

This is a summary of benefits for your Network POS Copay plan. In general, deductibles and Out-of-Pocket Maximums will accumulate in one direction (e.g. out-of-network will accumulate to in-network). All other plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between in- and out-of-network unless otherwise noted. All in-network services must be performed by the Primary Care Physician (PCP), referred by the PCP or approved by the local Healthplan. CIGNA Pharmacy plan deductibles, out-of-pocket maximums, copays and annual maximums do not integrate with the employer medical program.

Note: The standard accumulation of deductibles, OOP maximums and benefit maximums is on a "contract" year basis. As an alternative, accumulation on a "calendar" year basis can be accommodated. If offering the calendar year accumulation, this must apply to all accumulators (e.g. deductible, OOP and benefit maximums). For plans with an off-January 1st effective date, the plan will be structured with a short accumulation period for the number of remaining months in the calendar year (e.g. a 6/1 effective date will result in a 7 month policy year for the initial year of coverage. Subsequent years of coverage will be structured as full calendar years).

CIGNA HealthCare Benefit Summary City of Middletown Point of Service Managers Network POS Copay Plan 2007		
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	\$1,000,000
Deductible Accumulators		
Accumulation between In-Network and Out-of-Network Deductibles	One way cross accumulation	
Calendar Year Deductible		Includes Medical and MH/SA benefits. The plan deductible will apply to all Out-of-network services. The deductible must be satisfied before any benefits are payable for these services.
<i>Individual</i>	None per person	\$3,000 per person
<i>Family Maximum</i>	None per family	\$9,000 per family
<i>Aggregate</i>	Yes	Yes
Out-of-Pocket Maximum Accumulators	Includes inpatient facility copays, outpatient facility copays and advanced radiological imaging copays. Other copays do not accumulate.	Includes member paid coinsurance, inpatient facility deductibles, outpatient facility deductibles and advanced radiological imaging deductibles.
Accumulation between In-Network and Out-of-Network Maximums: One way cross accumulation	Note: Once the Out-of-Pocket Maximum is reached, inpatient facility copays (including MH/SA), outpatient facility copays and advanced radiological imaging copays will no longer be required. Note: Inpatient MH/SA facility copays can or cannot accumulate to the OOP Maximum.	
The following do not accumulate to the OOP Maximum	Copays not listed above	Non-compliance penalties or charges in excess of Reasonable and Customary
<i>Benefits for accident or sickness (excluding mental health, alcohol, and drug abuse benefits) are paid at 100%, once an individual's out-of-pocket has been reached.</i>		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<i>Out-of-Pocket Maximum</i> <i>Individual</i> <i>Family Maximum</i> <i>Aggregate</i>	None None Not Applicable	\$30,000 per person per person \$90,000 per family per family Yes
Automatic Annual Reinstatement	Not Applicable	
Physician's Services		
<i>Primary Care Physician's Office visit</i>	No charge after \$10 per office visit copay; No charge if only x-ray and/or lab services performed and billed.	50% after plan deductible
<i>Specialty Care Physician's Office Visit</i> <i>Office Visits</i> <i>Consultant and Referral Physician's Services</i> Note: OB/GYN provider is considered a Specialist.	No charge after \$10 per office visit copay; No charge if only x-ray and/or lab services performed and billed.	50% after plan deductible
<i>Surgery Performed In the Physician's Office</i>	No charge after the PCP or Specialist per office visit copay	50% after plan deductible
<i>Second Opinion Consultations (provided on a voluntary basis)</i>	No charge after the PCP or Specialist per office visit copay	50% after plan deductible
<i>Allergy Treatment/Injections</i>	No charge after either the PCP or Specialist per office visit copay or the actual charge, whichever is less	50% after plan deductible
<i>Allergy Serum (dispensed by the physician in the office)</i>	No charge	50% after plan deductible
Preventive Care		
<i>Routine Preventive Care: Well-Baby, Well-Child, Adult and Well-Woman (including immunizations)</i> Note: Well-Woman OB/GYN visits will be subject to the plan's Specialist copay.	No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed.	50% after plan deductible
<i>Immunizations</i>	No charge	
Mammograms, PSA, PAP Smear		
<i>Preventive Care Related Services (i.e. "routine" services)</i>	No charge (for the procedure itself); professional reading charges are covered under the plan's Outpatient professional services benefit Note: The associated wellness exam is subject to the PCP or Specialist per office visit copay	50% after plan deductible Note: The associated wellness exam is not covered
<i>Diagnostic Related Services (i.e. "non-routine")</i>	Subject to the plan's x-ray & lab benefit; based on place of service	Subject to the plan's x-ray & lab benefit; based on place of service

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<i>Inpatient Hospital - Facility Services</i> <i>Semi-Private Room and Board</i> <i>Private Room</i> <i>Special Care Units (ICU/CCU)</i>	No charge Limited to the semi-private negotiated rate Limited to the semi-private negotiated rate Limited to the negotiated rate	50% after plan deductible Limited to the semi-private room rate Limited to the semi-private room rate Limited to the ICU/CCU daily room rate
<i>Outpatient Facility Services</i> <i>Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room.</i> Note: The copay will apply as long as services billed include one or more of the facility room charges listed above.	No charge	50% coinsurance
<i>Inpatient Hospital Physician's Visits/Consultations</i>	No charge	50% after plan deductible
<i>Inpatient Hospital Professional Services</i> <i>Surgeon</i> <i>Radiologist</i> <i>Pathologist</i> <i>Anesthesiologist</i>	No charge	50% after plan deductible
<i>Multiple Surgical Reduction</i>	Not Applicable	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.
<i>Outpatient Professional Services</i> <i>Surgeon</i> <i>Radiologist</i> <i>Pathologist</i> <i>Anesthesiologist</i>	No charge	50% after plan deductible
<i>Emergency and Urgent Care Services</i> <i>Physician's Office</i> <i>Hospital Emergency Room</i> <i>Outpatient Professional Services (radiology, pathology, ER physician)</i> <i>Urgent Care Facility or Outpatient Facility</i> <i>Ambulance</i>	No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed. No charge after \$50 per visit copay** (Copay waived if admitted) No charge No charge after \$50 per visit copay** (Copay waived if admitted) No charge ** If not a true emergency, services are not covered	No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed ** (Covered same as in-network benefit) No charge after \$50 per visit copay** (Copay waived if admitted) No charge No charge after \$50 per visit copay** (Copay waived if admitted) No charge **If not a true emergency, services are not covered
<i>Inpatient Services at Other Health Care Facilities</i> <i>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</i> 60 days combined maximum per calendar year No prior hospitalization required	No charge	50% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Laboratory and Radiology Services (includes pre-admission testing)</p> <p><i>Physician's Office</i></p> <p><i>Outpatient Hospital Facility</i></p> <p><i>Emergency Room Facility (billed by the facility as part of the ER visit)</i></p> <p><i>Independent X-ray and/or Lab facility</i></p> <p><i>Independent X-ray and/or Lab Facility in conjunction with an ER visit</i></p>	<p>No charge</p> <p>No charge for facility charges; no charge for outpatient professional charges</p> <p>No charge</p> <p>No charge</p> <p>No charge (if ER visit is considered to be a true emergency)</p>	<p>50% after plan deductible</p> <p>50% after plan deductible</p> <p>50% after plan deductible</p> <p>50% after plan deductible</p> <p>No charge (if ER visit is considered to be a true emergency)</p>
<p>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans, etc.)</p> <p><i>Inpatient Facility</i></p> <p><i>Outpatient Facility</i></p> <p><i>Emergency Room</i></p> <p><i>Physician's Office</i></p> <p>Notes:</p> <ul style="list-style-type: none"> Scans are subject to the applicable place of service coinsurance and plan deductible. Associated ancillary charges are subject to the applicable place of service coinsurance level and plan deductible. Facility copay does not apply. 	<p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p>	<p>50% after plan deductible</p> <p>50% after plan deductible</p> <p>100% (unless not true emergency, then not covered)</p> <p>50% after plan deductible</p>
<p>Outpatient Short-Term Rehabilitative Therapy and Chiropractic Care Services</p> <p>90 days combined maximum per calendar year</p> <p>Includes:</p> <ul style="list-style-type: none"> Cardiac rehab Physical Therapy Speech Therapy Occupational Therapy Chiropractic Therapy (includes Chiropractors) Pulmonary Rehab Cognitive Therapy 	<p>No charge after the PCP or Specialist per office visit copay, No charge if only x-ray and/or lab services performed and billed.</p> <p>Note: The Outpatient Short Term Rehab copay does not apply to services provided as part of a Home Health Care visit.</p> <p>Note: Therapy days, provided as part of an approved Home health Care plan, accumulate to the Outpatient Short Term Rehab Therapy maximum. If multiple outpatient services are provided on the same day, they constitute one day, but separate copay will apply to the services provided by each Participating provider.</p>	<p>50% after plan deductible</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Home Health Care</p> <p>Unlimited days maximum per calendar year (includes outpatient private nursing when approved as medically necessary)</p> <p>The maximum number of hours per day is limited to 16 hours. Multiple visits can occur in one day; with a visit defined as a period of 2 hours or less (e.g. maximum of 8 visits per day)</p>	No charge	50% after plan deductible
<p>Hospice</p> <p><i>Inpatient Services</i></p> <p><i>Outpatient Services</i> (same coinsurance level as Home Health Care)</p>	<p>No charge</p> <p>Note: If plan includes Inpatient Hospital Facility copay, the Inpatient Hospital Facility copay does not apply.</p> <p>No charge</p>	<p>50% after plan deductible</p> <p>Note: If plan includes Inpatient Hospital Facility copay, the Inpatient Hospital Facility copay does not apply.</p> <p>50% after plan deductible</p>
<p>Bereavement Counseling</p> <p><i>Services Provided as part of Hospice Care</i></p> <p><i>Inpatient</i></p> <p><i>Outpatient</i></p> <p><i>Services Provided by Mental Health Professional</i></p>	<p>No charge</p> <p>No charge</p> <p>Covered under Mental Health benefit</p>	In-network coverage only
<p>Maternity Care Services</p> <p><i>Initial Visit to Confirm Pregnancy</i></p> <p>Note: OB/GYN visits will be subject to the plan's Specialist copay.</p> <p><i>All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)</i></p> <p><i>Office Visits in addition to the global maternity fee when performed by an OB or Specialist</i></p> <p><i>Delivery - Facility (Inpatient Hospital)</i></p>	<p>No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed.</p> <p>No charge</p> <p>No charge after the Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed</p> <p>No charge</p>	<p>50% after plan deductible</p> <p>50% after plan deductible</p> <p>50% after plan deductible</p> <p>50% after plan deductible</p>
<p>Abortion</p> <p><i>Includes elective and non-elective procedures</i></p> <p><i>Office Visit</i></p> <p><i>Inpatient Facility</i></p> <p><i>Outpatient Facility</i></p> <p><i>Inpatient Physician's Services</i></p>	<p>No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed</p> <p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>50% after plan deductible</p> <p>50% after plan deductible</p> <p>50% after plan deductible</p> <p>50% after plan deductible</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<i>Outpatient Physician's Services</i>	No charge	50% after plan deductible
Family Planning Services		
<i>Office Visit (tests, counseling)</i>	No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed	50% after plan deductible
<i>Surgical Sterilization Procedures for Vasectomy/Tubal Ligation (excludes reversals)</i>	Note: Charges billed by a separate independent x-ray/lab facility will be covered under the plan's Laboratory and Radiology benefit	
<i>Inpatient Facility</i>	No charge	50% after plan deductible
<i>Outpatient Facility</i>	No charge	50% after plan deductible
<i>Inpatient Physician's Services</i>	No charge	50% after plan deductible
<i>Outpatient Physician's Services</i>	No charge	50% after plan deductible
<i>Physician's Office</i>	No charge after the PCP or Specialist per office visit copay	50% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Dental Care <i>Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.</i></p> <p><i>Doctor's Office</i></p> <p><i>Inpatient Facility</i></p> <p><i>Outpatient Facility</i></p> <p><i>Physician's Services</i></p>	<p>No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed</p> <p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>50% after plan deductible</p> <p>50% after plan deductible</p> <p>50% after plan deductible</p> <p>50% after plan deductible</p>
<p>Surgical and Non-surgical TMJ <i>Provided on a limited, case by case, basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity.</i></p> <p><i>Doctor's Office</i></p> <p><i>Inpatient Facility</i></p> <p><i>Outpatient Facility</i></p> <p><i>Physician's Services</i></p>	<p>No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed</p> <p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>50% after plan deductible</p> <p>50% after plan deductible</p> <p>50% after plan deductible</p> <p>50% after plan deductible</p>
<p>Obesity/Bariatric Surgery Rider</p> <p>The following are specifically excluded with this buy-up:</p> <ul style="list-style-type: none"> • Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity. • Weight loss programs or treatments whether prescribed or recommended by a physician or under medical supervision. <p><i>Doctor's Office</i></p> <p><i>Inpatient Facility</i></p> <p><i>Outpatient Facility</i></p> <p><i>Physician's Services</i></p>	<p>Note: Coverage is provided subject to medical necessity and clinical guidelines.</p> <p>No charge after PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed.</p> <p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>50% after plan deductible</p> <p>50% after plan deductible</p> <p>50% after plan deductible</p> <p>50% after plan deductible</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<i>Routine Foot Disorders</i>	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.
<i>Pre-Existing Condition Limitation (PCL)</i>	Not Applicable	Applies to any injury or sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a physician during the 90 days before the earlier of the date a person begins an eligibility waiting period or becomes insured for these benefits. Coverage for the pre-existing condition is excluded until one year of being continuously insured and/or is satisfying a waiting period. Usually the PCL is waived for the initial group, but if not, the insured will receive credit for any portion of the PCL waiting period that was satisfied under the previous plan if they are enrolled in the subsequent plan within 63 days (or the applicable timeframe required per state law).
<i>Pre-Admission Certification - Continued Stay Review</i> CIGNA's PAC/CSR is not necessary for Medicare primary individuals <i>Inpatient Pre-Admission Certification - Continued Stay Review</i> (required for all inpatient admissions)	Coordinated by Provider/PCP	Mandatory: Employee is responsible for contacting CIGNA Healthcare. Penalties for non-compliance: <ul style="list-style-type: none">- 50% penalty applied to hospital inpatient charges for failure to contact CIGNA Healthcare to precertify admission.- Benefits are denied for any admission reviewed by CIGNA Healthcare and not certified.- Benefits are denied for any additional days not certified by CIGNA Healthcare.
<i>Outpatient Prior Authorization</i> (required for selected outpatient procedures and diagnostic testing).	Coordinated by Provider/PCP	Mandatory: Employee is responsible for contacting CIGNA Healthcare. Penalties for non-compliance: <ul style="list-style-type: none">- 50% penalty applied to outpatient procedures/diagnostic testing charges for failure to contact CIGNA Healthcare to precertify.- Benefits are denied for any outpatient procedures/diagnostic testing reviewed by CIGNA Healthcare and not certified.
<i>Case Management</i>	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.	
<i>Vision Care</i> <i>Eye Exam every 24 months.</i> <i>Eye Glasses/Contact Lenses Not Covered</i>	\$10 per office visit copay	In-network coverage only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Mental Health <i>Inpatient</i></p> <p>Acute: based on ratio of 1:1 Partial: based on a ratio of 2:1 Residential: based on a ratio of 2:1</p> <p><i>Outpatient</i> Note: Due to Mental Health Parity mandates, when offering a CIGNA Care Network plan design on a Non-ASO basis, the Outpatient Mental Health copay amount must be equal to the medical plan's PCP copay level.</p> <p><i>Outpatient Group Therapy (One group therapy session equal one individual therapy session)</i> <i>Intensive Outpatient</i> <i>Maximum: up to 3 programs per contract year</i> <i>Based on a ratio of 1:1</i></p>	<p>No charge</p> <p>Subject to the same coinsurance and copay level as the medical plan's Inpatient Hospital Facility benefit; after the medical plan deductible</p> <p>No charge after \$10 per visit copay</p> <p>No charge after \$10 per visit copay</p> <p>100% after \$100 per program copay</p>	<p>50% after plan deductible</p> <p>50% after plan deductible</p> <p>50% after plan deductible</p> <p>50% after plan deductible</p>
<p>Substance Abuse <i>Inpatient</i></p> <p>Acute detox: requires 24 hour nursing; based on a ratio of 1:1 Acute Inpatient Rehab: requires 24 hour nursing; based on a ratio of 1:1 Partial: based on a ratio of 2:1 Residential: based on a ratio of 2:1</p> <p><i>Outpatient</i> <i>Intensive Outpatient (alcohol & drug)</i> <i>Maximum: up to 3 programs per contract year</i> <i>Based on a ratio of 1:1</i></p>	<p>No charge</p> <p>Subject to the same coinsurance and copay level as the medical plan's Inpatient Hospital Facility benefit; after the medical plan deductible</p> <p>No charge after \$10 per visit copay 100% after \$100 per program copay</p>	<p>50% after plan deductible</p> <p>50% after plan deductible 50% after plan deductible</p>
<p>MH/SA Utilization Review & Case Management</p>	<p>Inpatient and Outpatient Management (CAP):</p> <ul style="list-style-type: none"> • CBH provides utilization review and case management for In-network and Out-of-network Inpatient Services and In-network Outpatient Management services. • Includes Lifestyle Management Program (Stress & Tobacco) 	

Medical Benefit Exclusions (by way of example but not limited to):

Your plan provides coverage for medically necessary services. Your plan does not provide coverage for the following except as required by law:

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public school system or school district.
3. Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
4. Treatment of an illness or injury which is due to war, declared or undeclared.
5. Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
6. Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
7. Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be: Not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or The subject of review or approval by an Institutional Review Board for the proposed use, except as provided in the "Clinical Trials" section of "Section IV. Covered Services and Supplies;" or the subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of "Section IV. Covered Services and Supplies."
8. Cosmetic Surgery and Therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
9. The following services are excluded from coverage regardless of clinical indications: Acupressure; Dance therapy, movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
10. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within 6 months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
11. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
12. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under "Section IV. Covered Services and Supplies."
13. Infertility donor services.
14. Reversal of male and female voluntary sterilization procedures.
15. Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
16. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
17. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
18. Non-medical counseling or ancillary services, including, but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
19. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.

20. 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 "Inpatient Hospital Services," "Outpatient Facility Services," "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of "Section IV. Covered Services and Supplies."
21. Private hospital rooms and/or private duty nursing except as provided in the Home Health Services section of "Section IV. Covered Services and Supplies".
22. 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 illness or injury.
23. Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
24. Hearing aids, including, but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
25. Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
26. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
27. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
28. All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Section IV. Covered Services and Supplies."
29. 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.
30. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
31. Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
32. Dental implants for any condition.
33. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
34. Blood administration for the purpose of general improvement in physical condition.
35. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
36. Cosmetics, dietary supplements and health and beauty aids.
37. All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
38. Expenses incurred for medical treatment by a person age 65 or older, who is covered under this Agreement as a retiree, or his Dependents, when payment is denied by the Medicare plan because treatment was not received from a Participating Provider of the Medicare plan.
39. Expenses incurred for medical treatment when payment is denied by the Primary Plan because treatment was not received from a Participating Provider of the Primary Plan.
40. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
41. Telephone, e-mail & Internet consultations and telemedicine.
42. Massage Therapy

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

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

"CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by



CIGNA HealthCare

A Business of Caring

Page 12

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