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

CIGNA HealthCare Benefit Summary
Trustees of IEEE

Open Access Plus Coinsurance Plan

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	**THE PLAN WILL PAY:** $1,000,000	**THE PLAN WILL PAY:** $1,000,000
Coinsurance Levels	**THE PLAN WILL PAY:** 80%	**THE PLAN WILL PAY:** 60% of Maximum Reimbursable Charge
Deductible Accumulators	One-way accumulation of Out-of-network to In-network deductibles	
Calendar Year Deductible	**THE INSURED WILL PAY:**	**THE INSURED WILL PAY:**
Individual	$5,000 per person	$10,000 per person
Family Maximum	$15,000 per family	$30,000 per family
Family Maximum Deductible Calculation	Individual Calculation	Individual Calculation
Out-of-Pocket Maximum Accumulators **Accumulation Between In-network and Out-of-Network OOP Maximum:** One-way accumulation of Out-of-network to In-network Out-of-Pocket Maximums		
Includes Deductible	No	No
Includes Copays	No	No
Does not apply to	Non-compliance penalties, deductibles, copays or charges for outpatient mental health benefits	Non-compliance penalties, deductibles, copays, or charges for outpatient mental health or charges in excess of Maximum Reimbursable Charge
Benefits for accident or sickness (including inpatient mental health, inpatient and outpatient alcohol and drug abuse benefits) are paid at 100% of charges once an individual's out-of-pocket has been reached.		
Out-of-Pocket Maximum	**THE INSURED WILL PAY:**	**THE INSURED WILL PAY:**
Individual	$25,000 per person	$25,000 per person
Family Maximum	$50,000 per family	$50,000 per family
Family Maximum OOP Calculation	Individual Calculation	Individual Calculation

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician's Services	**THE PLAN WILL PAY:**	**THE PLAN WILL PAY:**
Primary Care Physician's Office visit	80% after plan deductible; 80% after plan deductible if only x-ray and/or lab services performed and billed	60% after plan deductible
Specialty Care Physician's Office Visit Office Visits Consultant and Referral Physician's Services	80% after plan deductible; 80% after plan deductible if only x-ray and/or lab services performed and billed	60% after plan deductible
Surgery Performed In the Physician's Office	80% after plan deductible	60% after plan deductible
Second Opinion Consultations (services will be provided on a voluntary basis)	80% after plan deductible	60% after plan deductible
Allergy Treatment/Injections	80% after plan deductible	60% after plan deductible
Allergy Serum (dispensed by the physician in the office)	80% after plan deductible	60% after plan deductible
Preventive Care	**THE PLAN WILL PAY:**	**THE PLAN WILL PAY:**
Routine Preventive Care for children **through age18** (including immunization)	80% after plan deductible; 80% after plan deductible 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.	60% after plan deductible
Immunizations	No charge; no plan deductible	60% after plan deductible
Routine Preventive Care for children and adults **from age19**; Unlimited maximum per calendar year (including routine immunization)	80% after plan deductible; 80% after plan deductible 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.	60% after plan deductible
Immunizations	No charge after deductible	60% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Mammograms and Pap Smear	**THE PLAN WILL PAY:** 100%, no plan deductible for 1st mammogram or pap smear each calendar year 80% after plan deductible for subsequent mammogram or pap smear each calendar year **Note:** The associated wellness exam will be covered at 80% after plan deductible.	**THE PLAN WILL PAY:** 100%, no plan deductible for 1st mammogram or pap smear each calendar year 60% after plan deductible for subsequent mammogram or pap smear each calendar year
PSA	**THE PLAN WILL PAY:** 80% after plan deductible	**THE PLAN WILL PAY:** 60% after plan deductible
Inpatient Hospital - Facility Services	**THE PLAN WILL PAY:** 80% after plan deductible	**THE PLAN WILL PAY:** 60% 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, Procedures Room, Treatment Room and Observation Room	**THE PLAN WILL PAY:** 80% after plan deductible	**THE PLAN WILL PAY:** 60% after plan deductible
Inpatient Hospital Physician's Visits/Consultations	**THE PLAN WILL PAY:** 80% after plan deductible	**THE PLAN WILL PAY:** 60% after plan deductible
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	**THE PLAN WILL PAY:** 80% after plan deductible	**THE PLAN WILL PAY:** 60% after plan deductible
Multiple Surgical Reduction	Multiple surgeries performed during one operating session result in payment reduction of 50% of charges to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.	
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	**THE PLAN WILL PAY:** 80% after plan deductible	**THE PLAN WILL PAY:** 60% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Emergency and Urgent Care Services	**THE PLAN WILL PAY:**	**THE PLAN WILL PAY:**
Physician's Office	80% after plan deductible; 80% after plan deductible if only x-ray and/or lab services performed and billed	80% after plan deductible; 80% after plan deductible if only x-ray and/or lab services performed and billed (except if not a true emergency, then 60% after plan deductible).
Hospital Emergency Room	80% after plan deductible	80% after plan deductible (except if not a true emergency, then 60% after plan deductible)
Outpatient Professional services (radiology, pathology and ER physician)	80% after plan deductible	80% after plan deductible (except if not a true emergency, then 60% after plan deductible)
Urgent Care Facility or Outpatient Facility	80% after plan deductible	80% after plan deductible (except if not a true emergency, then 60% after plan deductible)
Ambulance	80% after plan deductible	80% after plan deductible (except if not a true emergency, then 60% after plan deductible)
Inpatient Services at Other Health Care Facilities	**THE PLAN WILL PAY:**	**THE PLAN WILL PAY:**
Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities **Maximum:** Unlimited days combined per calendar year	80% after plan deductible	60% after plan deductible
Laboratory and Radiology Services (includes pre-admission testing)	**THE PLAN WILL PAY:**	**THE PLAN WILL PAY:**
Physician's Office	80% after plan deductible	60% after plan deductible
Outpatient Hospital Facility	80% after plan deductible	60% after plan deductible
Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	80% after plan deductible	80% after plan deductible (except if not a true emergency, then 60% after plan deductible)
Independent X-ray and/or Lab Facility	80% after plan deductible	60% after plan deductible
Independent X-ray and/or Lab Facility in conjunction with an ER visit	80% after plan deductible	80% after plan deductible (except if not a true emergency, then 60% after plan deductible)

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Advanced Radiological Imaging (i.e. MRI's, MRAs, CAT Scans PET Scans, etc.)	**THE PLAN WILL PAY:**	**THE PLAN WILL PAY:**
Inpatient Facility	80% after plan deductible	60% after plan deductible
Outpatient Facility	80% after plan deductible	60% after plan deductible
Emergency Room/Urgent Care Facility (billed by the facility as part of the ER visit)	80% after plan deductible	80% after plan deductible (unless not a true emergency, then 60% after plan deductible)
Physician's Office	80% after plan deductible	60% after plan deductible
Notes: • Scans are subject to the applicable place of service coinsurance and plan deductible.		
Outpatient Short-Term Rehabilitative Therapy and Chiropractic Care Services **Maximum:** 90 day maximum per calendar year for all therapies combined Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Chiropractic Therapy (includes Chiropractors) Pulmonary Rehab Cognitive Therapy	**THE PLAN WILL PAY:** 80% after plan deductible; 80% after plan deductible if only x-ray and/or lab services performed and billed. **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.	**THE PLAN WILL PAY:** 60% after plan deductible
Home Health Care (includes outpatient private duty nursing when approved as medically necessary) **Maximum:** 90 days per calendar year **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).	**THE PLAN WILL PAY:** 80% after plan deductible	**THE PLAN WILL PAY:** 60% after plan deductible
Hospice	**THE PLAN WILL PAY:**	**THE PLAN WILL PAY:**
Inpatient Services	80% after plan deductible	60% after plan deductible
Outpatient Services	80% after plan deductible	60% after plan deductible
Bereavement Counseling	**THE PLAN WILL PAY:**	**THE PLAN WILL PAY:**
Services provided as part of Hospice Care		
Inpatient	80% after plan deductible	60% after plan deductible
Outpatient	80% after plan deductible	60% after plan deductible
Services provided by Mental Health Professional	Covered under Mental Health benefit	Covered under Mental health benefit

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Maternity Care Services	**THE PLAN WILL PAY:**	**THE PLAN WILL PAY:**
Initial Visit to Confirm Pregnancy	80% after plan deductible; 80% after plan deductible if only x-ray and/or lab services performed and billed.	60% after plan deductible
All Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges (i.e. global maternity fee)	80% after plan deductible	60% after plan deductible
Office Visits in addition to the global maternity fee when performed by an OB or Specialist.	80% after plan deductible; 80% after plan deductibleif only x-ray and/or lab services performed and billed.	60% after plan deductible
Delivery – Facility (Inpatient Hospital, Birthing Center)	80% after plan deductible	60% after plan deductible
Abortion Includes elective and non-elective procedures	**THE PLAN WILL PAY:**	**THE PLAN WILL PAY:**
Inpatient Facility	80% after plan deductible	60% after plan deductible
Outpatient Surgical Facility	80% after plan deductible	60% after plan deductible
Physician's Office	80% after plan deductible	60% after plan deductible
Outpatient Professional Services	80% after plan deductible	60% after plan deductible
Inpatient Professional Services	80% after plan deductible	60% after plan deductible
Family Planning Services	**THE PLAN WILL PAY:**	**THE PLAN WILL PAY:**
Office Visits, Test and Counseling	80% after plan deductible; 80% after plan deductible if only x-ray and/or lab services performed and billed.	60% after plan deductible
Note: The standard benefit will include coverage for contraceptive devices (e.g. Depo-Provera, Norplant and Intrauterine Devices (IUDs). Diaphragms will also be covered when services are provided in the physician's office.	**Note:** Charges billed by an independent x-ray/lab facility or outpatient hospital will be covered under the plan's x-ray/lab benefit.	
Surgical Sterilization Procedures for Vasectomy/Tubal Ligation (excludes reversals)		
Inpatient Facility	80% after plan deductible	60% after plan deductible
Outpatient Facility	80% after plan deductible	60% after plan deductible
Inpatient Physician's Services	80% after plan deductible	60% after plan deductible
Outpatient Physician's Services	80% after plan deductible	60% after plan deductible
Physician's Office	80% after plan deductible; 80% after plan deductible if only x-ray and/or lab services performed and billed.	60% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment - Optional Buy-up Benefit #1 Services not covered include: • In-vitro, GIFT, ZIFT, etc. Coverage will be provided for the following services: • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial Insemination	**THE PLAN WILL PAY:**	In-network coverage only
Office Visit (Lab and Radiology Test, Counseling) **Note:** Charges billed by an independent x-ray/lab facility or outpatient hospital will be covered under the plan's x-ray/lab benefit.	80% after plan deductible; 80% after plan deductible if only x-ray and/or lab services performed and billed.	
Surgical Treatment: Limited to procedures for the correction of infertility (excludes In-vitro, GIFT, ZIFT, etc).		
Inpatient Facility	80% after plan deductible	
Outpatient Facility	80% after plan deductible	
Physician's Services	80% after plan deductible	
Organ Transplant Includes all medically appropriate, non-experimental transplants	**THE PLAN WILL PAY:**	In-network coverage only
Inpatient Facility	100% at Lifesource center; otherwise, 80% after plan deductible	
Physician's Services	100% at Lifesource center; otherwise, 80% after plan deductible	
Travel Services Maximum - only available for Lifesource facilities	$10,000	Not Covered
Durable Medical Equipment Unlimited maximum per calendar year	**THE PLAN WILL PAY:** 80% after plan deductible	**THE PLAN WILL PAY:** 60% after plan deductible
External Prosthetic Appliances Unlimited maximum per calendar year	**THE PLAN WILL PAY:** 80% after plan deductible	**THE PLAN WILL PAY:** 60% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.	**THE PLAN WILL PAY:**	**THE PLAN WILL PAY:**
Doctor's Office	80% after plan deductible; 80% after plan deductible if only x-ray and/or lab services performed and billed.	60% after plan deductible
Inpatient Facility	80% after plan deductible	60% after plan deductible
Outpatient Surgical Facility	80% after plan deductible	60% after plan deductible
Physician's Services	80% after plan deductible	60% after plan deductible
TMJ - Surgical and Non-surgical	Not Covered	Not Covered
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 No Mandatory Generic, Incentive Prescription Drug List Includes oral contraceptives and contraceptive devices	**THE PLAN WILL PAY:** 70% per 30-day supply for generic drugs 60% per 30-day supply for preferred brand-name drugs 50% per 30-day supply for non-preferred brand-name drugs	**THE PLAN WILL PAY:** 60%, no deductible
CIGNA Tel-Drug Mail Order Drug Program No Mandatory Generic, Incentive Prescription Drug List Includes oral contraceptives and contraceptive devices	**THE PLAN WILL PAY:** 75% per 90-day supply for generic drugs 65% per 90-day supply for preferred brand-name drugs 50% per 90-day supply for non-preferred brand-name drugs	In-network coverage only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
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	**THE PLAN WILL PAY:**	**THE PLAN WILL PAY:**
Inpatient (45 day maximum per calendar year) **Acute:** Based on ratio of 1:1 **Partial:** Based on ratio of 2:1 **Residential:** Based on ratio of 2:1	80% after plan deductible	60% after plan deductible
Outpatient (Unlimited visit maximum per calendar year)	Visits 1- 40: 75% after plan deductible Visits 41+: 60% after plan deductible	Visits 1- 40: 75% after plan deductible Visits 41+: 60% after plan deductible
Outpatient Group Therapy (Two group therapy sessions equal one individual therapy session)	Visits 1- 40: 75% after plan deductible Visits 41+: 60% after plan deductible	Visits 1- 40: 75% after plan deductible Visits 41+: 60% after plan deductible
Intensive Outpatient Mental Health Maximum: Up to 3 programs per calendar year Based on ratio of 1:1	$50 per program copay, then 80% no plan deductible	$50 per program deductible, then 60% no plan deductible
Substance Abuse (Alcohol & Drug)	**THE PLAN WILL PAY:**	**THE PLAN WILL PAY:**
Inpatient (30 day maximum per calendar year) **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	80% after plan deductible	60% after plan deductible
Outpatient (Unlimited visits per contract year)	80% after plan deductible	60% after plan deductible
Intensive Outpatient Maximum: Up to 3 programs per calendar year Based on ratio of 1:1	80% no plan deductible	60% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK OUT-OF-NETWORK
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 Inpatient Services and In-network Outpatient Management services. • Includes Lifestyle Management Program (Stress & Tobacco)
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).

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Pre-Admission Certification - Continued Stay Review *CIGNA's PAC/CSR is not necessary for Medicare Primary individuals		
Inpatient Pre-Admission Certification - Continued Stay Review (required for all inpatient admissions)	Coordinated by Provider/PCP	**Mandatory**: Insured 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. • 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**: Insured 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. • 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.	

Medical Benefit Exclusions (*by way of example but not limited to*):

Your plan provides coverage for medically necessary services. Your plan does not provide coverage for the following except as required by law:

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public school system or school district.
3. Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
4. Treatment of an illness or injury which is due to war, declared or undeclared.
5. Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
6. Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
7. Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be: Not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or Not approved by

the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or The subject of review or approval by an Institutional Review Board for the proposed use, except as provided in the "Clinical Trials" section of "Section IV. Covered Services and Supplies;" or The subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of "Section IV. Covered Services and Supplies."

8. Cosmetic Surgery and Therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
9. The following services are excluded from coverage regardless of clinical indications: 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. Treatment of TMJ disorder.
11. 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.
12. 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.
13. 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.
14. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under "Section IV. Covered Services and Supplies."
15. 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. Cryopreservation of donor sperm and eggs are also excluded from coverage.
16. Reversal of male and female voluntary sterilization procedures.
17. Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
18. 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.
19. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
20. 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.
21. 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.
22. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Inpatient Hospital Services," "Outpatient Facility Services," "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of "Section IV. Covered Services and Supplies."
23. Private hospital rooms and/or private duty nursing except as provided in the Home Health Services section of "Section IV. Covered Services and Supplies".
24. 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.
25. Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
26. 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.
27. 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.

28. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
29. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
30. Treatment by acupuncture.
31. All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Section IV. Covered Services and Supplies."
32. 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.
33. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
34. 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.
35. Dental implants for any condition.
36. 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.
37. Blood administration for the purpose of general improvement in physical condition.
38. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
39. Cosmetics, dietary supplements and health and beauty aids.
40. All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
41. 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.
42. 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.
43. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
44. Telephone, e-mail & Internet consultations and telemedicine.
45. 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.