

# SUMMARY OF BENEFITS



## *Your CIGNA HealthCare CIGNA Care Network Open Access Plus plan*

### Features that Add Value

- Your plan offers the convenience of **referral-free access** to doctors, and the option to select a **personal Primary Care Physician (PCP)** as your source for routine care and guidance when you need specialized care. As your needs change, so may your choice of doctors. That's why you can change your PCP for any reason.
- In certain areas your employer has selected **CIGNA Care Network®**. If you need certain types of specialty care, you will receive a higher level of in-network benefits when you receive covered services from providers with the CIGNA Care Network designation. CIGNA Care Network designated specialists meet CIGNA HealthCare credentialing standards and additional criteria.
- The CIGNA HealthCare 24-Hour Health Information Line<sup>SM</sup> connects you to **trained nurses** and a **library** of hundreds of recorded programs on important health topics 24 hours a day, seven days a week, from anywhere in the U.S.
- **CIGNA Healthy Rewards®** includes special offers on programs and services designed to enhance your health and wellness. Just call 1.800.870.3470 or visit our web site at [www.cigna.com](http://www.cigna.com).

### Quality Service Is Part of Quality Care

- **Service** is at the heart of everything we do. Our goal is to give you: fast, accurate answers; responsive, courteous and professional assistance; and ease and convenience in finding the information you need to manage your health.
- **www.cigna.com** – Visit our **interactive Web site** to learn more about your plan and get health information, 24 hours a day. Once you enroll, register for [myCIGNA.com](http://myCIGNA.com), our convenient, secure web site that combines helpful easy-to-use tools with personalized benefits information to help you make the most of your plan.
- **We Speak Many Languages<sup>SM</sup>**. We offer Language Line Services so that you can **talk with us** in 150 different languages. Just call Customer Service and ask for an interpreter to assist you.

### It's Your Health

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

- We encourage you to use a **PCP** as a valuable resource and personal health advocate.
- **Preventive care services** for your children through age 2 and any additional preventive care benefits described in the Benefits Highlights.
- **CIGNA Well Informed** provides members with customized medical and wellness information to help them make healthier choices, better understand a diagnosis or treatment, and manage their health. The program includes personalized letters and other educational information to help you improve your health. Only you, your doctor and CIGNA have access to this information.
- **CIGNA Healthy Pregnancies, Healthy Babies®** is designed to help prevent complications during pregnancy and improve the chances for healthy pregnancies and deliveries. The program aims to identify expectant mothers with risk factors, and help them lower their risk of complications with patient education, wellness programs and targeted support from nurse case managers.

### You Can Depend on CIGNA HealthCare

- **Quality comes first.** We select participating providers carefully. And we make sure you have a **wide range** of doctors to choose from.
- **Emergency and urgent care are covered** wherever you go, worldwide, **24 hours a day**. Urgent care centers can take care of your urgent care needs, and your cost is lower.

### It's Your Choice

- When you visit network providers, you get access to quality care at the lowest out-of-pocket costs available under your plan. Your plan also offers the freedom to choose the providers you prefer — even if they aren't part of the network. Your benefits are the highest when you see "participating providers," but you're still covered for visits to other providers. Participating providers charge a discounted rate for CIGNA members. If you use a non-network provider, the provider may bill you for the difference between the billed charge and the allowed amount under your benefit plan, in addition to applicable (higher than in-network) deductibles and coinsurance amounts.

**For Employees of Maricopa County  
Open Access Plus Low Option Plan**

## **Patient Protection and Affordable Care Act Required Notices**

### **Direct Access to Obstetricians and Gynecologists:**

**You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit [www.mycigna.com](http://www.mycigna.com) or contact customer service at the phone number listed on the back of your ID card.**

### **Selection of a Primary Care Provider:**

**Your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, CIGNA may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit [www.mycigna.com](http://www.mycigna.com) or contact customer service at the phone number listed on the back of your ID card.**

**For children, you may designate a pediatrician as the primary care provider.**

## CIGNA CARE NETWORK (CCN)

### Provider Designation – Specialists

#### Designated as CIGNA Care Network (CCN)

##### Specialists Included:

Major Specialties within a CCN geography as follows:

Endocrinology, Allergy/Immunology, Ear/Nose/Throat, Cardiology, General Surgery, Dermatology, Gastroenterology, Hematology/Oncology, OB/GYN, Infectious Disease, Neurology, Nephrology, Ophthalmology, Orthopedics/Surgery, Rheumatology, Cardio-Thoracic Surgery, Neurosurgery, Urology, Colon and Rectal Surgery and Vascular Surgery

**Specialist Benefit Level:** CIGNA Care Network (CCN) Specialist

**Unassessed Specialists:** - Providers who are not one of the major specialties (i.e. PCP, Facilities, Ancillary), or who are not in a CCN activated geography, are not evaluated against the CIGNA Care Network criteria. They are considered unassessed and are available to members at the Non-CIGNA Care Network (Non-CCN) benefit level.

**Specialists Included:** Outside the CCN Geography or not one of the Major Specialties

**Specialist Benefit Level:** Non-CIGNA Care Network (Non-CCN) Specialist

#### Designated as Non-CIGNA Care Network (Non-CCN) Specialist

**Specialists Included:** Major Specialties within a CCN geography

**Specialist Benefit Level:** Non-CIGNA Care Network (Non-CCN) Specialist

BENEFIT INFORMATION	IN-NETWORK	OUT-OF-NETWORK
<b>Contract Year Plan Deductible</b>		
<i>Individual</i>	\$500	\$1,000
<i>Family Maximum</i>	\$1,000	\$2,000
<b>Contract Year Out-of-Pocket Maximum</b>		
<i>Individual</i>	Excludes Plan Deductible \$5,000	Excludes Plan Deductible \$10,000
<i>Family Maximum</i>	\$10,000	\$20,000
<b>Coinsurance</b>	<b>Standard Plan:</b> CIGNA HealthCare pays 90% of eligible charges. You pay 10% of charges after plan deductible. <b>CCN Specialists:</b> CIGNA HealthCare pays 90% of eligible charges. You pay 10% of charges after plan deductible. <b>Non – CCN Specialists:</b> CIGNA HealthCare pays 90% of eligible charges. You pay 10% of charges after plan deductible.	CIGNA HealthCare pays 70% of eligible charges. You pay 30% of charges after plan deductible.
<b>Precertification -Inpatient – PHS+ (required for all inpatient admissions)</b>	Coordinated by your physician	Participant must obtain approval for inpatient admission; subject to penalty/reduction or denial for non-compliance
<b>Precertification – Outpatient – PHS+ (required for selected outpatient procedures and diagnostic testing or outpatient services)</b>	Coordinated by your physician	Participant must obtain approval for selected outpatient procedures and diagnostic testing; subject to penalty/reduction or denial for non-compliance.
<b>Lifetime Maximum</b>	Unlimited	Unlimited
<b>Pre-existing Condition Limitation</b>	Yes Not applicable to anyone under 19 years old.  Applies to anyone injury or sickness that you are diagnosed with and receive treatment for, or incur expenses for during the 90 days before you are insured by these benefits or you begin an eligibility waiting period (whichever is earlier). Please refer to your plan documents for specific details.	Yes

BENEFIT INFORMATION	IN-NETWORK	OUT-OF-NETWORK
<p><b>Physician Services – Primary Care Physician</b>  <b>Primary Care Physician (PCP) Office Visit</b>  <u>Note:</u> A copayment applies for OB/GYN visits. If your doctor is listed as a PCP in the provider directory, you will pay a PCP copayment. If your doctor is listed as a specialist, you will pay the specialist copayment.</p> <p>Second Opinion Consultations performed by the PCP (provided on voluntary basis)</p> <p>Surgery Performed by the PCP in the Physician's Office</p> <p>Allergy Treatment/Injections performed by the PCP</p> <p>Allergy Serum (dispensed by the PCP physician in the office)</p>	<p>\$45 copayment per PCP office visit; No charge after office visit copay if only x-ray and/or lab services performed and billed.</p> <p>\$45 copayment per office visit</p> <p>\$45 copayment per office visit</p> <p>\$23 copayment per office visit</p> <p>No charge, no plan deductible</p>	<p>30% of charges**</p> <p>30% of charges**</p> <p>30% of charges**</p> <p>30% of charges**</p> <p>30% of charges**</p>
<p><b>Physician Services – Specialist</b>  <b>Specialist Physician Office Visit</b>  Consultant and Referral Physician Services  <u>Note:</u> A copayment applies for OB/GYN visits. If your doctor is listed as a PCP in the provider directory, you will pay a PCP copayment. If your doctor is listed as a specialist, you will pay the specialist copayment.</p> <p>Second Opinion Consultations performed by the Specialist (provided on voluntary basis)</p> <p>Surgery Performed by the Specialist in the Physician's Office</p> <p>Allergy Treatment/Injections performed by the Specialist</p> <p>Allergy Serum (dispensed by physician in office)</p>	<p>\$60 copayment per CCN Specialist office visit;  \$75 copayment per Non-CCN Specialist office visit  No charge after office visit copay if only x-ray and/or lab services performed and billed.</p> <p>\$60 copayment per CCN Specialist office visit;  \$75 copayment per Non-CCN Specialist office visit</p> <p>\$60 copayment per CCN Specialist office visit;  \$75 copayment per Non-CCN Specialist office visit</p> <p>\$23 copay per CCN Specialist office visit;  \$38 copay per Non-CCN Specialist office visit</p> <p>No charge, no plan deductible</p>	<p>30% of charges**</p> <p>30% of charges**</p> <p>30% of charges**</p> <p>30% of charges**</p> <p>30% of charges**</p> <p>30% of charges**</p> <p>30% of charges**</p>
<p><b>Preventive Care</b>  Routine Preventive Care – Well Baby, Well Child Care, Adult Care and Well Woman (including immunizations)</p> <p>Immunizations</p>	<p>No charge, no plan deductible</p> <p>No charge, no plan deductible</p>	<p>Covered in-network only</p> <p>Covered in-network only</p>
<p><b>Convenience Care Visit</b></p>	<p>\$35 copayment per office visit</p>	<p>30% of charges**</p>
<p><b>Preventive Mammograms, PSA, Pap Test</b></p> <p><b>Diagnostic Mammograms, PSA, Pap Test</b>  <u>Note:</u> 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>No charge, no plan deductible</p> <p>10% of charges*</p>	<p>Covered in-network only</p> <p>30% of charges**</p>
<p><b>Inpatient Hospital Services including:</b>  Semi-Private Room and Board  Diagnostic/Therapeutic Lab and X-ray  Drugs and Medication  Operating and Recovery Room  Radiation Therapy and Chemotherapy  Anesthesia and Inhalation Therapy  (MRIs, MRAs, CAT Scans, PET Scans, etc.)</p>	<p>\$500 copayment per admission, plus 10% of charges*</p>	<p>\$1,000 deductible per admission, plus 30% of charges*</p> <p>Precertification required</p>
<p><b>Inpatient Hospital Doctor's Visits/Consultations</b></p>	<p>PCP: 10% of charges*  CCN Specialist: 10% of charges*  Non-CCN Specialist: 10% of charges*</p>	<p>30% of charges**  30% of charges**  30% of charges**</p>
<p><b>Inpatient Hospital Professional Services</b>  (Surgeon, Radiologist, Pathologist, Anesthesiologist)</p>	<p><b>Surgeon:</b></p> <ul style="list-style-type: none"> <li>• CCN Specialist: 10% of charges*</li> <li>• Non-CCN Specialist: 10% of charges*</li> </ul> <p><b>Radiologist, Pathologist, Anesthesiologist</b></p> <ul style="list-style-type: none"> <li>• Non-CCN Specialist: 10% of charges*</li> </ul>	<p>30% of charges**  30% of charges**  30% of charges**</p>

BENEFIT INFORMATION	IN-NETWORK	OUT-OF-NETWORK
<p><b>Outpatient Facility Services includes:</b>  <i>Operating Room, Recovery Room, Procedure Room and Treatment Room and Observation Room including:</i>  <i>Diagnostic/Therapeutic Lab and X-rays</i>  <i>Anesthesia and Inhalation Therapy</i>  <b>Note:</b> <i>Non-surgical treatment procedures are not subject to the facility copay.</i></p>	\$500 copayment per facility visit, plus 10% of charges*	\$1,000 deductible per facility visit, plus 30% of charges**
<p><b>Outpatient Professional Services</b>  <i>(Surgeon, Radiologist, Pathologist, Anesthesiologist)</i></p>	<p><b>Surgeon:</b></p> <ul style="list-style-type: none"> <li>• CCN Specialist: 10% of charges*</li> <li>• Non-CCN Specialist: 10% of charges*</li> </ul> <p><b>Radiologist, Pathologist, Anesthesiologist</b></p> <ul style="list-style-type: none"> <li>• Non-CCN Specialist: 10% of charges*</li> </ul>	<p>30% of charges**  30% of charges**  30% of charges**</p>
<p><b>Laboratory and Radiology Services (includes preadmission testing)</b>  <i>Physician's Office</i></p> <p><i>Outpatient Hospital Facility</i></p> <p><i>Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit)</i></p> <p><i>Independent X-Ray and/or Lab Facility</i>  <i>Independent X-Ray and/or Lab Facility (in conjunction with an Emergency Room visit)</i></p>	<p>\$45 copayment per PCP office visit; or \$60 copayment per CCN Specialist office visit;  \$75 copayment per Non-CCN Specialist office visit</p> <p>10% of charges*</p> <p>No charge</p> <p>10% of charges*  No charge</p>	<p>30% of charges**  30% of charges**</p> <p>30% of charges**</p> <p>30% of charges**</p> <p>No charge</p> <p>30% of charges**  No charge</p>
<p><b>Advanced Radiological Imaging</b>  <i>(MRIs, MRAs, CAT Scans, PET Scans, etc.)</i></p> <p><i>Outpatient Facility</i></p> <p><i>Emergency Room (billed by facility as part of the Emergency Room visit)</i></p> <p><i>Physician's Office</i></p>	<p>10% of charges*</p> <p>No charge</p> <p>No charge</p>	<p>30% of charges**</p> <p>No charge</p> <p>30% of charges**</p>
<p><b>Short-Term Rehabilitative Therapy and Chiropractic Services--(includes physical, speech, occupational, chiropractic, pulmonary rehab &amp; cognitive therapy)</b>  120 days maximum per contract year# for all therapies combined</p> <p><b>Note:</b> <i>therapy sessions provided as part of Home Health Care accumulate to the Short-Term Rehab Therapy maximum.</i></p> <p><b>Outpatient Cardiac Rehabilitation –</b>  up to 36 days maximum per contract year#</p>	<p>\$45 copayment per office visit  No charge after office visit copay if only x-ray and/or lab services performed and billed.</p> <p>\$45 copayment per office visit</p>	<p>30% of charges**</p> <p>30% of charges**</p>
<p><b>Emergency and Urgent Care Services</b>  <i>Physician's Office – PCP or Specialist Physician</i></p> <p><i>Hospital Emergency Room</i></p> <p><i>Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician)</i></p> <p><i>Urgent Care Facility or Outpatient Facility</i></p> <p><i>Ambulance</i></p>	<p>\$45 copayment per PCP office visit; or \$60 copayment per CCN Specialist office visit;  \$75 copayment per Non-CCN Specialist office visit  No charge after office visit copay if only x-ray and/or lab services performed and billed.</p> <p>\$175 copayment per visit (<i>copay waived if admitted</i>)</p> <p>No charge</p> <p>\$75 copayment per visit (<i>copay waived if admitted</i>)</p> <p>10% of charges*</p>	

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p><b>Maternity Care Services</b>  <i>Initial Office Visit to Confirm Pregnancy</i>  <b>Note:</b> A copayment applies for OB/GYN visits. If your doctor is listed as a PCP in the provider directory, you will pay a PCP copayment. If your doctor is listed as a specialist, you will pay the specialist copayment.</p> <p><i>All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (total maternity fee)</i></p> <p><i>Office Visits not included in the total maternity fee performed by OB or Specialty Physician</i></p> <p><i>Delivery - Facility (Inpatient Hospital/Birthing Center Charges)</i></p>	<p>\$45 copayment per PCP office visit; or \$60 copayment per CCN Specialist office visit;  \$75 copayment per Non-CCN Specialist office visit  No charge after office visit copay if only x-ray and/or lab services performed and billed.</p> <p>CCN Specialist: 10% of charges*  Non-CCN Specialist: 10% of charges*</p> <p>\$45 copayment per PCP office visit; or \$60 copayment per CCN Specialist office visit;  \$75 copayment per Non-CCN Specialist office visit  No charge after office visit copay if only x-ray and/or lab services performed and billed.</p> <p>\$500 copayment per admission, plus 10% of charges*</p>	<p>30% of charges**  30% of charges**</p> <p>30% of charges**</p> <p>30% of charges**  30% of charges**</p> <p>30% of charges**  30% of charges**</p> <p>\$1,000 deductible per admission, plus 30% of charges*, precertification required</p>
<p><b>Inpatient Services at Other Health Care Facilities</b>  <i>Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities-</i>  90 days maximum per contract year# combined for all facilities listed</p>	<p>10% of charges*</p>	<p>30% of charges**</p>
<p><b>Home Health Services</b> – Includes outpatient private duty nursing when approved as medically necessary  Unlimited day maximum per contract year; 16 hour maximum per day#</p>	<p>10% of charges*</p>	<p>30% of charges**</p>
<p><b>Family Planning Services</b>  <i>Office Visits (lab &amp; radiology tests, counseling)</i></p> <p><i>Vasectomy/Tubal Ligation (excludes reversals)</i>  <i>Inpatient Facility</i></p> <p><i>Outpatient Facility</i></p> <p><i>Inpatient/Outpatient Physician's Services</i></p> <p><i>Physician's Office</i></p>	<p>\$45 copayment per PCP office visit; or \$60 copayment per CCN Specialist office visit;  \$75 copayment per Non-CCN Specialist office visit  No charge after office visit copay if only x-ray and/or lab services performed and billed.</p> <p>\$500 copayment per admission, plus 10% of charges*</p> <p>\$500 copayment per facility visit, plus 10% of charges*</p> <p>CCN Specialist: 10% of charges*  Non-CCN Specialist: 10% of charges*</p> <p>\$45 copayment per PCP office visit; or \$60 copayment per CCN Specialist office visit;  \$75 copayment per Non-CCN Specialist office visit  No charge after office visit copay if only x-ray and/or lab services performed and billed.</p>	<p>Covered in-network only  Covered in-network only</p> <p>Covered in-network only</p> <p>\$1,000 deductible per admission, plus 30% of charges*, precertification required</p> <p>\$1,000 deductible per facility visit, plus 30% of charges**</p> <p>30% of charges**  30% of charges**</p> <p>30% of charges**  30% of charges**</p>

<b>BENEFIT HIGHLIGHTS</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Infertility Services</b> <i>Office Visit (lab &amp; radiology tests, counseling)-PCP or Specialist Physician</i>	\$45 copayment per PCP office visit; or \$60 copayment per CCN Specialist office visit; \$75 copayment per Non-CCN Specialist office visit No charge after office visit copay if only x-ray and/or lab services performed and billed.	Covered in-network only Covered in-network only  Covered in-network only
<i>Treatment/Surgery (includes artificial insemination) (excludes in-vitro fertilization, GIFT, ZIFT, etc.) Inpatient Facility</i>	\$500 copayment per admission, plus 10% of charges*	Covered in-network only
<i>Outpatient Facility</i>	\$500 copayment per facility visit, plus 10% of charges*	Covered in-network only
<i>Inpatient/Outpatient Physician's Services</i>	CCN Specialist: 10% of charges* Non-CCN Specialist: 10% of charges*	Covered in-network only Covered in-network only
<b>TMJ - Surgical and Non-Surgical</b>	Not covered	Not covered
<b>Hearing Services (all providers covered)</b>	\$75 copayment per Non-CCN Specialist office visit	30% of charges**
<b>Hearing Aids -- \$2,000 maximum per ear per member every 3 years</b>	No charge*	30% of charges**
<b>Durable Medical Equipment</b> Unlimited maximum per contract year	\$75 copayment per item, plus 10% of charges*	30% of charges**
<b>Consumable Medical Supplies</b>	10% of charges*	30% of charges**
<b>External Prosthetic Appliances</b> Unlimited maximum per contract year	10% of charges*	30% of charges**
<b>Mental Health and Substance Abuse Rehabilitative Services</b>	Carved out to Magellan	
<b>Prescription Drugs</b>	Carved out to Walgreen's Health Initiatives	

\*Services are subject to contract year deductible

\*\*Out-of-network services are subject to the contract year deductible and maximum reimbursable charge limitations. Providers may bill the member the difference between their billed charge and the maximum reimbursable charge as determined by the benefit plan.

# In-network and out-of-network services apply to the same treatment or dollar maximum.

**Footnotes:**

**Regarding In-Network and Out-of-Network Services:**

- Once the out-of-pocket maximum is reached, the plan pays 100% of eligible charges for the remainder of the plan year.

**Regarding In-Network Services:**

- All services must be provided by one of the participating providers on our list in order to be covered.

**Regarding Out-of-Network Services:**

- Your out-of-pocket costs will be higher than with a participating provider.
- All out-of-network hospital admissions and certain outpatient surgical and diagnostic procedures must be precertified and are subject to Continued Stay Review (CSR). A penalty applies to admissions which are not precertified. Non-approved admissions/days result in denial of benefits. The precertification penalty or cost of denied benefits does not apply to deductible or out-of-pocket maximum.

**Case Management**

Coordinated by CIGNA HealthCare. This is a service designed to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

**Benefit Exclusions (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):

- 1.
2. Any service or supply not described as covered in the Covered Expenses section of the plan.
3. Any medical service or device that is not medically necessary.
4. Treatment of an illness or injury which is due to war or care for military service disabilities treatable through governmental services.
5. Any services and supplies for or in connection with experimental, investigational or unproven services.
6. Treatment of TMJ disorder.

**Benefit Exclusions-Continued:**

7. Dental treatment of the teeth, gums or structures directly supporting the teeth, however, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within 6 months of the accident.
8. Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, including clinically severe (morbid) obesity, including: 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; and weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.
9. 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.
10. Court ordered treatment or hospitalizations.
11. Infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
12. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction.
13. Medical and hospital care and costs for the child of a Dependent, unless this infant child is otherwise eligible under the plan.
14. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance.
15. Consumable medical supplies other than ostomy supplies and urinary catheters.
16. Private hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
17. Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
18. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
19. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
20. 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 the plan.
21. Routine foot care, however, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.
22. Genetic screening or pre-implantation genetic screening.
23. Fees associated with the collection or donation of blood or blood products.
24. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
25. All nutritional supplements and formulae are excluded, except infant formula needed for the treatment of inborn errors of metabolism.
26. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
27. Mental Health and Substance Abuse services.
28. Expenses incurred for medical treatment for a person age 65 or older, who is covered under the plan as a retiree, or his dependent, when payment is denied by the Medicare plan because treatment was not received from a participating provider of the Medicare plan.
29. 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.
30. The following services are excluded from coverage regardless of clinical indications: Cosmetic Surgery and Therapies; Macromastia or Gynecomastia Surgeries; Abdominoplasty/Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant Skin Surgery; Removal of Skin Tags; Dance Therapy, Movement Therapy; Applied Kinesiology; Rolfing; Prolotherapy; Transsexual Surgery; Non-medical counseling or ancillary services; Assistance in the activities of daily living; Cosmetics; Personal or Comfort Items; Dietary Supplements; Health and Beauty Aids; Aids or devices that assist with non-verbal communications; Dental implants for any condition; Telephone Consultations; E-mail & Internet Consultations; Telemedicine; Health Club Membership fees; Weight Loss Program fees; Smoking Cessation Program fees; Reversal of male and female voluntary sterilization procedures; and Extracorporeal Shock Wave Lithotripsy for musculoskeletal and orthopedic conditions.

**These Are Only the Highlights**

*As you can see, the plan is designed to combine in-depth coverage with cost-effective prices. This summary contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations including legislated benefits are contained in the Summary Plan Description or Insurance Certificate. This plan is insured and/or administered by Connecticut General Life Insurance Company, a CIGNA Company.*

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