This is a summary of benefits for your Open Access Plus plan. All deductibles and plan out-of-pocket maximums cross accumulate. 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
Charlotte County Board of Commissioners
Effective January 01, 2009
Open Access Plus Copay Plan

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	$5,000,000	$5,000,000
Coinsurance Levels	90%	70%
Maximum Reimbursable Charge *determined based on the lesser of the provider's normal charge for a similar service or supply;* ***or*** • A percentile of charges made by physicians in a given geographic area where it is received. These charges are compiled in a database maintained by a third party. **Note:** The provider may bill the member the difference between the provider's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles, copayments and coinsurance.	Not applicable	110% of Medicare Allowable
Deductible Accumulators	Cross accumulation	
Calendar Year Deductible		
Individual	$200 per person	$200 per person
Family Maximum	$600 per family	$600 per family
Family Maximum Deductible Calculation	Individual Deductible	Individual Deductible
Out-of-Pocket Maximum Accumulators		
Accumulation Between In-network and Out-of-Network OOP Maximum: Cross Accumulation		
Includes Deductible	Yes	Yes
Includes Copays	No	No
Does not apply to Benefits for accident or sickness (excludes mental health, alcohol and drug abuse benefits) are paid at 100% of charges once an individual's out-of-pocket has been reached.	Non-compliance penalties or charges for mental health, alcohol and drug abuse benefits.	Non-compliance penalties or charges for mental health, alcohol and drug abuse benefits or charges in excess of Maximum Reimbursable Charge
Out-of-Pocket Maximum		
Individual	$1,500 per person	$1,500 per person
Family Maximum	$4,500 per family	$4,500 per family
Family Maximum OOP Calculation	Individual OOP	Individual OOP
Automated Annual Reinstatement	Not Applicable	

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician's Services		
Primary Care Physician's Office visit	No charge after $15 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.	70% after plan deductible
Specialty Care Physician's Office Visit *Office Visits* *Consultant and Referral Physician's Services* **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 $15 Specialist per office visit copay; No charge after the Specialist per visit copay if only x-ray and/or lab services performed and billed.	70% after plan deductible
Surgery Performed In the Physician's Office	No charge after the PCP or Specialist per office visit copay	70% after plan deductible
Second Opinion Consultations (services will be provided on a voluntary basis)	No charge after the PCP or Specialist per office visit copay	70% after plan deductible
Allergy Treatment/Injections	No charge after either the PCP or Specialist per office visit copay or the actual charge, whichever is less	70% after plan deductible
Allergy Serum (dispensed by the physician in the office)	No charge	70% after plan deductible
Preventive Care		
Routine Preventive Care for children through age 15 (including immunization)	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. **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.	70%, no deductible
Immunizations	No charge; no plan deductible	

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Routine Preventive Care for children and adults from age16 and above; subject to an unlimited maximum per calendar year (including routine immunization) **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). **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.	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. **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.	In-network coverage only
Immunizations	No charge; no plan deductible	
Mammograms, PSA, Pap Smear **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. **Notes:** • 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.	90% after plan deductible if billed by an independent diagnostic facility or outpatient hospital. **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.	70% after plan deductible
Inpatient Hospital - Facility Services	90% after plan deductible	$300 per admission deductible then 70% after plan deductible
Semi Private Room and Board	Limited to semi-private room negotiated rate	Limited to semi-private room rate
Private Room	Limited to semi-private room negotiated rate	Limited to semi-private room rate
Special Care Units (ICU/CCU)	Limited to negotiated rate	Limited ICU/CCU daily room rate
Outpatient Facility Services *Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room*	90% after plan deductible	70% after plan deductible
Inpatient Hospital Physician's Visits/Consultations	90% after plan deductible	70% after plan deductible
Inpatient Hospital Professional Services *Surgeon* *Radiologist* *Pathologist* *Anesthesiologist*	90% after plan deductible	70% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
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.	
Outpatient Professional Services *Surgeon* *Radiologist* *Pathologist* *Anesthesiologist*	90% after plan deductible	70% after plan deductible
Emergency and Urgent Care Services *Physician's Office*	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	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 70% after plan deductible).
Hospital Emergency Room	90% after plan deductible	90% after plan deductible (except if not a true emergency, then 70% after plan deductible)
Outpatient Professional services (radiology, pathology and ER Physician)	No charge after plan deductible (if the ER facility benefit is subject to 100% coinsurance after the plan deductible and per visit copay)	No charge after plan deductible (if the ER facility benefit is subject to 100% coinsurance after the plan deductible and per visit copay) (except if not a true emergency, then 70% after plan deductible)
Urgent Care Facility or Outpatient Facility	90% after plan deductible	90% after plan deductible (except if not a true emergency, then 70% after plan deductible)
Ambulance	90% after plan deductible	90% after plan deductible (except if not a true emergency, then 70% after plan deductible)
Inpatient Services at Other Health Care Facilities *Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities* 60 days combined maximum per calendar year	90% after plan deductible **Note:** If plan includes an inpatient hospital copay, the copay does not apply	70% after plan deductible **Note:** If plan includes an inpatient hospital deductible, the deductible does not apply
Laboratory and Radiology Services (includes pre-admission testing)		
Physician's Office	No charge after PCP or Specialist per visit copay	70% after plan deductible
Outpatient Hospital Facility	90% after plan deductible	70% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	No charge (if ER/UC facility is covered at no charge after plan deductible and per visit copay)	No charge (if ER/UC facility is covered at no charge after plan deductible and per visit copay) (except if not a true emergency, then 70% after plan deductible)
Independent X-ray and/or Lab facility	90% after plan deductible	70% after plan deductible
Independent X-ray and/or Lab Facility in conjunction with an ER visit	No charge (if ER facility is covered at no charge after plan deductible and per visit copay)	No charge (if ER facility is covered at no charge after plan deductible and per visit copay) (except if not a true emergency, then 70% after plan deductible)
	*waived if admitted	*waived if admitted
Advanced Radiological Imaging (i.e. MRI's, MRAs, CAT Scans and PET Scans, etc.)		
Inpatient Facility	90% after plan deductible	$300 per admission deductible then 70% after plan deductible
Outpatient Facility	90% after plan deductible	70% after plan deductible
Emergency Room/Urgent Care Facility (billed by the facility as part of the ER visit)	100%	100% (unless not a true emergency then 70% after scan deductible and plan deductible)
Physician's Office	100%	70% after plan deductible
Notes: • Scans are subject to the applicable place of service coinsurance and plan deductible.		
Outpatient Short-Term Rehabilitative Therapy 60 days combined maximum per calendar year Includes: Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy	No charge after $5.00 per office visit copay; No charge after $5.00 per visit copay if only x-ray and/or lab services are performed and billed. **Note:** Outpatient Short Term Rehab copay applies, regardless of place of service, including the home. **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.	70% after plan deductible
Chiropractic Services *Office Visit* ***$2500 Maximum per calendar year***	No charge after $15 per office visit copay	70% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Cardiac Rehabilitation 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	70% after plan deductible
Home Health Care 120 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).	90% after plan deductible	70% after plan deductible
Hospice *Inpatient Services*	90% after plan deductible	70% after plan deductible
Outpatient Services	90% after plan deductible	70% after plan deductible
Bereavement Counseling		
Services provided as part of Hospice Care *Inpatient (same coinsurance level as Inpatient Hospice Facility)* *Outpatient (same coinsurance level as Outpatient Hospice)*	 90% after plan deductible 90% after plan deductible	 70% after plan deductible 70% after plan deductible
Services provided by Mental Health Professional	Covered under Mental Health benefit	Covered under Mental health benefit
Maternity Care Services *Initial Visit to Confirm Pregnancy* **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 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.	70% after plan deductible
All Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges (i.e. global maternity fee)	90% after plan deductible	70% after plan deductible
Office Visits in addition to the global maternity fee when performed by an OB or Specialist	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.	70% after plan deductible
Delivery – Facility (Inpatient Hospital, Birthing Center)	90% after plan deductible	$300 per admission deductible then 70% after plan deductible
Abortion *Includes elective and non-elective procedures*		
Inpatient Facility	90% after plan deductible	$300 per admission deductible then 70% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Surgical Facility	90% after plan deductible	70% after plan deductible
Physician's Office	No charge after the PCP or Specialist per office visit copay	70% after plan deductible
Outpatient Professional Services	90% after plan deductible	70% after plan deductible
Inpatient Professional Services	90% after plan deductible	70% after plan deductible
Family Planning Services *Office Visits, Lab and Radiology Tests and Counseling* **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.	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.	In-network coverage only
Surgical Sterilization Procedure *for Vasectomy/Tubal Ligation (excludes reversals)* *Inpatient Facility*	90% after plan deductible	$300 per admission deductible then 70% after plan deductible
Outpatient Facility	90% after plan deductible	70% after plan deductible
Inpatient Physician's Services	90% after plan deductible	70% after plan deductible
Outpatient Physician's Services	90% after plan deductible	70% after plan deductible
Physician's Office	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.	70% after plan deductible
Infertility Treatment - Standard Benefit Services not covered include: • 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). **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.	Not Covered	Not Covered

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Organ Transplant *Includes all medically appropriate, non-experimental transplants*		In-network coverage only
Inpatient Facility	100% at Lifesource center , otherwise 90% after plan deductible	
Physician's Services	100% at Lifesource center; otherwise 90% after plan deductible	
Travel Services Maximum- only available for Lifesource facilities	$10,000	
Durable Medical Equipment	90% after plan deductible	70% after plan deductible
Unlimited maximum per calendar year		
External Prosthetic Appliances	90% after plan deductible	70% after plan deductible
Unlimited maximum per calendar year		
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.		
Physician's Office	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.	70% after plan deductible
Inpatient Facility	90% after plan deductible	$300 per admission deductible then 70% after plan deductible
Outpatient Surgical Facility	90% after plan deductible	70% after plan deductible
Physician's Services	90% after plan deductible	70% after plan deductible
TMJ - Surgical and Non-surgical *Provided on a limited, case by case basis. Always exclude appliances and orthodontic treatment. Subject to medical necessity.*		
Physician's Office	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.	70% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Facility	90% after plan deductible	$300 per admission deductible then 70% after plan deductible
Outpatient Surgical Facility	90% after plan deductible	70% after plan deductible
Physician's Services	90% after plan deductible	70% after plan deductible
Routine Foot Disorders	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.
Prescription Drugs *CIGNA Pharmacy Retail Drug Program* Generic Push, Incentive Prescription Drug List Includes oral contraceptives, contraceptive devices and lifestyle drugs.	$5 per 30-day supply for generic drugs $15 per 30-day supply for preferred brand-name drugs $15 per 30-day supply for non-preferred brand-name drugs	70%
CIGNA Tel-Drug Mail Order Drug Program Generic Push, Incentive Prescription Drug List Includes oral contraceptives, contraceptive devices and lifestyle drugs.	$10 per 90-day supply for generic drugs $30 per 90-day supply for preferred brand-name drugs $30 per 90-day supply for non-preferred brand-name drugs	In-network coverage only
Mental Health/Substance Abuse	***Please note the following regarding Mental Health (MH) and Substance Abuse (SA) benefit administration:*** • Substance Abuse includes Alcohol and Drug Abuse services. • Transition of Care benefits are provided for a 90-day time period.	
Mental Health		
Inpatient **Acute**: based on ratio of 1:1 **Partial**: based on a ratio of 2:1 **Residential**: based on a ratio of 2:1	90% after plan deductible; 30 days combined maximum per calendar year	$300 per admission deductible then 70% after plan deductible; 30 days combined maximum per calendar year
Outpatient	No charge after $15 per visit copay; 20 visits combined maximum per calendar year	70% after plan deductible; 20 visits combined maximum per calendar year
Outpatient Group Therapy Mental Health (One group therapy session equals one individual therapy session)	No charge after $15 per visit copay	Subject to the same coinsurance and medical plan deductible as Outpatient MH visits
Intensive Outpatient Maximum: up to 3 programs per calendar year Based on a ratio of 1:1	50% after $50 per program copay	50% after $50 per program deductible
Substance Abuse		

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Inpatient **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	90% after plan deductible; 30 days combined maximum per calendar year	$300 per admission deductible then 70% after plan deductible; 30 days combined maximum per calendar year
Outpatient	No charge after $15 per visit copay; 20 visits combined maximum per calendar year	70% after plan deductible; 20 visits combined maximum per calendar year
Intensive Outpatient Maximum: up to 3 programs per calendar year Based on a ratio of 1:1	50% after $50 per program copay	50% after $50 per program deductible
MH/SA Service Specific Administration	Partial Hospitalization, Residential Treatment and Intensive Outpatient Programs: The following administration will apply: • ***Partial Hospitalization:*** 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. • ***Standard Option for Residential Treatment:*** 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. • ***Intensive Outpatient Program (IOP):*** 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.	
MH/SA Utilization Review & Case Management	Inpatient and Outpatient Management (CAP):	
	• 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 Management, Tobacco Cessation and CIGNA's Healthy Steps to Weight Loss)	
Pre-existing Condition Limitation (PCL)	Applies to any injury or sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a physician during the 90 days before the earlier of the date a person begins an eligibility waiting period or becomes insured for these benefits. Coverage for the pre-existing condition is excluded until one year of being continuously insured and/or is satisfying a waiting period. Usually the PCL is waived for the initial group, but if not, the insured will receive credit for any portion of the PCL waiting period that was satisfied under the previous plan if they are enrolled in the subsequent plan within 63 days (or the applicable timeframe required per state law).	
Pre-Admission Certification - Continued Stay Review Personal Health Solutions+ *CIGNA's PAC/CSR is not necessary for Medicare Primary individuals		

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Pre-Admission Certification - Continued Stay Review (required for all inpatient admissions)	Coordinated by Provider/PCP	**Mandatory**: Employee is responsible for contacting CIGNA Healthcare. Penalties for non-compliance: • 50% penalty applied to hospital inpatient charges for failure to contact CIGNA Healthcare to precertify admission. • Benefits are denied for any admission reviewed by CIGNA Healthcare and not certified. • Benefits are denied for any additional days not certified by CIGNA Healthcare.
Outpatient Prior Authorization (required for selected outpatient procedures and diagnostic testing)	Coordinated by Provider/PCP	**Mandatory**: Employee is responsible for contacting CIGNA Healthcare. Penalties for non-compliance: • 50% penalty applied to outpatient procedures/diagnostic testing charges for failure to contact CIGNA Healthcare to precertify admission. • Benefits are denied for any outpatient procedures/diagnostic testing reviewed by CIGNA Healthcare and not certified.
Case Management	Coordinated by CIGNA Healthcare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost-effective care while maximizing the patient's quality of life.	

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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; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; 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.

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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

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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.

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