This is a summary of benefits for your Network POS Copay plan. Deductibles and Out-of-Pocket Maximums will cross accumulate in and out of network. All other plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between in- and out-of-network unless otherwise noted. All in-network services must be performed by the Primary Care Physician (PCP), referred by the PCP or approved by the local Healthplan. CIGNA Pharmacy plan deductibles, out-of-pocket maximums, copays and annual maximums do not integrate with the employer medical program.

Note: The standard accumulation of deductibles, OOP maximums and benefit maximums is on a "contract" year basis. As an alternative, accumulation on a "calendar" year basis can be accommodated.

Revised 10/16/05

CIGNA HealthCare Benefit Summary
Long Island University
Network POS Copay Plan – Benefit Option = POS

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	Unlimited
Coordination Type	**Standard COB no benefit credit**	
Coverage Level	100%	80% of Reasonable & Customary Claims paid at the 80th percentile
Calendar Year Deductible		
Individual	None	$200 per person
Family Maximum	None	$400 per family
Aggregate	Not Applicable	Yes
Out-of-Pocket Maximum		
Includes Coinsurance	Not Applicable	Yes
Includes Deductible	Not Applicable	Yes
Includes Copays	Inpatient Hospital Facility (including MH/SA) and Outpatient Facility copays	Inpatient Hospital Facility (including MH/SA) and Outpatient Facility deductibles
Individual	None	$1,250 per person
Family Maximum	None	**$3,750** per family
Aggregate	Not Applicable	Yes
Does Not Apply To	Copays not listed above	Non-compliance penalties or charges for charges in excess of Reasonable and Customary
Benefits for accident or sickness (including mental health, alcohol, and drug abuse benefits) are paid at 100%, once an individual's out-of-pocket has been reached.		
Accumulators (Deductibles and Out of Pocket Maximum)	No cross accumulation	
Automatic Reinstatement ***Multiple Birth*** ***Common Accident*** ***3 Month Carryover***	Not Applicable	

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician's Services		
Primary Care Physician's Office visit	No charge after $10 per office visit copay; No charge if only x-ray and/or lab services performed and billed.	80% after plan deductible
Specialty Care Physician's Office Visit *Office Visits* *Consultant and Referral Physician's Services*	No charge after $10 per office visit copay; No charge if only x-ray and/or lab services performed and billed.	80% after plan deductible
Note: OB/GYN provider is considered a Specialist.		
Surgery Performed In the Physician's Office	No charge after the PCP or Specialist per office visit copay	80% after plan deductible
Second Opinion Consultations (provided on a voluntary basis)	No charge after the PCP or Specialist per office visit copay	80% after plan deductible
Allergy Treatment/Injections	No charge after either the PCP or Specialist per office visit copay or the actual charge, whichever is less	80% after plan deductible
Allergy Serum (dispensed by the physician in the office)	No charge	80% after plan deductible
Preventive Care	NY Residents only	
Routine Preventive Care; :birth through age 18 *Well-Baby, Well-Child* (including immunizations)	No charge **(State Mandate)**	80% after plan deductible
	Non-NY residents	
Routine Adult Preventive Care *age 19 and above (including Well Woman)*	No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed.	Not covered.
Note: OB/GYN provider is considered a Specialist.		
Immunizations	No charge	Not covered
Mammograms, PSA, PAP Smear	No charge **Note:** The associated wellness exam is subject to the PCP or Specialist per office visit copay	80% after plan deductible **Note:** The associated wellness exam is not covered
Inpatient Hospital - Facility Services	No charge	80% after plan deductible
Semi-Private Room and Board	Limited to the semi-private negotiated rate	Limited to the semi-private room rate
Private Room	Limited to the semi-private negotiated rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate
Outpatient Facility Services		
Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room	No charge	No charge
Inpatient Hospital Physician's Visits/Consultations	No charge	80% after plan deductible
Inpatient Hospital Professional Services *Surgeon* *Radiologist* *Pathologist* *Anesthesiologist*	No charge	80% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Multiple Surgical Reduction	Not Applicable	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.
Outpatient Professional Services *Surgeon* *Radiologist* *Pathologist* *Anesthesiologist*	No charge	80% after plan deductible
Emergency and Urgent Care Services		
Physician's Office	No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed.	No charge after $10 per office visit copay **
Hospital Emergency Room	No charge after $25 per visit copay** (Copay waived if admitted)	No charge after $25 per visit copay**
Urgent Care Facility or Outpatient Facility	No charge after $25 per visit copay** (Copay waived if admitted)	No charge after $25 per visit copay**
Ambulance	No charge** ** If not a true emergency, services are not covered	No charge** **If not a true emergency services are not covered
Inpatient Services at Other Health Care Facilities *Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities* 60 days combined maximum per calendar year No prior hospitalization required	No charge	80% after plan deductible
Laboratory and Radiology Services (includes pre-admission testing)		
Advanced Radiological Imaging (i.e. MRIs, CAT Scans and PET Scans) **Note:** Associated ancillary charges are subject to the applicable place of service coinsurance level, place of service copay and/or plan deductible (e.g. injections, dye, etc.)	No charge	80% after plan deductible
Other Laboratory and Radiology Services:		
Physician's Office	No charge	80% after plan deductible
Outpatient Hospital Facility	No charge for facility charges; no charge for outpatient professional charges	80% after plan deductible
Independent X-ray and/or Lab facility	No charge	80% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Short-Term Rehabilitative Therapy 60 days combined maximum per calendar year Includes: Cardiac rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy	No charge after the PCP or Specialist per visit copay, No charge if only x-ray and/or lab services performed and billed. **Note:** The Outpatient Short Term Rehab copay does not apply to services provided as part of a Home Health Care visit. **Note:** Therapy days, provided as part of an approved Home health Care plan, accumulate to the Outpatient Short Term Rehab Therapy maximum. If multiple outpatient services are provided on the same day, they constitute one visit, but separate copays will apply to the services provided by each participating provider.	80% after plan deductible
NY Mandate (Chiro separate from S/T rehab): ***Outpatient Chiropractic Therapy*** Unlimited visits combined max per calendar year	No charge after the PCP or Specialist per visit copay	80% after plan deductible
Home Health Care **Unlimited** days maximum per calendar year (includes outpatient private nursing when approved as medically necessary) The maximum number of hours per day is limited to 16 hours. Multiple visits can occur in one day; with a visit defined as a period of 2 hours or less (e.g. maximum of 8 visits per day)	No charge	80% after maximum of $50 deductible, plan deductible waiver (NY State Mandate) Maximum of 120 days per calendar year (reduced by any in-network days)
Hospice *Inpatient Services* *Outpatient Services* (same coinsurance level as Home Health Care)	 No charge No charge	 80% after plan deductible 80% after plan deductible
Bereavement Counseling *Services Provided as part of Hospice Care* *Inpatient* *Outpatient* *Services Provided by Mental Health Professional*	 No charge No charge Covered under Mental Health benefit	 80% after plan deductible 80% after plan deductible Covered under Mental Health benefit

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Maternity Care Services		
Initial Visit to Confirm Pregnancy **Note:** OB/GYN visits will be subject to the plan's Specialist copay.	No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed.	80% after plan deductible
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	No charge	80% after plan deductible
Office Visits in addition to the global maternity fee when performed by an OB or Specialist	No charge after the Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed	80% after plan deductible
Delivery - Facility (Inpatient Hospital, Birthing Center)	No charge	80% after plan deductible
Abortion *Includes elective and non-elective procedures*		
Office Visit	No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed	80% after plan deductible
Inpatient Facility	No charge	80% after plan deductible
Outpatient Facility	No charge	80% after plan deductible
Inpatient Physician's Services	No charge	80% after plan deductible
Outpatient Physician's Services	No charge	80% after plan deductible
Family Planning Services		
Office Visit (tests, counseling)	No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed	80% after plan deductible
Surgical Sterilization Procedures for Vasectomy/Tubal Ligation (excludes reversals)	Note: Charges billed by a separate independent x-ray/lab facility will be covered under the plan's Laboratory and Radiology benefit	
Inpatient Facility	No charge	80% after plan deductible
Outpatient Facility	No charge	80% after plan deductible
Inpatient Physician's Services	No Charge	80% after plan deductible
Outpatient Physician's Services	No charge	80% after plan deductible
Physician's Office	No charge after the PCP or Specialist per office visit copay	80% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment *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*** *Services Not Covered include: In-vitro, GIFT, ZIFT, etc.*	**Note:** Charges billed by a separate independent x-ray/lab facility or outpatient hospital will be covered under the plan's Laboratory and Radiology benefit.	80% after plan deductible
Office Visit (Lab and Radiology Tests, Counseling)	No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed	80% after plan deductible
Surgical Procedure Copay:	$200 surgical copay	80% after plan deductible and $200 surgical copay
Inpatient Facility	No charge	80% after plan deductible
Outpatient Facility	No charge	80% after plan deductible
Physician's Services	No charge	80% after plan deductible
Organ Transplant *Includes all medically appropriate, non-experimental transplants*		80% after plan deductible
Office Visit	No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed	80% after plan deductible
Inpatient Facility	No charge	80% after plan deductible
Inpatient Physician's Services	No charge	80% after plan deductible
Travel Maximum (Provided when using Lifesource Centers only.	$10,000 per transplant/per Lifetime maximum (only available when using Lifesource facility)	Not Covered
Durable Medical Equipment *Note: Service maximums do not cross accumulate between in-network and out-of-network services.*	No charge Unlimited maximum per calendar year	80% after plan deductible; subject to a separate $700 maximum per calendar year
External Prosthetic Appliances *Note: Service maximums do not cross accumulate between in-network and out-of-network services.*	No charge after $200 EPA deductible $1,000 maximum per calendar year	80% after plan deductible; subject to a separate $1,000 maximum per calendar year

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 t sound, natural teeth.*		
Doctor's Office	No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed	80% after plan deductible
Inpatient Facility	No charge	80% after plan deductible
Outpatient Facility	No charge	80% after plan deductible
Physician's Services	No charge	80% after plan deductible
Surgical and Non-surgical TMJ **NY State Mandate** **(Covered with medical necessity case specifically)**	No charge after the PCP or Specialist per office visit copay	80% after plan deductible
Obesity/Bariatric Surgery **NY State Mandate** **(Covered when medically necessary based on state requirements)**	**Note**: **Coverage is provided subject to medical necessity and clinical guidelines.** **Note**: Covered only at approved centers through the pre-certification process.	
Doctor's Office	No charge after PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed.	80% after plan deductible
Inpatient Facility	No charge	80% after plan deductible
Outpatient Facility	No charge	80% after plan deductible
Physician's Services	No charge	80% after plan deductible
Routine Foot Disorders ***When medically necessary***	No charge after the PCP or Specialist per office visit copay	80% after plan deductible
Acupuncture	No charge after the PCP or Specialist per office visit copay	80% after plan deductible
Pre-Existing Condition Limitation (PCL)	**NONE**	**NONE**

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**: Employee is responsible for contacting CIGNA Healthcare. Penalties for non-compliance: – 50% penalty applied to hospital inpatient charges for failure to contact CIGNA Healthcare to precertify admission. – Benefits are reduced by 50% for any admission reviewed by CIGNA Healthcare and not certified. – Benefits are reduced by 50% for any additional days not certified by CIGNA Healthcare.
Outpatient Prior Authorization (required for selected outpatient procedures and diagnostic testing).	Coordinated by Provider/PCP	**Mandatory**: Employee is responsible for contacting CIGNA Healthcare. Penalties for non-compliance: – 50% penalty applied to outpatient procedures/diagnostic testing charges for failure to contact CIGNA Healthcare to precertify. – Benefits are reduced by 50% 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.	

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Prescription Drugs *CIGNA Pharmacy Retail Drug Program* **DAW, Basic Clinical Management, Open Formulary** *Includes: Self administered injectables, oral contraceptives and contraceptive devices, oral fertility drugs, Insulin, Insulin needles & syringes, glucose test strips, lancets, prenatal vitamins, prescription vitamins, injectable drugs, lifestyle drugs.* *Excludes Injectable infertility drugs, fluoride preps, smoking cessation, anti-obesity drugs, pre-filled pens & cartridges.*	**$2** per 30-day supply for generic drugs **$2** per 30-day supply for brand-name drugs	80% no pharmacy deductible
Pharmacy Deductible ***Pharmacy Out of Pocket Maximum***	None None	None None
CIGNA Tel-Drug Mail Order Drug Program **DAW, Open Formulary** *Includes oral contraceptives and contraceptive devices, oral fertility drugs, Insulin, Insulin needles & syringes, glucose test strips, lancets, prenatal vitamins, prescription vitamins, injectable drugs, lifestyle drugs.* *Excludes Injectable infertility drugs, oral fertility drugs, fluoride preps, smoking cessation, anti-obesity drugs, pre-filled pens & cartridges.*	**$4** per 90-day supply for generic drugs **$4** per 90-day supply for brand-name drugs	
Vision Care *Eye Exam every 24 months* *Eye Glasses/Contact Lenses Not Covered*	$10 per office visit copay	In-network coverage only

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Mental Health *Inpatient* *Limited to 30 days maximum per calendar year* *Acute: based on ratio of 1:1* *Partial: based on a ratio of 2:1* *Residential: based on a ratio of 2:1* *Outpatient* *Limited to 45 visits per calendar year* *Outpatient Group Therapy (One group therapy session equal one individual therapy session)* ***Intensive Outpatient*** ***Maximum: up to 3 programs per calendar year*** ***Based on a ratio of 1:1***	No charge No charge after $10 per visit copay No charge after $10 per visit copay 100% after $30 per program copay	80% after plan deductible 80% after plan deductible 80% after plan deductible
Substance Abuse *Inpatient* *Limited to 30 days 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* *Outpatient* *Limited to 60 visits maximum per calendar year* *Intensive Outpatient (alcohol & drug)* *Maximum: up to 3 programs per calendar year* *Based on a ratio of 1:1*	No charge No charge after $10 per visit copay 100% after $30 per program copay	80% after plan deductible 80% after plan deductible 80% after plan deductible
MH/SA Utilization Review & Case Management	• CBH provides utilization review and case management services for In-network Inpatient and Outpatient services only.	

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; Orthognathic Surgeries; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
10. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within 6 months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
11. 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.
12. 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."
13. Infertility services, infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
14. Reversal of male and female voluntary sterilization procedures.
15. Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
16. 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.

17. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
18. 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.
19. 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.
20. 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."
21. Private hospital rooms and/or private duty nursing except as provided in the Home Health Services section of “Section IV. Covered Services and Supplies”.
22. 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.
23. Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
24. 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.
25. 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.
26. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
27. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
28. 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.”
29. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
30. 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.
31. Dental implants for any condition.
32. 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.
33. Blood administration for the purpose of general improvement in physical condition.
34. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
35. Cosmetics, dietary supplements and health and beauty aids.
36. All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
37. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
38. Telephone, e-mail & Internet consultations and telemedicine.
39. 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.