SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.
For - Rocky Hill Board of Education
Open Access Plus Plan

Selection of a Primary Care Provider - your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

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

Plan Highlights	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Coinsurance	Your plan pays 100%	Your plan pays 80%
Maximum Reimbursable Charge	Not Applicable	200%
Calendar Year Deductible	Individual: None Family: None	Individual: $200 Family: $600

- Only the amount you pay for in-network covered expenses counts toward your in-network deductible. The amount you pay for out-of-network covered expenses only counts toward your out-of-network deductible.
- After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan.

Note: Services where plan deductible applies are noted with a caret (^)

Plan Highlights	In-Network	Out-of-Network
Calendar Year Out-of-Pocket Maximum	Individual: $6,350 Family: $12,700	Individual: $1,000 Family: $3,000

- Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. Only the amount you pay for out-of-network covered expenses counts toward your out-of-network out-of-pocket maximum.
- Plan deductible contributes towards your out-of-pocket maximum.
- All copays and benefit deductibles contribute towards your out-of-pocket maximum.
- Mental Health and Substance Use Disorder covered expenses contribute towards your out-of-pocket maximum.
- After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.
- This plan includes a combined Medical/Pharmacy out-of-pocket maximum.
- Retail and home delivery Pharmacy costs contribute to the combined Medical/Pharmacy out-of-pocket.

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^)		
Physician Services		
Physician Office Visit • All services including Lab & X-ray • Plan pays 100% after you pay copay	$25 Primary Care Physician (PCP) copay or $25 Specialist copay	Your plan pays 80% ^
Surgery Performed in Physician's Office	$25 PCP or $25 Specialist copay	Your plan pays 80% ^
Allergy Treatment/Injections	$25 copay or actual charge (if less)	Your plan pays 80% ^
Allergy Serum Dispensed by the physician in the office	Your plan pays 100%	Your plan pays 80% ^
Preventive Care		
Preventive Care	Your plan pays 100%	Your plan pays 80% ^
• Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.		
Immunizations	Your plan pays 100%	Your plan pays 80% ^
Mammogram, PAP, and PSA Tests	Your plan pays 100%	Your plan pays 80% ^
• Coverage includes the associated Preventive Outpatient Professional Services. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.		
Inpatient		
Inpatient Hospital Facility	$100 per day copay up to $300 maximum, then your plan pays 100%	Your plan pays 80% ^
Semi-Private Room: In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate **Private Room:** In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate **Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):** In-Network: Limited to the negotiated rate / Out-of-Network: Limited to ICU/CCU daily room rate		
Inpatient Hospital Physician's Visit/Consultation	Your plan pays 100%	Your plan pays 80% ^

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^)		
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Your plan pays 100%	Your plan pays 80% ^
Outpatient		
Outpatient Facility Services • Non-surgical treatment procedures are not subject to the facility per visit copay/benefit deductible	$150 per facility visit copay, then your plan pays 100%	Your plan pays 80% ^
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Your plan pays 100%	Your plan pays 80% ^
Short-Term Rehabilitation	$25 PCP or $25 Specialist copay	Your plan pays 80% ^
Calendar Year Maximums: • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy and Chiropractic Care – Unlimited days • Cardiac Rehabilitation - 36 days Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.		
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private duty nursing subject to medical necessity) • Unlimited days maximum per Calendar Year • 16 hour maximum per day • Home Health Care deductible is $50 per individual	Your plan pays 100%	Your plan pays 80% after Home Health Care Deductible is met . Home Health Care deductible is $50 per individual
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • 60 days maximum per Calendar Year	Your plan pays 100%	Your plan pays 80% ^
Durable Medical Equipment • Unlimited maximum per Calendar Year	Your plan pays 100%	Your plan pays 80% ^
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician. • Includes related supplies	Your plan pays 100%	Your plan pays 80% ^
External Prosthetic Appliances (EPA) • Unlimited maximum per Calendar Year	Your plan pays 100%	Your plan pays 80% ^
Routine Foot Disorders	Not Covered	Not Covered
Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.		

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^)		
Hearing Aid • Unlimited maximum In-Network per 24 months • $1,000 maximum Out-of-Network per 24 months • Includes testing and fitting of hearing aid devices covered at PCP or Specialist Office visit level • Coverage through age 12	Your plan pays 100%	Your plan pays 80% ^
Wigs • Unlimited maximum per Calendar Year	Your plan pays 100%	Your plan pays 80% ^

Place of Service - your plan pays based on where you receive services

Note: Services where plan deductible applies are noted with a caret (^)

Benefit	Physician's Office		Independent Lab		Emergency Room/ Urgent Care Facility		Outpatient Facility	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Lab and X-ray	$25 PCP or $25 Specialist copay	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%		Plan pays 100%	Plan pays 80% ^
Advanced Radiology Imaging	Plan pays 100%	Plan pays 80% ^	Not Applicable	Not Applicable	Plan pays 100%		Plan pays 100%	Plan pays 80% ^

Advanced Radiology Imaging (ARI) includes MRI, MRA, CAT Scan, PET Scan, etc...
Note: All lab and x-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit

Benefit	Emergency Room / Urgent Care Facility		Outpatient Professional Services		*Ambulance	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Emergency Care	$100 per visit (copay waived if admitted)		Plan pays 100%		Plan pays 100%	
Urgent Care	$75 per visit (copay waived if admitted)		Plan pays 100%		Not Applicable	

*Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.

Benefit	Inpatient Hospital and Other Health Care Facilities		Outpatient Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospice	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^
Bereavement Counseling	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^

Note: Services provided as part of Hospice Care Program
Note: Services where plan deductible applies are noted with a caret (^)

Benefit	Initial Visit to Confirm Pregnancy		Global Maternity Fee (All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges)		Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)		Delivery - Facility (Inpatient Hospital, Birthing Center)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Maternity	$25 PCP or $25 Specialist copay	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	$25 PCP or $25 Specialist copay	Plan pays 80% ^	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit

Note: Services where plan deductible applies are noted with a caret (^)

Benefit	Physician's Office		Inpatient Facility		Outpatient Facility		Inpatient Professional Services		Outpatient Professional Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Abortion (Elective and non-elective procedures)	$25 PCP or $25 Specialist copay	Plan pays 80% ^	$100 per day copay up to $300 maximum per admission, then your plan pays 100%	Plan pays 80% ^	$150 per facility visit copay, then plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^
Family Planning - Men's Services	$25 PCP or $25 Specialist copay	Plan pays 80% ^	$100 per day copay up to $300 maximum per admission, then your plan pays 100%	Plan pays 80% ^	$150 per facility visit copay, then plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^
Includes surgical services, such as vasectomy (excludes reversals)										
Family Planning - Women's Services	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^
Includes surgical services, such as tubal ligation (excludes reversals) Contraceptive devices as ordered or prescribed by a physician.										

Benefit	Physician's Office		Inpatient Facility		Outpatient Facility		Inpatient Professional Services		Outpatient Professional Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Infertility	$25 PCP or $25 Specialist copay	Plan pays 80% ^	$100 per day copay up to $300 maximum per admission, then your plan pays 100%	Plan pays 80% ^	$150 per facility visit copay, then plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc.										
Unlimited lifetime maximum										
TMJ, Surgical and Non-Surgical	$25 PCP or $25 Specialist copay	Plan pays 80% ^	$100 per day copay up to $300 maximum per admission, then your plan pays 100%	Plan pays 80% ^	$150 per facility visit copay, then plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^
Services provided on a case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity.										
Unlimited maximum per lifetime										
Bariatric Surgery	$25 PCP or $25 Specialist copay	Plan pays 80% ^	$100 per day copay up to $300 maximum per admission, then your plan pays 100%	Plan pays 80% ^	$150 per facility visit copay, then plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^
Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered. The following are excluded: • 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. • weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision										
Note: Services where plan deductible applies are noted with a caret (^)										

Benefit	Inpatient Hospital Facility			Inpatient Professional Services		
	Lifesource Facility In-Network	Non-Lifesource Facility In-Network	Out-of-Network	Lifesource Facility In-Network	Non-Lifesource Facility In-Network	Out-of-Network
Organ Transplants	$100 per day copay up to $300 maximum per admission, then your plan pays 100%	$100 per day copay up to $300 maximum per admission, then your plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 100%	Plan pays 80% ^

- Travel Lifetime Maximum - Lifesource Facility: In-Network: $10,000 maximum per Transplant per Lifetime
- Standard maximums apply Out of Network

Note: Services where plan deductible applies are noted with a caret (^)

Benefit	Inpatient		Outpatient - Physician's Office		Outpatient – All Other Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health	$100 per day copay up to $300 maximum, then plan pays 100%	Plan pays 80% ^	$25 copay	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^
Substance Abuse	$100 per day copay up to $300 maximum, then plan pays 100%	Plan pays 80% ^	$25 copay	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^

Note: Services where plan deductible applies are noted with a caret (^)

Note: Detox is covered under medical

- Unlimited maximum per Calendar Year
- Services are paid at 100% after you reach your out-of-pocket maximum.
- Inpatient includes Residential Treatment.
- Outpatient includes partial hospitalization and individual, intensive outpatient and group therapy.

Mental Health and Substance Use Disorder Services

Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs

Cigna Total Behavioral Health - Inpatient and Outpatient Management

- Inpatient utilization review and case management
- Outpatient utilization review and case management
- Partial Hospitalization
- Intensive outpatient programs
- Changing Lives by Integrating Mind and Body Program
- Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management.
- Narcotic Therapy Management
- Complex Psychiatric Case Management

Pharmacy	In-Network	Out-of-Network
Cigna Pharmacy three-tier copay plan • Retail drugs may be obtained In-Network at a wide range of pharmacies across the nation. • Patient is responsible for the applicable copay based upon the tier of the dispensed medication. • Your pharmacy benefits have a combined out-of-pocket maximum with the medical/behavioral benefits. • Self Administered injectable and optional injectable drugs are covered • Oral contraceptives included • Includes oral contraceptives - with specific products covered 100% • Lifestyle drugs included - limited to sexual dysfunction • Prescription smoking cessation drugs included • Oral Fertility drugs included • Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges included • Specialty medications are limited to a 90-day supply for Home Delivery • Specialty medications are limited to a 30-day supply at Retail	**Retail** - 30 day supply Generic: You pay $5 Preferred Brand: You pay $25 Non-Preferred Brand: You pay $40 **Home delivery** - 90 day supply Generic: You pay $10 Preferred Brand: You pay $50 Non-Preferred Brand: You pay $80	You pay 20% Your plan pays 80%

Pharmacy Program Information

Pharmacy Clinical Management and Prior Authorization

- Your plan is subject to refill-too-soon and other clinical edits as well as prior authorization requirements.
- Plan exclusion edits are always included.
- Additional clinical management - Basic package - provides a limited set of clinical edits such as prior authorization, age edits and quantity limits for a specific list of prescription medications.

Prescription Drug List:

- Your Cigna Standard Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. To check which drugs are included in your plan, please log on to myCigna.com.

Specialty Pharmacy Management:

- Clinical Programs
  - Prior authorization is required on specialty medications but quantity limits may apply.
  - Theracare® Program
- Medication Access Option
  - Retail and/or Home Delivery

Additional Information

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.

Comprehensive Oncology Program • Care Management outreach • Case Management	Included
Health Advisor - A Support for healthy and at-risk individuals to help them stay healthy • Health and Wellness Coaching • Gaps in Care coaching for select conditions • Preference Sensitive Care/Treatment Decision Support Coaching	Included

Maximum Reimbursable Charge
Out-of-Network services are subject to a Calendar Year deductible and maximum reimbursable charge limitations. Payments made to health care professionals not participating in Cigna's network are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a percentage (200%) of a fee schedule developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule is not used, and the maximum reimbursable charge for covered services is determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or the amount charged for that service by 80% of the health care professionals in the geographic area where it is received. The health care professional may bill the customer the difference between the health care professional's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles, co-payments and coinsurance.

Multiple Surgical Reduction
Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

Pre-Certification - Continued Stay Review - PHS+ Inpatient - required for all inpatient admissions
In Network: Coordinated by your physician
Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.
- The lesser of 50% or $500 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.

Pre-Certification - Continued Stay Review - PHS+ Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing
In Network: Coordinated by your physician
Out-of-Network: Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.
- The lesser of 50% or $500 penalty applied to outpatient procedures/diagnostic testing charges for failure to contact Cigna Healthcare and to precertify admission.
- Benefits are denied for any outpatient procedures/diagnostic testing reviewed by Cigna Healthcare and not certified.

Pre-Existing Condition Limitation (PCL) does not apply.

Additional Information

Your Health First - 300
Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:

- Condition Management
- Medication adherence
- Risk factor management
- Lifestyle issues
- Health & Wellness issues
- Pre/post-admission
- Treatment decision support
- Gaps in care

Holistic health support for the following chronic health conditions:

- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- Peripheral Arterial Disease
- Asthma
- Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)
- Diabetes Type 1
- Diabetes Type 2
- Metabolic Syndrome/Weight Complications
- Osteoarthritis
- Low Back Pain
- Anxiety
- Bipolar Disorder
- Depression

Definitions

Coinsurance - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.
Copay - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.
Deductible - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.
Out-of-Pocket Maximum - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.
Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.
Transition of Care - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

Exclusions

What's Not Covered (not all-inclusive):
Your plan provides for most medically necessary services. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared.

Exclusions

- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- 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.
- For or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
    - Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
    - Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
    - The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section of this plan; or
    - The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section of this plan.
- 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.
- The following services are excluded from coverage regardless of clinical indications: Acupressure; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- 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. 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 six months of an 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.
- Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance 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.
- Unless otherwise covered in this plan, for 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.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Infertility services when the infertility is caused by or related to voluntary sterilization; donor charges and services; cryopreservation of donor sperm and eggs; gestational carriers and surrogate parenting arrangements; and any experimental, investigational or unproven infertility procedures or therapies.
- Reversal of male or female voluntary sterilization procedures.
- Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- Nonmedical 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 nonmedical ancillary services for learning disabilities, developmental delays (other than neuropsychological testing ordered by a licensed physician to assess the extent of any cognitive or developmental delays in a Dependent child due to chemotherapy or radiation treatment), autism (other than coverage for services for the treatment of autism spectrum disorders as described in Covered Expenses) or mental retardation.

Exclusions

- 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.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, and skin preparations, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- 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 an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs (other than as described in Covered Expenses).
- Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs) , except as provided for a child age 12 or younger in the Covered Expenses section. A hearing aid is any device that amplifies sound.
- Aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- All non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- 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.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations 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.
- Dental implants for any condition.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism and except as provided for in the Covered Expenses section.
- To the extent permitted by law, for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit. For Medical Benefits, this will not apply to any of the Policyholder's partners, proprietor's or corporate officers, however, if payment is made for expenses in the event that third-party liability is determined and satisfied (whether by settlement, judgment, arbitration or otherwise), Cigna shall be refunded the lesser of: the amount of Cigna's payment for such expenses; or the amount actually received from the third party for such expenses. In the event that a workers' compensation claim is filed, Cigna shall have a lien on the proceeds of any award or settlement to the extent of its payment of benefits.
- Telephone, e-mail, and Internet consultations, and telemedicine.
- Massage therapy.

These are only the highlights
This summary outlines the highlights of your plan. For a complete list of both covered and not covered services, including benefits required by your state, see your employer's insurance certificate or summary plan description -- the official plan documents. If there are any differences between this summary and the plan documents, the information in the plan documents takes precedence. This summary provides additional information not provided in the Summary of Benefits and Coverage document required by the Federal Government.

EHB State: CT