

This is a summary of benefits for your Open Access Plus In Network Copay plan. All CIGNA Pharmacy deductibles, out-of-pocket maximums, copays and annual maximums do not integrate with the employer medical program.

CIGNA HealthCare Benefit Summary	
Charlotte County Board of Commissioners	
Effective January 1, 2010	
Open Access Plus In-Network Copay Plan(HMO) Low Option	
BENEFIT HIGHLIGHTS	IN-NETWORK
Lifetime Maximum	Unlimited
Coinsurance Levels	100%
Calendar Year Deductible	
<i>Individual</i>	None
<i>Family Maximum</i>	None
<i>Family Maximum Deductible Calculation</i>	Individual Deductible
Out-of-Pocket Maximum Accumulators	
<i>Includes Deductible</i>	Yes
<i>Includes Copays</i>	Yes
<i>Does not apply to</i>	Non-compliance penalties.
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>	\$1,500 per person
<i>Family Maximum</i>	\$3,000 per family
<i>Family Maximum OOP Calculation</i>	Individual OOP
Automated Annual Reinstatement	Not Applicable
Physician's Services	
<i>Primary Care Physician's Office visit</i>	No charge after \$25 PCP per office visit copay; No charge after the PCP per visit copay if only x-ray and/or lab services performed and billed.
<i>Specialty Care Physician's Office Visit</i> <i>Office Visits</i> <i>Consultant and Referral Physician's Services</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).	No charge after \$35 Specialist per office visit copay; No charge after the Specialist per visit copay if only x-ray and/or lab services performed and billed.
<i>Surgery Performed In the Physician's Office</i>	No charge after the PCP or Specialist per office visit copay
<i>Second Opinion Consultations (services will be provided on a voluntary basis)</i>	No charge after the PCP or Specialist per office visit copay
<i>Allergy Treatment/Injections</i>	No charge
<i>Allergy Serum (dispensed by the physician in the office)</i>	No charge

BENEFIT HIGHLIGHTS	IN-NETWORK
<p>Preventive Care <i>Routine Preventive Care for children through age 15 (including immunization)</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><i>Immunizations</i></p>	<p>No charge; no plan deductible</p>
<p><i>Routine Preventive Care for children and adults from age 16 and above; subject to an unlimited maximum per calendar year (including routine immunization)</i></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>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>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><i>Immunizations</i></p>	<p>No charge; no 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% if billed by an independent diagnostic facility or outpatient hospital.</p> <p>Note: The associated wellness exam will be covered at no charge after the PCP or Specialist per visit copay.</p>
<p>Inpatient Hospital - Facility Services</p>	<p>\$250 per admission copay, then 100%</p>
<p><i>Semi Private Room and Board</i></p>	<p>Limited to semi-private room negotiated rate</p>
<p><i>Private Room</i></p>	<p>Limited to semi-private room negotiated rate</p>
<p><i>Special Care Units (ICU/CCU)</i></p>	<p>Limited to negotiated rate</p>
<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>	<p>\$100 per visit copay, then 100%</p>
<p>Inpatient Hospital Physician's Visits/Consultations</p>	<p>No charge</p>

BENEFIT HIGHLIGHTS	IN-NETWORK
<i>Inpatient Hospital Professional Services</i> <i>Surgeon</i> <i>Radiologist</i> <i>Pathologist</i> <i>Anesthesiologist</i>	No charge
<i>Multiple Surgical Reduction</i>	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.
<i>Outpatient Professional Services</i> <i>Surgeon</i> <i>Radiologist</i> <i>Pathologist</i> <i>Anesthesiologist</i>	No charge
<i>Emergency and Urgent Care Services</i> <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 lab services performed and billed.
<i>Hospital Emergency Room</i>	\$50 per visit copay, then 100%*
<i>Outpatient Professional services (radiology, pathology and ER Physician)</i>	No charge (if the ER facility benefit is subject to 100% coinsurance and per visit copay)
<i>Urgent Care Facility or Outpatient Facility</i>	No charge after \$25 per visit copay*
<i>Ambulance</i>	No charge
	*waived if admitted
<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 charge Note: If plan includes an inpatient hospital copay, the copay does not apply
<i>Laboratory and Radiology Services (includes pre-admission testing)</i>	
<i>Physician's Office</i>	No charge after PCP or Specialist per visit copay
<i>Outpatient Hospital Facility</i>	No charge
<i>Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)</i>	No charge (if ER/UC facility is covered at no charge and per visit copay)
<i>Independent X-ray and/or Lab facility</i>	No charge
<i>Independent X-ray and/or Lab Facility in conjunction with an ER visit</i>	No charge (if ER facility is covered at no charge and per visit copay)
	*waived if admitted
<i>Advanced Radiological Imaging (i.e. MRI's, MRAs, CAT Scans and PET Scans, etc.)</i>	
<i>Inpatient Facility</i>	Same as plan's Inpatient Hospital Facility benefit
<i>Outpatient Facility</i>	No charge

BENEFIT HIGHLIGHTS	IN-NETWORK
<i>Emergency Room/Urgent Care Facility (billed by the facility as part of the ER visit)</i>	100%
<i>Physician's Office</i>	100%
<i>Copay/Deductible (per type of scan per day)</i>	Scan Copay: 100%
Notes: <ul style="list-style-type: none"> The scan copay does not apply to inpatient facility services. Scans are subject to the applicable place of service coinsurance and plan deductible. 	
<i>Outpatient Short-Term Rehabilitative Therapy</i> 90 days combined maximum per calendar year Includes: Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy	No charge after the \$5.00 per office visit copay, No charge after \$5.00 per office visit copay if only x-ray and/or lab services are performed and billed. Note: The Outpatient Short Term Rehab copay does not apply to services provided as part of a Home Health Care visit. 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.
<i>Outpatient Cardiac Rehabilitation</i> Maximum: Up to 36 days per calendar year (maximum may vary based on individual member needs, not to exceed 36 days)	No charge after \$5.00 per office visit copay
<i>Chiropractic Services</i> <i>Office Visit</i> 20 Days maximum per calendar year	No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed.
<i>Home Health Care</i> 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
<i>Hospice</i> <i>Inpatient Services</i>	No charge Note: If plan includes an inpatient hospital copay, the copay does not apply.
<i>Outpatient Services</i>	No charge
<i>Bereavement Counseling</i> <i>Services provided as part of Hospice Care</i> <i>Inpatient</i> <i>Outpatient</i>	No charge No charge
<i>Services provided by Mental Health Professional</i>	Covered under Mental Health benefit

BENEFIT HIGHLIGHTS	IN-NETWORK
<p>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).</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 are performed and billed.</p>
<p><i>All Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges (i.e. global maternity fee)</i></p>	<p>No charge</p>
<p><i>Office Visits in addition to the global maternity fee when performed by an OB or Specialist</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><i>Delivery – Facility (Inpatient Hospital, Birthing Center)</i></p>	<p>\$250 per admission copay, then 100%</p>
<p>Abortion <i>Includes elective and non-elective procedures</i></p>	
<p><i>Inpatient Facility</i></p>	<p>\$250 per admission copay, then 100%</p>
<p><i>Outpatient Surgical Facility</i></p>	<p>\$100 per visit copay, then 100%</p>
<p><i>Physician's Office</i></p>	<p>No charge after the PCP or Specialist per office visit copay</p>
<p><i>Outpatient Professional Services</i></p>	<p>No charge</p>
<p><i>Inpatient Professional Services</i></p>	<p>No charge</p>
<p>Family Planning Services <i>Office Visits, Lab and Radiology Tests and Counseling</i> <i>Maximum: subject to plan's Preventive Care dollar maximum</i> Note: The standard benefit will include coverage for contraceptive devices (e.g. Depo-Provera and Intrauterine Devices (IUDs). Diaphragms will also be covered when services are provided in the physician's office.</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. Note: Preventive care related services and diagnostic related services are paid at the same level of benefits as other xray and lab services, based on place of service.</p>
<p><i>Surgical Sterilization Procedure for Vasectomy/Tubal Ligation (excludes reversals)</i> <i>Inpatient Facility</i></p>	<p>\$250 per admission copay, then 100%</p>
<p><i>Outpatient Facility</i></p>	<p>\$100 per visit copay, then 100%</p>
<p><i>Inpatient Physician's Services</i></p>	<p>No charge</p>
<p><i>Outpatient Physician's Services</i></p>	<p>No charge</p>
<p><i>Physician's Office</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>

BENEFIT HIGHLIGHTS	IN-NETWORK
<p><i>Infertility Treatment - Standard Benefit</i></p> <p>Services not covered include:</p> <ul style="list-style-type: none"> • 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). • Artificial means of becoming pregnant are (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc). <p>Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.</p>	Not Covered
<p><i>Organ Transplant</i> Includes all medically appropriate, non-experimental transplants</p>	
<p><i>Inpatient Facility</i></p>	100% at Lifesource center after \$250 per admission copay, otherwise \$250 per admission copay, then 100%
<p><i>Physician's Services</i></p>	100% at Lifesource center; otherwise No charge
<p><i>Travel Services Maximum- only available for Lifesource facilities</i></p>	\$10,000
<p><i>Durable Medical Equipment</i> Unlimited maximum per calendar year</p>	No charge
<p><i>External Prosthetic Appliances</i> Unlimited maximum per calendar year</p>	No charge
<p><i>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.</p>	
<p><i>Physician's Office</i></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><i>Inpatient Facility</i></p>	\$250 per admission copay, then 100%
<p><i>Outpatient Surgical Facility</i></p>	\$100 per visit copay, then 100%
<p><i>Physician's Services</i></p>	No charge
<p><i>TMJ - Surgical and Non-surgical</i> Provided on a limited, case by case basis. Always exclude appliances and orthodontic treatment. Subject to medical necessity.</p>	

BENEFIT HIGHLIGHTS	IN-NETWORK
<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.
<i>Inpatient Facility</i>	\$250 per admission copay, then 100%
<i>Outpatient Surgical Facility</i>	\$100 per visit copay, then 100%
<i>Physician's Services</i>	No charge
<i>Routine Foot Disorders</i>	Not covered, except for services associated with foot care for diabetes and peripheral vascular disease, when medically necessary.
<i>Prescription Drugs</i> <i>CIGNA Pharmacy Retail Drug Program</i> Generic Push, Incentive Prescription Drug List Includes oral contraceptives and contraceptive devices; lifestyle drugs	\$10 per 30-day supply for generic drugs \$20 per 30-day supply for preferred brand-name drugs \$40 per 30-day supply for non-preferred brand-name drugs
<i>Out-of-Network Pharmacy Coinsurance</i>	In-network coverage only
<i>CIGNA Tel-Drug Mail Order Drug Program</i> Generic Push, Incentive Prescription Drug List Includes oral contraceptives and contraceptive devices; lifestyle drugs	\$20 per 90-day supply for generic drugs \$40 per 90-day supply for preferred brand-name drugs \$80 per 90-day supply for non-preferred brand-name drugs
<i>Mental Health/Substance Abuse</i>	<i>Please note the following regarding Mental Health (MH) and Substance Abuse (SA) benefit administration:</i> <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.
<i>Mental Health</i>	
<i>Inpatient</i> – Unlimited maximum per year	\$250 per admission copay, then 100%
<i>Outpatient Mental Health (includes Individual, Group Therapy and Intensive Outpatient services) – Unlimited maximum per calendar year</i> <i>Physician's Office</i>	No charge after the applicable PCP or Specialist per visit copay
<i>Outpatient Facility</i>	\$100 per visit copay, then 100%
<i>Substance Abuse (Alcohol & Drug)</i>	
<i>Inpatient</i> – Unlimited maximum per calendar year	\$250 per admission copay, then 100%

BENEFIT HIGHLIGHTS	IN-NETWORK
<p>Outpatient Substance Abuse (includes Individual and Intensive Outpatient services) – Unlimited maximum per calendar year</p> <p><i>Physician's Office</i></p>	<p>No charge after the applicable PCP or Specialist per visit copay</p>
<p><i>Outpatient Facility</i></p>	<p>\$100 per visit copay, then 100%</p>
<p>MH/SA Service Specific Administration</p>	<p>Partial Hospitalization, Residential Treatment and Intensive Outpatient Programs:</p> <p>The following administration will apply:</p> <ul style="list-style-type: none"> • Partial Hospitalization and Residential Treatment: Covered as inpatient Mental Health and/or Substance Abuse. • Intensive Outpatient Program (IOP): Covered as outpatient Mental Health and/or Substance Abuse.
	<ul style="list-style-type: none"> • Includes Lifestyle Management Program (Stress Management, Tobacco Cessation and CIGNA's Healthy Steps to Weight Loss)
<p>Pre-existing Condition Limitation (PCL)</p>	<p>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.</p> <p>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).</p>
<p>Pre-Admission Certification - Continued Stay Review Personal Health Solutions+</p> <p>*CIGNA's PAC/CSR is not necessary for Medicare Primary individuals</p>	
<p><i>Inpatient Pre-Admission Certification - Continued Stay Review</i> (required for all inpatient admissions)</p>	<p>Coordinated by Provider/PCP</p>
<p><i>Outpatient Prior Authorization</i> (required for selected outpatient procedures and diagnostic testing)</p>	<p>Coordinated by Provider/PCP</p>
<p>Case Management</p>	<p>Coordinated by CIGNA Healthcare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost-effective care while maximizing the patient's quality of life.</p>

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 "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 "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: Macromastia or Gynecomastia Surgeries; Abdominoplasty; Panniculectomy; Rhinoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; 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. 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.
12. 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.
13. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under "Covered Services and Supplies."
14. Infertility services, 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.
15. Reversal of male and female voluntary sterilization procedures.
16. Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
17. 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.
18. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
19. 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.

20. 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.
21. 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 "Covered Services and Supplies."
22. Private hospital rooms and/or private duty nursing except as provided in the Home Health Services section of "Covered Services and Supplies".
23. 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.
24. Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
25. 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.
26. 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.
27. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
28. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
29. Treatment by acupuncture.
30. 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 "Covered Services and Supplies."
31. 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.
32. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
33. 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.
34. Dental implants for any condition.
35. 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.
36. Blood administration for the purpose of general improvement in physical condition.
37. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
38. Cosmetics, dietary supplements and health and beauty aids.
39. All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
40. 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.
41. 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.
42. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
43. Telephone, e-mail & Internet consultations and telemedicine.
44. 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.