscopy, GI endoscopy or arthroscopy, make sure you know your options. Using a freestanding outpatient surgery center for these procedures instead of a hospital can often save hundreds of dollars, while maintaining the same high quality as a hospital. Talk with your doctor about options. For help locating the most appropriate facility, you can use our cost comparison tools on myCigna.com or call the customer service number on the back of your Cigna ID card.

### **Cigna Home Delivery Pharmacy**

You can save money and enjoy convenient home delivery by using Cigna Home Delivery Pharmacy for your prescription medications. You can get up to a 90-day supply of your medication.

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## Exclusions

### What's Not Covered (not all-inclusive):

Your plan provides for most medically necessary services. 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. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- 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 plan.
- 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.
- For or in connection with experimental, investigational or unproven services.
- Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services do not include routine patient care costs related to qualified clinical trials as described in your plan document. 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.
- 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.
- The following services are excluded from coverage regardless of clinical indications: Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolwing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Surgical or nonsurgical treatment of TMJ disorders.
- 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. 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 six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance 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.
- Unless otherwise covered in this plan, 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.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- Any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile

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## Exclusions

- dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Nonmedical 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 nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
- 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.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, and dentures.
- Aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- 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.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations 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.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- Medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- Medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Telephone, e-mail, and Internet consultations, and telemedicine.

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## EXCLUSIONS

- Reversal of male and female voluntary sterilization.

### **These are only the highlights**

This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence. This summary provides additional information not provided in the Summary of Benefits and Coverage document required by the Federal Government.

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**APPENDIX III**  
**Buildings and Grounds Supervisory Annual Evaluation**

Name: \_\_\_\_\_

Title: \_\_\_\_\_ Date of Review: \_\_\_\_\_

**INSTRUCTIONS:**

2. Evaluate all factors on the basis of the approved job description for the position.
3. State the performance standard level of satisfactory (average performance).
4. Comments may be made on each factor, positive or negative or both.
5. Before signing off on the appraisal, a personal interview should be held with the employee for the purpose of giving appropriate praise, suggestions, and/or constructive criticism where needed.

1. **JOB KNOWLEDGE:** Consider the understanding and knowledge necessary to perform duties of a supervisor.

Needs Training  Unsatisfactory  Satisfactory  Above Average  Exceptional

Comments: \_\_\_\_\_  
\_\_\_\_\_

2. **QUALITY OF WORK:** Consider the ability to supervise repairs, cleaning and the neatness, accuracy and completeness which are shown.

Needs Training  Unsatisfactory  Satisfactory  Above Average  Exceptional

Comments: \_\_\_\_\_  
\_\_\_\_\_

3. **QUANTITY OF WORK:** Consider the volume of work produced under normal circumstances.

Needs Training  Unsatisfactory  Satisfactory  Above Average  Exceptional

Comments: \_\_\_\_\_  
\_\_\_\_\_

4. **INITIATIVE:** Consider if the employee undertakes activities related to their job on their own. Also consider if the employee offers suggestions to improve the job environment and acts as a team player.

Needs Training  Unsatisfactory  Satisfactory  Above Average  Exceptional

Comments: \_\_\_\_\_  
\_\_\_\_\_

5. COOPERATION: Consider the employee's cooperation toward work with co-workers, faculty and students. Also consider the ability to respond to requests from staff members and dedication.

Needs Training  Unsatisfactory  Satisfactory  Above Average  Exceptional

Comments: \_\_\_\_\_  
\_\_\_\_\_

6. ATTENDANCE: Consider the employee's frequency of absences.

Needs Training  Unsatisfactory  Satisfactory  Above Average  Exceptional

Comments: \_\_\_\_\_  
\_\_\_\_\_

7. SAFETY: Measures to protect persons and structures from hazards, code violations, OSHA regulations and basic safety factors.

Needs Training  Unsatisfactory  Satisfactory  Above Average  Exceptional

Comments: \_\_\_\_\_  
\_\_\_\_\_

8. OVERALL EVALUATION OF EMPLOYEE'S PERFORMANCE:

Needs Training  Unsatisfactory  Satisfactory  Above Average  Exceptional

Comments: \_\_\_\_\_  
\_\_\_\_\_

9. LEADERSHIP PERFORMANCE: Consider the ability of the supervisor to motivate, train, direct and supervise the daily activities of the department or employees.

Needs Training  Unsatisfactory  Satisfactory  Above Average  Exceptional

Comments: \_\_\_\_\_  
\_\_\_\_\_

EMPLOYEE'S COMMENTS: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Administrator or Manager

\_\_\_\_\_  
Date

I have received the above evaluation but my signature does not mean I agree with it and I'm aware that I can proceed through the Union grievance procedure.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date