

# SUMMARY OF BENEFITS

*Your CIGNA HealthCare Network and Point of Service plans*

**For Employees and Retirees Under Age 65 That Live in the Service Area of  
The George Washington University**



**CIGNA HealthCare**

## Features that Add Value

- The reassurance of having a **personal Primary Care Physician (PCP)** who is your source for routine care and guidance when you need more than routine care. As your needs change, so may your choice of doctors. That's why you can change your PCP for any reason.
- The CIGNA HealthCare 24-Hour Health Information Line<sup>SM</sup> connects you to **registered 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**<sup>®</sup> includes special offers on many health and wellness programs and services often not covered by traditional benefits plans. Just call 1.800.870.3470 or visit our web site at [www.cigna.com](http://www.cigna.com).
- Our Guest Privileges program **brings** your CIGNA HealthCare **benefits along** when you temporarily relocate or send kids to schools away from home. Call CIGNA HealthCare Member Services to learn more.
- CIGNA Behavioral Health offers you access to **professional consultation** over the phone to **help you** with problems that affect you, your family, or your work.

## 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, our convenient, secure web site that combines WebMD<sup>®</sup> 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 Member Services and ask for an interpreter to assist you.
- Our interactive voice response system helps you find what you need faster over the phone. Use the speech recognition feature for information on your benefits, level of coverage, claims status, and more.

## It's Your Health

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

- **Preventive care services** for every covered family member.
- See a participating OB/GYN – **no referral** required.

- CIGNA Well Aware for Better Health<sup>®</sup> can **help you manage** certain chronic conditions.
- The CIGNA HealthCare Healthy Babies<sup>®</sup> program provides you with information to help you have a **healthy pregnancy** and a **healthy baby**. And there's no copayment for prenatal care office visits after the first visit that confirms you're pregnant.
- **Quality comes first**. We select participating providers carefully. And we make sure you have a **wide range** of PCPs and specialists 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 you pay a lower copayment.

## It's Your Choice

- When your PCP coordinates your care and you visit network providers, you get access to quality care and lower out-of-pocket costs. Your plan also offers the **freedom to choose** the providers you prefer — even if they aren't part of the network. Your benefits are higher when you see participating providers, but you're still covered for visits to other providers.

Benefit Highlights	Network	Point of Service In-Network	Point of Service Out of-Network
<p><b>Physician Services</b> <i>Primary Care Physician (PCP) Office Visit</i></p> <p><i>Specialty Physician Office Visit</i> <i>Consultant and Referral Physician Services</i></p> <p><i>Allergy Treatment/Injections</i> <i>Allergy Serum (dispensed by physician in office)</i></p> <p><b>Second Opinion Consultations (provided on voluntary basis)</b> <i>Adult/Child Medical Care for Illness or Injury – PCP or Specialty Physician</i></p> <p><i>Surgery Performed in the Physician’s Office- PCP or Specialty Physician</i></p>	<p>\$15 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.</p> <p>\$25 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.</p> <p>\$15 or \$25 copayment per office visit or actual charge, whichever is less No charge</p> <p>\$15 or \$25 copayment per office visit</p> <p>\$15 or \$25 copayment per office visit</p> <p>\$15 or \$25 copayment per office visit</p>	<p>\$20 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.</p> <p>\$30 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.</p> <p>\$20 or \$30 copayment per office visit or actual charge, whichever is less No charge</p> <p>\$20 or \$30 copayment per office visit</p> <p>\$20 or \$30 copayment per office visit</p> <p>\$20 or \$30 copayment per office visit</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> <i>Routine Preventive Care – Well Baby, Well Child Care, Adult and Well Woman (including immunizations)</i> <i>Note: Well Woman OB/GYN visits are subject to the Specialist Physician’s office visit copay.</i></p> <p><i>Routine Immunizations and Injections</i></p>	<p>\$15 or \$25 copayment per office visit; No charge if only x-ray and/or lab services performed and billed</p> <p>The office visit copayment will be waived when immunization is the only service provided.</p>	<p>\$20 or \$30 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.</p> <p>The office visit copayment will be waived when immunization is the only service provided.</p>	<p>30% of charges**</p> <p>30% of charges**</p>
<p><b>Routine Mammograms, PSA, Pap Test</b></p>	<p>No charge; Note: \$15 or \$25 copayment per office visit for associated wellness exam</p>	<p>No charge; Note: \$20 or \$30 copayment per office visit for associated wellness exam</p>	<p>30% of charges** the associated wellness exam is not covered.</p>
<p><b>Inpatient Hospital Services – includes</b> <i>Semi-Private Room and Board</i> <i>Diagnostic/Therapeutic Lab and X-ray</i> <i>Drugs and Medication</i> <i>Operating and Recovery Room</i> <i>Radiation Therapy and Chemotherapy</i> <i>Anesthesia and Inhalation Therapy</i></p>	<p>\$200 copayment per admission</p>	<p>90% coinsurance after \$150 per day copay; maximum of 5 days, after deductible</p>	<p>30% of charges** Precertification required</p>
<p><b>Inpatient Hospital Doctor’s Visits/Consultations</b> <i>Inpatient Hospital Professional Services</i></p>	<p>No charge No charge</p>	<p>90% coinsurance, after deductible 90% coinsurance, after deductible</p>	<p>30% of charges** 30% of charges**</p>

Benefit Highlights	Network	Point of Service In-Network	Point of Service Out of-Network
<b>Outpatient Facility Services</b> <i>Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room including: Diagnostic/Therapeutic Lab and X-rays Anesthesia and Inhalation Therapy Physician and Outpatient Professional Services</i>	\$100 copayment per facility visit  No charge	90% coinsurance after \$100 copay, after deductible  90 % coinsurance after deductible	30% of charges**  30% of charges**
<b>Laboratory and Radiology Services (includes preadmission testing)</b> <i>Physician's Office Outpatient Hospital Facility</i>  <i>Emergency Room (billed by facility as part of the Emergency Room visit)</i>  <i>Independent X-Ray and/or Lab Facility Independent X-Ray and/or Lab Facility (in conjunction with an Emergency Room visit)</i>	No charge No charge for facility charges; No charge for outpatient professional charges  No charge  No charge No charge (if ER visits is considered to be a true emergency)	No charge 90% coinsurance for facility charges; 90% coinsurance for outpatient professional charges, after plan deductible  No charge  No charge No charge (if ER visits is considered to be a true emergency)	30% of charges** 30% of charges**  No charge; <i>except if not a true emergency, then not covered</i>  30% of charges** No charge (if ER visits is considered to be a true emergency)
<b>Advanced Radiological Imaging (MRIs, MRAs, CAT Scans, PET Scans, etc.)</b> <i>Inpatient Facility</i>  <i>Outpatient Facility</i>  <i>Emergency Room</i>  <i>Physician's Office</i> <b>Note:</b> <i>The scan copayment will be administered on a per type of scan per day basis</i>	No charge  No charge  No charge  No charge	No charge  90% coinsurance after deductible  No Charge  No Charge	30% of charges**  30% of charges**  30% of charges**; <i>except if not a true emergency, then not covered</i>  30% of charges**
<b>Short-Term Rehabilitative Therapy and Chiropractic Services - (includes cardiac rehab, physical, speech, occupational, chiropractic, pulmonary rehab and cognitive therapy)</b>	\$25 copayment per office visit; No charge if only x-ray and/or lab services performed and billed. 60 visits maximum per contract year for all therapies combined	\$30 copayment per office visit; No charge if only x-ray and/or lab services performed and billed. 60 visits maximum per contract year# for all therapies combined	30% of charges** 60 visits maximum per contract year# for all therapies combined

Benefit Highlights	Network	Point of Service In-Network	Point of Service Out of-Network
<p><b>Emergency and Urgent Care Services</b> <i>Physician's Office-PCP or Specialty 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>\$15 or \$25 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.</p> <p>\$100 copayment per visit (<i>copay waived if admitted</i>)</p> <p>No charge</p> <p>\$50 copayment per visit (<i>copay waived if admitted</i>)</p> <p>No charge</p> <p><b>Note:</b> <i>if not a true emergency, services are not covered</i></p>	<p>\$20 or \$30 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.</p> <p>No Charge after \$100 copayment per visit (<i>copay waived if admitted</i>)</p> <p>90% coinsurance after deductible</p> <p>\$50 copayment per visit (<i>copay waived if admitted</i>)</p> <p>90% coinsurance</p> <p><b>Note:</b> <i>if not a true emergency, services are not covered</i></p>	<p>\$20 or \$30 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.</p> <p>No Charge after \$150 copayment per visit (<i>copay waived if admitted</i>) except if not a true emergency then 70% after deductible</p> <p>No charge</p> <p>\$50 copayment per visit (<i>copay waived if admitted</i>)</p> <p>90% coinsurance (except if not a true emergency, then 70% after deductible)</p>
<p><b>Maternity Care Services</b> <i>Initial Office Visit to Confirm Pregnancy</i></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>\$15 or \$25 copayment for initial office visit</p> <p>No charge</p> <p>\$25 copayment per office visit; No charge if only x-ray and/or lab services performed and billed</p> <p>\$200 copayment per admission</p>	<p>\$20 or \$30 copayment for initial office visit</p> <p>90% coinsurance after deductible</p> <p>\$30 copayment per office visit; No charge if only x-ray and/or lab services performed and billed</p> <p>90% coinsurance after \$150 copayment per day, maximum of 5 days, after deductible</p>	<p>30% of charges**</p> <p>30% of charges**</p> <p>30% of charges**</p> <p>30% of charges**, Precertification required</p>
<p><b>Inpatient Services at Other Health Care Facilities</b> <i>Skilled Nursing, Rehabilitation and Sub-Acute Facilities</i></p>	<p>No charge <i>60 days maximum per contract year for all facilities listed</i></p>	<p>90% coinsurance after deductible <i>60 days maximum per contract year# for all facilities listed</i></p>	<p>30% of charges**, Precertification required <i>60 days maximum per contract year# for all facilities listed</i></p>
<p><b>Home Health Services-</b> <i>Includes outpatient private duty nursing when approved as medically necessary.</i></p>	<p>No charge <i>Unlimited maximum per contract year; 16 hour maximum per day</i></p>	<p>No charge <i>Unlimited maximum per contract year; 16 hour maximum per day</i></p>	<p>30% of charges**</p>

Benefit Highlights	Network	Point of Service In-Network	Point of Service Out-of-Network
<p><b>Family Planning Services</b> Office Visits (tests, counseling) – PCP or Specialty Physician</p> <p>Vasectomy/Tubal Ligation (excludes reversals) Inpatient Facility</p> <p>Outpatient Facility Physician’s Services – Inpatient or Outpatient Physician’s Office</p>	<p>\$15 or \$25 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.</p> <p>\$200 copayment per admission</p> <p>\$100 copayment per facility visit No charge \$15 or \$25 copayment per office visit</p>	<p>\$20 or \$30 copayment per office visit; No charge if only x-ray and/or lab services performed and billed.</p> <p>90% coinsurance after \$150 copayment per day; maximum of 5 days, after deductible</p> <p>90% coinsurance, after deductible 90% coinsurance, after deductible \$20 or \$30 copayment per office visit</p>	<p>30% of charges**</p> <p>30% of charges**, Precertification required</p> <p>30% of charges** 30% of charges** 30% of charges**</p>
<p><b>Infertility Services</b> Office Visit (lab &amp; radiology tests, counseling) – PCP or Specialty Physician</p> <p>Treatment/Surgery (excludes in-vitro fertilization, GIFT, ZIFT, etc.) Inpatient Facility</p> <p>Outpatient Facility Physician’s Services</p>	<p>\$15 or \$25 copayment per office visit; No charge if only x-ray and/or lab services performed and billed</p> <p>\$200 copayment per admission</p> <p>\$100 copayment per facility visit No charge</p>	<p>\$20 or \$30 copayment per office visit; No charge if only x-ray and/or lab services performed and billed</p> <p>90% coinsurance, \$150 copayment per day, limited to \$750 copayment per admission after deductible \$100 copayment per facility visit \$20 or \$30 copayment per visit</p>	<p>30% of charges**</p> <p>30% of charges**, Precertification required</p> <p>30% of charges** 30% of charges**</p>
<p><b>Mental Health</b> Inpatient</p> <p>Acute: Based on a ratio of 1:1 Partial: Based on a ratio of 2:1 Residential: Based on a ratio of 2:1</p> <p>Outpatient – Individual and Group Therapy</p> <p>Intensive Outpatient Mental Health –</p>	<p>\$200 copayment per admission Unlimited maximum per contract year</p> <p>\$25 copayment per office visit Unlimited maximum per contract year</p> <p>\$50 per program copayment up to 3 programs maximum per contract year based on a ratio of 1:1 with outpatient Mental Health visits</p>	<p>\$90% coinsurance after \$150 copayment per day; maximum of 5 days, after deductible; unlimited days</p> <p>\$30 copayment per office visit Unlimited maximum per contract year</p> <p>\$50 per program copayment up to 3 programs maximum per contract year# based on a ratio of 1:1 with outpatient Mental Health visits</p>	<p>50% of charges**</p> <p>70% of charges** Unlimited maximum per contract year</p> <p>\$50 per program deductible up to 3 programs maximum per contract year# based on a ratio of 1:1 with outpatient Mental Health visits</p>

<b>Benefit Highlights</b>	<b>Network</b>	<b>Point of Service In-Network</b>	<b>Point of Service Out of-Network</b>
<p><b>Substance Abuse</b> <i>Inpatient</i></p> <p><i>Acute Detox:</i> Based on a ratio of 1:1 (requires 24 hour nursing) <i>Acute Inpatient Rehab:</i> Based on a ratio of 1:1 (requires 24 hour nursing) <i>Partial:</i> Based on a ratio of 2:1 <i>Residential:</i> Based on a ratio of 2:1</p> <p><i>Outpatient</i></p> <p><i>Intensive Outpatient Substance Abuse –</i></p>	<p>\$200 copayment per admission <i>Unlimited maximum per contract year</i></p> <p>\$25 copayment per office visit <i>Unlimited maximum per contract year</i></p> <p>\$50 per program copayment <i>up to 3 programs maximum per contract year based on a ratio of 1:1 with outpatient Substance Abuse visits</i></p>	<p>\$90% coinsurance after \$150 copayment per day; maximum of 5 days, after deductible <i>unlimited maximum per contract year#</i></p> <p>\$30 copayment per office visit <i>unlimited maximum per contract year#</i></p> <p>\$50 per program copayment <i>up to 3 programs maximum per contract year# based on a ratio of 1:1 with outpatient Substance Abuse visits</i></p>	<p>50% of charges** <i>unlimited maximum per contract year#</i></p> <p>70% of charges** <i>unlimited maximum per contract year#</i></p> <p>\$50 per program deductible <i>up to 3 programs maximum per contract year# based on a ratio of 1:1 with outpatient Substance Abuse visits</i></p>
<b>Durable Medical Equipment</b>	No charge <i>Unlimited maximum benefit per contract year</i>	No charge <i>Unlimited maximum benefit per contract year</i>	<i>In-network coverage only</i>
<b>External Prosthetic Appliances</b>	No charge <i>Unlimited maximum benefit per contract year</i>	No charge <i>Unlimited maximum benefit per contract year</i>	<i>In-network coverage only</i>
<p><b>Prescription Drugs</b> <b><u>Retail Drugs Program</u></b> <i>(administered by AdvancePCS)</i> <i>Member Services Phone Number 877-357-4032</i></p> <p><b><u>Mail Order Drugs Program</u></b></p> <p><b><u>Pharmacy Deductible</u></b></p>	<p>\$5 after pharmacy deductible per 30-day supply for generic drugs \$15 after pharmacy deductible per 30-day supply for brand-name drugs \$25 after pharmacy deductible per 30-day supply for non-preferred brand-name drugs</p> <p>\$15 after pharmacy deductible per 90-day supply for generic drugs \$30 after pharmacy deductible per 90-day supply for brand name drugs \$50 after pharmacy deductible per 90-day supply for non-preferred brand-name drugs</p> <p>\$150</p>	<p>\$5 after pharmacy deductible per 30-day supply for generic drugs \$15 after pharmacy deductible per 30-day supply for brand-name drugs \$25 after pharmacy deductible per 30-day supply for non-preferred brand-name drugs</p> <p>\$15 after pharmacy deductible per 90-day supply for generic drugs \$30 after pharmacy deductible per 90-day supply for brand name drugs \$50 after pharmacy deductible per 90-day supply for non-preferred brand-name drugs</p> <p>\$150</p>	<p>Covered in-network only</p> <p>Covered in-network only</p> <p>Covered in-network only</p> <p>Covered in-network only</p> <p>Covered in-network only</p> <p>Covered in-network only</p>

Other Benefit Information	Network	Point of Service In-Network	Point of Service Out of-Network
<b>Annual Deductible</b> <i>Individual</i> <i>Family</i>	None None	\$300 \$600	\$750 \$1,500
<b>Annual Out-of-Pocket Maximum</b> <i>Individual</i> <i>Family</i>	None None	\$2,500 \$5,000	<b>Excludes Plan Deductible</b> \$5,000 \$10,000
<b>Coinsurance</b>	CIGNA HealthCare pays 100% of eligible charges. You pay 0% of charges.	CIGNA HealthCare pays 100% of eligible charges. You pay 0% of charges.	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	Coordinated by your physician	Coordinated by your physician
<b>Precertification – Outpatient – PHS+ (required for selected outpatient procedures and diagnostic testing)</b>	Coordinated by your physician	Coordinated by your physician	Coordinated by your physician
<b>Lifetime Maximum</b>	Unlimited	Unlimited	Unlimited
<b>Pre-existing Condition Limitation</b>	No	No	No

**\*\* Out-of-network services are subject to contract year deductible and reasonable and customary charge/maximum reimbursable charge limitations  
# Day, visit or dollar maximums apply to In-Network and Out-of-Network services combined.**

**Footnotes:**

**Regarding In-Network Services:**

- All services, except for emergency services, routine care provided by a participating OB/GYN, and inpatient mental health and substance abuse services authorized by CIGNA Behavioral Health, Inc., must be provided by or authorized by your Primary Care Physician (PCP) in order to be covered.

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

- 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.
- Once the out-of-pocket maximum for Out-of-Network is reached, the plan pays 100% of eligible charges for the remainder of the plan year except for Mental Health and Substance Abuse which remain at the levels specified.

## **Mental Health**

All inpatient Mental Health and Substance Abuse benefits are authorized by CIGNA Behavioral Health, Inc., or its affiliates.

### **Benefit Exclusions .**

These are examples of the exclusions in your plan. 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.

1. Any service or supply not described as covered in the Covered Expenses section of the plan.
2. Any medical service or device that is not medically necessary.
3. Treatment of an illness or injury which is due to war or care for military service disabilities treatable through governmental services.
4. Any services and supplies for or in connection with experimental, investigational or unproven services.
5. 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.
6. 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.
7. 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.
8. Court ordered treatment or hospitalizations.
9. 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.
10. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction.
11. Medical and hospital care and costs for the child of a Dependent, unless this infant child is otherwise eligible under the plan.
12. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance.
13. Consumable medical supplies other than ostomy supplies and urinary catheters.
14. Private hospital rooms and/or private duty nursing unless determined to be Medically Necessary by the Medical Director.
15. Artificial aids, including but not limited to hearing aids, semi-implantable hearing devices, audiant bone conductors, bone anchored hearing aids, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
16. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
17. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
18. All non-injectable prescription drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in the plan.
19. Routine foot care, however, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.
20. Genetic screening or pre-implantation genetic screening.
21. Fees associated with the collection or donation of blood or blood products.
22. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
23. All nutritional supplements and formulae are excluded, except infant formula needed for the treatment of inborn errors of metabolism.
24. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.

**Benefit Exclusions – continued:**

25. Expenses incurred for medical treatment by 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.
26. 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.
27. The following services are excluded from coverage regardless of clinical indications: Massage Therapy; Cosmetic Surgery and Therapies; 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; 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; Treatment by Acupuncture; 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.*

*“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, 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.*

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