

This is a summary of benefits for your Open Access Plus plan. All deductibles and plan out-of-pocket maximums accumulate in one direction toward in-network unless otherwise noted. Plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between in- and out-of-network unless otherwise noted. Pharmacy plan deductibles, out-of-pocket maximums, copays and annual maximums do not integrate with the employer medical program.

CIGNA HealthCare Benefit Summary
City of Middletown
Open Access Plus
Managers
Open Access Plus Copay Plan 2007

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	Unlimited
Coinsurance Levels	100%	80%
Deductible Accumulators	One-way accumulation of Out-of-network to In-network deductibles	
Calendar Year Deductible		
<i>Individual</i>	None	\$400 per person
<i>Family Maximum</i>	None	\$800 per family
<i>Family Maximum Deductible Calculation</i>	Not Applicable	Collective Deductible
Out-of-Pocket Maximum Accumulators		
Accumulation Between In-network and Out-of-Network OOP Maximum: One-way accumulation of Out-of-network to In-network Out-of-Pocket Maximums		
Includes Deductible	No	Yes
Includes Copays	No	No
Does not apply to	Non-compliance penalties, deductibles, or copays.	Non-compliance penalties, copays or charges in excess of Maximum Reimbursable Charge
Benefits for accident or sickness are paid at 100% of charges once an individual's out-of-pocket has been reached.		
Out-of-Pocket Maximum		
<i>Individual</i>	\$500 per person	\$1,800 per person
<i>Family Maximum</i>	\$1,000 per family	\$3,000 per family
<i>Family Maximum OOP Calculation</i>	Collective OOP	Collective OOP
Automated Annual Reinstatement	Not Applicable	

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician's Services		
<i>Primary Care Physician's Office visit</i>	No charge after \$20 PCP per office visit copay; No charge after the PCP per office visit copay if only x-ray and/or lab services performed and billed.	80% after plan deductible
<i>Specialty Care Physician's Office Visit Office Visits Consultant and Referral Physician's Services</i>	No charge after \$20 Specialist per office visit copay; No charge after the Specialist per visit copay if only x-ray and/or lab services performed and billed.	80% after plan deductible
Note: OB-GYN visits will be subject to either the PCP or Specialist copay depending on how the provider contracts with CIGNA (i.e. as a PCP or as a Specialist).		
<i>Surgery Performed In the Physician's Office</i>	No charge	80% after plan deductible
<i>Second Opinion Consultations (services will be provided on a voluntary basis)</i>	No charge after the PCP or Specialist per office visit copay	80% 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	80% after plan deductible
<i>Allergy Serum (dispensed by the physician in the office)</i>	No charge	80% after plan deductible



BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Preventive Care <i>Routine Preventive Care for children through age 6 (including immunization)</i></p> <p><i>Immunizations</i></p> <p><i>Routine Preventive Care for children and adults from age 7 (including routine immunization)</i></p> <p>Note: OB-GYN visits will be subject to either the PCP or Specialist copay depending on how the provider contracts with CIGNA (i.e. as a PCP or as a Specialist).</p> <p>Note: Charges for lab and radiology services, when billed by the physician's office, will be subject to the plan's Preventive Care dollar maximum. Charges for lab and radiology services, when billed by an independent diagnostic facility or outpatient hospital do not apply to the plan's Preventive Care dollar maximum.</p> <p><i>Immunizations</i></p>	<p>No charge after PCP or Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only x-ray and/or lab services performed and billed.</p> <p>Note: x-ray and/or lab services performed and billed by an independent diagnostic facility or outpatient hospital are covered under the plan's x-ray/lab benefit.</p> <p>No charge</p> <p>No charge after the PCP or Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only x-ray and/or lab services performed and billed.</p> <p>Note: x-ray and/or lab services performed and billed by an independent diagnostic facility or outpatient hospital are covered under the plan's x-ray/lab benefit.</p> <p>No charge</p>	<p>80% after plan deductible</p> <p>80% after plan deductible</p>
<p>Mammograms, PSA, Pap Smear</p> <p>Note: Preventive care related services and diagnostic related services are paid at the same level of benefits as other x-ray and lab services, based on place of service.</p> <p>Notes:</p> <ul style="list-style-type: none"> Preventive care related Mammogram charges do not accumulate to the plan's Preventive Care dollar maximum, regardless of place of service. Preventive care related PSA and Pap smear charges, when billed by the physician's office, will be subject to the plan's Preventive Care dollar maximum. Preventive care related PSA and Pap smear charges, when billed by an independent diagnostic facility or outpatient hospital, do not accumulate to the plan's Preventive Care dollar maximum. 	<p>100% coinsurance if billed by an independent diagnostic facility or outpatient hospital.</p> <p>Note: If the optional Preventive Care benefit is selected, the associated wellness exam will be covered at no charge after the PCP or Specialist per visit copay.</p>	<p>80% after plan deductible</p>
<p>Inpatient Hospital - Facility Services</p> <p><i>Semi Private Room and Board</i></p> <p><i>Private Room</i></p> <p><i>Special Care Units (ICU/CCU)</i></p>	<p>100% after \$200 per admission copay</p> <p>Limited to semi-private room negotiated rate</p> <p>Limited to semi-private room negotiated rate</p> <p>Limited to negotiated rate</p>	<p>80% after plan deductible</p> <p>Precertification required</p> <p>Limited to semi-private room rate</p> <p>Limited to semi-private room rate</p> <p>Limited ICU/CCU daily room rate</p>



BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Outpatient Facility Services <i>Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room</i></p> <p>Note: Non-surgical treatment procedures are not subject to the facility copay.</p>	100% coinsurance	80% after plan deductible
Inpatient Hospital Physician's Visits/Consultations	No charge	80% after plan deductible
<p>Inpatient Hospital Professional Services <i>Surgeon Radiologist Pathologist Anesthesiologist</i></p>	No charge	80% after plan deductible
Multiple Surgical Reduction	Multiple surgeries performed during one operating session result in payment reduction of 50% of charges to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.	
<p>Outpatient Professional Services <i>Surgeon Radiologist Pathologist Anesthesiologist</i></p>	No charge	80% after plan deductible
<p>Emergency and Urgent Care Services <i>Physician's Office</i></p> <p><i>Hospital Emergency Room</i></p> <p><i>Outpatient Professional services (radiology, pathology and ER Physician)</i></p> <p><i>Urgent Care Facility or Outpatient Facility</i></p> <p><i>Ambulance</i></p>	<p>No charge after the PCP or Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only x-ray and lab services performed</p> <p>\$50 copayment per visit (Copay waived if admitted)</p> <p>100% after plan deductible (if the ER facility benefit is subject to coinsurance and plan deductible)</p> <p>\$50 copayment per visit (Copay waived if admitted)</p> <p>No charge</p>	<p>No charge after the PCP or Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only x-ray and lab services performed (except if not a true emergency, then 80% after plan deductible).</p> <p>\$50 copayment per visit (except if not a true emergency, then 80% after plan deductible) (Copay waived if admitted)</p> <p>100% after plan deductible (if the ER facility benefit is subject to coinsurance and plan deductible) (except if not a true emergency, then 80% after plan deductible)</p> <p>\$50 copayment per visit (except if not a true emergency, then 80% after plan deductible) (Copay waived if admitted)</p> <p>No charge (except if not a true emergency, then 80% after plan deductible)</p>
<p>Inpatient Services at Other Health Care Facilities <i>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</i></p> <p>60 days combined maximum per calendar year</p>	<p>No charge</p> <p>Note: If plan includes an inpatient hospital copay, the copay does not apply</p>	<p>80% after plan deductible</p> <p>Note: If plan includes an inpatient hospital deductible, the deductible does not apply</p>

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/Urgent Care Facility (billed by the facility as part of the ER/UC 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 after PCP or Specialist per visit copay</p> <p>No charge</p> <p>100% after plan deductible (if the ER/UC facility is covered subject to plan coinsurance and deductible)</p> <p>No charge</p> <p>100% after plan deductible (if the ER facility is covered subject to plan coinsurance and deductible)</p>	<p>80% after plan deductible</p> <p>80% after plan deductible</p> <p>100% after plan deductible (if the ER/UC facility is covered subject to plan coinsurance and deductible) (except if not a true emergency, then 80% after plan deductible)</p> <p>80% after plan deductible</p> <p>100% after plan deductible (if the ER facility is covered subject to plan coinsurance and deductible) (except if not a true emergency, then 80% after plan deductible)</p>
<p>Advanced Radiological Imaging (i.e. MRI's, MRAs, CAT Scans and PET Scans, etc.)</p> <p><i>Inpatient Facility</i></p> <p><i>Outpatient Facility</i></p> <p><i>Emergency Room/Urgent Care Facility (billed by the facility as part of the ER visit)</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. 	<p>No charge</p> <p>No charge</p> <p>No charge</p> <p>100%</p>	<p>80% after plan deductible</p> <p>80% after plan deductible</p> <p>No charge (unless not a true emergency then 80% after scan deductible and plan deductible)</p> <p>80% after plan deductible</p>
<p>Outpatient Short-Term Rehabilitative Therapy 60 days combined maximum per calendar year</p> <p>Includes:</p> <ul style="list-style-type: none"> Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy 	<p>No charge after PCP or Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only x-ray and/or lab services are performed and billed.</p> <p>Note: Outpatient Short Term Rehab copay applies, regardless of place of service, including the home.</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>80% after plan deductible</p>

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Chiropractic Care Services \$1,500 maximum per calendar year	No charge after PCP or Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only x-ray and/or lab services are performed and billed	80% after plan deductible
Home Health Care Unlimited days maximum per calendar year (includes outpatient private duty nursing when approved as medically necessary) Note: 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).	No charge	\$100 deductible, plus 20% of charges
Hospice <i>Inpatient Services</i> <i>Outpatient Services</i>	No charge Note: If plan includes inpatient hospital facility copay, the inpatient hospital facility copay does not apply. No charge	80% after plan deductible Note: If plan includes an inpatient hospital facility deductible, the inpatient hospital facility deductible does not apply. 80% after plan deductible
Bereavement Counseling <i>Services provided as part of Hospice Care</i> <i>Inpatient (same coinsurance level as Inpatient Hospice Facility)</i> <i>Outpatient (same coinsurance level as Outpatient Hospice)</i> <i>Services provided by Mental Health Professional</i>	No charge No charge Covered under Mental Health benefit	80% after plan deductible 80% after plan deductible Covered under Mental health benefit
Maternity Care Services <i>Initial Visit to Confirm Pregnancy</i> Note: OB-GYN visits will be subject to either the PCP or Specialist copay depending on how the provider contracts with CIGNA (i.e. as a PCP or as a Specialist). <i>All Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges (i.e. global maternity fee)</i> <i>Office Visits in addition to the global maternity fee when performed by an OB or Specialist</i> <i>Delivery – Facility (Inpatient Hospital)</i>	No charge after PCP or Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only x-ray and/or lab services are performed No charge No charge after the PCP or Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only x-ray and/or lab services are performed 100% after \$200 per admission copay	80% after plan deductible 80% after plan deductible 80% after plan deductible 80% after plan deductible
Abortion <i>Includes elective and non-elective procedures</i> <i>Inpatient Facility</i>	100% after \$200 per admission copay	80% after plan deductible copay

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<i>Outpatient Surgical Facility</i>	100% coinsurance	80% after plan deductible
<i>Physician's Office</i>	No charge after \$20 per office visit copay	80% after plan deductible
<i>Outpatient Professional Services</i>	No charge	80% after plan deductible
<i>Inpatient Professional Services</i>	No charge	80% after plan deductible
Family Planning Services <i>Office Visits, Lab and Radiology Tests and Counseling</i> <i>Maximum: subject to plan's Preventive Care dollar maximum</i>	No charge after the PCP or Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only x-ray and/or lab services are performed and billed.	80% after plan deductible
Note: The standard benefit will include coverage for contraceptive devices (e.g. Depo-Provera, Norplant and Intrauterine Devices (IUDs). Diaphragms will also be covered when services are provided in the physician's office.	Note: Charges billed by an independent x-ray/lab facility or outpatient hospital will be covered under the plan's x-ray/lab benefit.	
<i>Surgical Sterilization Procedure for Vasectomy/Tubal Ligation (excludes reversals)</i>		
<i>Inpatient Facility</i>	100% after \$200 per admission copay	80% after plan deductible
<i>Outpatient Facility</i>	100% coinsurance	80% after plan deductible
<i>Inpatient Physician's Services</i>	No charge	80% after plan deductible
<i>Outpatient Physician's Services</i>	No charge	80% after plan deductible
<i>Physician's Office</i>	No charge after the PCP or Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only x-ray and/or lab services are performed and billed.	80% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Infertility Treatment - Optional Buy-up Benefit #2</p> <p>Coverage will be provided for the following services:</p> <ul style="list-style-type: none"> • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). <p>Artificial Insemination, In-vitro, GIFT, ZIFT, etc).</p> <p><i>Office Visit (Lab and Radiology Test, Counseling)</i></p> <p><i>Inpatient Facility</i></p> <p><i>Outpatient Facility</i></p> <p><i>Physician Services</i></p> <p>Unlimited lifetime maximum per member Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility).</p>	<p>No charge after the PCP or Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only x-ray and/or lab services performed.</p> <p>Note: Charges billed by an independent x-ray/lab facility or outpatient hospital will be covered under the plan's x-ray/lab benefit.</p> <p>100% after \$200 per admission copay</p> <p>100% coinsurance</p> <p>No charge</p>	<p>80% after plan deductible</p> <p>80% after plan deductible</p> <p>80% after plan deductible</p> <p>80% after plan deductible</p>
<p>Organ Transplant <i>Includes all medically appropriate, non-experimental transplants</i></p> <p><i>Inpatient Facility</i></p> <p><i>Physician's Services</i></p> <p><i>Travel Services Maximum- only available for Lifesource facilities</i></p>	<p>100% at Lifesource center after \$200 per admission copay, otherwise after \$200 per admission copay</p> <p>100% at Lifesource center; otherwise No charge</p> <p>\$10,000</p>	<p>80% after plan deductible</p> <p>80% after plan deductible</p>
<p>Durable Medical Equipment \$10,000 maximum per calendar year</p>	<p>No charge</p>	<p>80% after plan deductible</p>
<p>External Prosthetic Appliances \$5,000 maximum per calendar year</p>	<p>No charge</p>	<p>80% after plan deductible</p>

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 Surgical Facility</i></p> <p><i>Physician's Services</i></p>	<p>No charge after the PCP or Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only x-ray and/or lab services are performed</p> <p>100% after \$200 per admission copay</p> <p>100% coinsurance</p> <p>No charge</p>	<p>80% after plan deductible</p> <p>80% after plan deductible</p> <p>80% after plan deductible</p> <p>80% after plan deductible</p>
<p>TMJ - Surgical and Non-surgical <i>Provided on a limited, case by case basis. Always exclude 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 Surgical Facility</i></p> <p><i>Physician's Services</i></p>	<p>No charge after the PCP or Specialist per office visit copay; No charge after the PCP or Specialist per visit copay if only x-ray and/or lab services are performed and billed.</p> <p>100% after \$200 per admission copay</p> <p>100% coinsurance</p> <p>No charge</p>	<p>80% after plan deductible</p> <p>80% after plan deductible</p> <p>80% after plan deductible</p> <p>80% after plan deductible</p>
<p>Obesity/Bariatric Surgery Rider 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>Note: Coverage is provided subject to medical necessity and clinical guidelines.</p>	

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<i>Doctor's Office</i>	No charge after PCP or Specialist office visit copay; No charge after the PCP or Specialist per visit copay if only x-ray and/or lab services performed and billed.	80% after plan deductible
<i>Inpatient Facility</i>	100% after \$200 per admission copay	80% after plan deductible
<i>Outpatient Facility</i>	100% coinsurance	80% after plan deductible
<i>Physician's Services</i>	No charge	80% after plan deductible
<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>Vision Care</i> <i>Eye exam every 24 month period</i> <i>Eye Glasses/Contact Lenses not covered</i>	\$10 copayment per visit	80% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<i>Mental Health/Substance Abuse</i>	<p><i>Please note the following regarding Mental Health (MH) and Substance Abuse (SA) benefit administration:</i></p> <ul style="list-style-type: none"> • Substance Abuse includes Alcohol and Drug Abuse services. • Transition of Care benefits are provided for a 90-day time period. 	
<p><i>Mental Health and Substance Abuse (Combined)</i></p> <p><i>Inpatient</i></p> <p><u><i>Mental Health</i></u> 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><u><i>Substance Abuse (Alcohol & Drug)</i></u> 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></p> <p><i>Outpatient Group Therapy Mental Health (One group therapy session equals one individual therapy session)</i></p> <p><i>Intensive Outpatient</i> Maximum: up to 3 programs per calendar year Based on a ratio of 1:1</p>	<p>No charge after \$200 per admission deductible</p> <p>No charge after \$20 per visit copay</p> <p>No charge after \$20 per visit copay</p> <p>100% after \$100 per program copay</p>	<p>80% after plan deductible</p> <p>80% after plan deductible copay</p> <p>Subject to the same coinsurance and medical plan deductible as Outpatient MH visits</p> <p>80% after \$100 per program deductible</p>
<i>MH/SA Service Specific Administration</i>	<p>Partial Hospitalization, Residential Treatment and Intensive Outpatient Programs:</p> <p>The following administration will apply:</p> <ul style="list-style-type: none"> • <i>Partial Hospitalization:</i> MH and/or SA partial hospitalization services maximum is 50% of the inpatient benefit maximum; e.g. day limits are combined (2:1 ratio). The coinsurance level for partial hospitalization services is the same as the coinsurance level for inpatient MH/SA services. • <i>Standard Option for Residential Treatment:</i> MH and/or SA Residential Treatment at 50% of Inpatient benefit; day limits are combined (2:1 ratio). Coverage only if approved through CBH Case Management. • <i>Intensive Outpatient Program (IOP):</i> MH and/or SA Intensive Outpatient Program at 1 to 1 Outpatient visits. Visit limits are combined with Outpatient Visit limits (1:1 ratio). Coverage only if approved through CBH Case Management. 	
<i>MH/SA Utilization Review & Case Management</i>	<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 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.



