# SUMMARY OF BENEFITS

***Your CIGNA HealthCare Open Access Plus plan, Silver Plan***

CIGNA HealthCare

## Features that Add Value

- The convenience of **referral-free access** to physicians, and the option to select a **personal Primary Care Physician (PCP)** as your source for routine care and guidance when you need specialized care. As your needs change, so may your choice of doctors. That's why you can change your PCP for any reason.
- The CIGNA HealthCare 24-Hour Health Information Line℠ connects you **to registered nurses** and a **library** of hundreds of recorded programs on important health topics 24 hours a day, seven days a week, from anywhere in the U.S.
- **CIGNA *Healthy Rewards*®** includes special offers on health and wellness programs and services often not covered by many traditional benefits plans. Just call 1.800.870.3470 or visit our web site at www.cigna.com.
- Prescription drug coverage is a **part of your plan**. More than 50,000 pharmacies participate nationwide, so you can have your prescription filled **wherever you go**. Mail-order service means quick, **convenient** delivery of your medications right to your home.

## Quality Service Is Part of Quality Care

- **Service** is at the heart of everything we do. Our goal is to give you: fast, accurate answers; responsive, courteous and professional assistance; and ease and convenience in finding the information you need to manage your health.
- **www.cigna.com** – Visit our **interactive Web site** to learn more about your plan and get health information, 24 hours a day. Once you enroll, register for myCIGNA.com, our convenient, secure web site that combines WebMD® tools with personalized benefits information to help you make the most of your plan.
- **We Speak Many Languages℠**. We offer Language Line Services so that you can **talk with us** in 150 different languages. Just call Customer Service and ask for an interpreter to assist you.
- Our interactive voice response system helps you find what you need faster over the phone. Use the speech recognition feature for information on your benefits, level of coverage, claims status, and more.

## It's Your Health

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

- **Preventive care services** for you and your children and any additional preventive care benefits described in the Benefits Highlights.
- The CIGNA HealthCare Healthy Babies® program provides you with information to help you have a **healthy pregnancy** and **a healthy baby.**

## You Can Depend on CIGNA HealthCare

- **Quality comes first**. We select "preferred providers" carefully. And we make sure you have a **wide range** of doctors to choose from.
- **Emergency and urgent care are covered** wherever you go, worldwide, **24 hours a day**. Urgent care centers can take care of your urgent care needs, and your cost is lower.

## It's Your Choice

When you visit network providers, you get access to quality care at the lowest out-of-pocket costs available under your plan. Your plan also offers the freedom to choose the providers you prefer — even if they aren't part of the network. Your benefits are the highest when you see "preferred providers," but you're still covered for visits to other providers.

Knox County Government, Silver Plan, 2009

| BENEFIT INFORMATION | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Calendar Year Plan Deductible***<br>*Individual / Family Maximum* | $750/ $1,500 | $1,500 / $3,000 |
| ***Calendar Year Out-of-Pocket Maximum***<br>*Individual / Family Maximum* | Includes Plan Deductible<br>$2,250 / $4,500 | Includes Plan Deductible<br>$4,500 / $9,000 |
| ***Coinsurance*** | CIGNA HealthCare pays 80% of eligible charges. You pay 20% of charges after plan deductible. | CIGNA HealthCare pays 60% of eligible charges. You pay 40% of charges after plan deductible. |
| ***Precertification -Inpatient – PHS+ (required for all inpatient admissions)***<br><br>***Precertification – Outpatient – PHS+ (required for selected outpatient procedures and diagnostic testing or outpatient services)*** | Coordinated by your physician<br><br>Coordinated by your physician | Participant must obtain approval for inpatient admission; subject to penalty/reduction or denial for non-compliance<br><br>Participant must obtain approval for selected outpatient procedures and diagnostic testing; subject to penalty/reduction or denial for non-compliance. |
| ***Lifetime Maximum*** | Unlimited | Unlimited |
| ***Pre-existing Condition Limitation*** | No | No |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Physician Services***<br>***Primary Care Physician (PCP) Office Visit*** | $25 co-payment; No charge after office visit copay if only x-ray and/or lab services are performed and billed. | 40% of charges** |
| ***Specialty Care Physician Office Visit***<br>*Consultant and Referral Physician Services*<br>***Note:*** *A copayment applies for OB/GYN visits. If your doctor is listed as a PCP in the provider directory, you will pay a PCP copayment. If your doctor is listed as a specialist, you will pay the specialist copayment.* | $35 co-payment; No charge after office visit copay if only x-ray and/or lab services are performed and billed | 40% of charges** |
| *Allergy Treatment/Injections - PCP or Specialist Physician* | No charge; no deductible | 40% of charges** |
| *Allergy Serum (dispensed by physician in office)* | No charge; no deductible | 40% of charges** |
| *Second Opinion Consultations (provided on voluntary basis)* | $25 or $35 co-payment; No charge after office visit copay if only x-ray and/or lab services are performed and billed. | 40% of charges** |
| *Surgery Performed in the Physician's Office- PCP or Specialist Physician* | $25 or $35 co-payment; No charge after office visit copay if only x-ray and/or lab services are performed and billed. | 40% of charges** |
| ***Preventive Care***<br>*Routine Preventive Care (including routine immunizations)*<br><br>*Immunizations* | $25 or $35 co-payment; No charge after office visit copay if only x-ray and/or lab services are performed and billed.<br><br>No charge, no plan deductible | Covered in-network only<br><br>Covered in-network only |
| ***Preventive Mammograms, PSA, Pap Tests***<br>***Note:*** *diagnostic related mammograms, PSA, Pap Tests are paid at the same level of benefits as other x-ray and lab services.* | No charge; no deductible | 40% of charges** |
| ***Inpatient Hospital Services including:***<br>*Semi-Private Room and Board*<br>*Diagnostic/Therapeutic Lab and X-ray*<br>*Drugs and Medication*<br>*Operating and Recovery Room*<br>*Radiation Therapy and Chemotherapy*<br>*Anesthesia and Inhalation Therapy* | 20% of charges* | 40% of charges*<br><br>Precertification required |
| ***Inpatient Hospital Doctor's Visits/Consultations***<br>*Inpatient Hospital Professional Services* | 20% of charges*<br>20% of charges* | 40% of charges**<br>40% of charges** |
| ***Outpatient Facility Services includes:***<br>*Operating Room, Recovery Room, Procedure Room and Treatment Room and Observation Room including:*<br>*Diagnostic/Therapeutic Lab and X-rays*<br>*Anesthesia and Inhalation Therapy*<br>*Physician & Outpatient Professional Services* | $250 copayment, then 100%, no deductible | 40% of charges**<br><br>40% of charges** |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Laboratory and Radiology Services (includes preadmission testing)*** | | |
| *Physician's Office* | No charge after PCP or Specialist per visit copay | 40% of charges** |
| *Outpatient Hospital Facility* | 20% of charges* | 40% of charges** |
| *Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit)* | No charge after Emergency Room/Urgent Care facility per visit copay | No charge after Emergency Room/Urgent Care facility per visit copay; *if not a true emergency, then 40% of charges*** |
| *Independent X-Ray and/or Lab Facility* | No charge; no deductible | 40% of charges** |
| *Independent X-Ray and/or Lab Facility (in conjunction with an Emergency Room visit)* | No charge after Emergency Room/Urgent Care facility per visit copay | No charge after Emergency Room/Urgent Care facility per visit copay; *if not a true emergency, then 40% of charges*** |
| ***Advanced Radiological Imaging*** *(MRIs, MRAs, CAT Scans, PET Scans, etc.)* | | |
| *Inpatient Facility* | 20% of charges* | 40% of charges** |
| *Outpatient Facility* | 20% of charges* | 40% of charges** |
| *Emergency Room/Urgent Care (billed by facility as part of the Emergency Room/Urgent Care visit)* | No charge; no deductible | No charge; no deductible; *except if not a true emergency, then 40% of charges*** |
| *Physician's Office* | No charge; no deductible | 40% of charges** |
| ***Short-Term Rehabilitative Therapy and Cardiac Rehabilitation--(includes cardiac rehab, chiropractic therapy, physical, speech, occupational, pulmonary rehab & cognitive therapy);*** 60 day maximum per calendar year for all therapies combined | $25 or $35 co-payment; No charge after office visit copay if only x-ray and/or lab services are performed and billed. | 40% of charges** |
| ***Emergency and Urgent Care Services*** | | *Care will be provided at in-network levels if it meets the "prudent layperson" definition of an emergency. Otherwise 40% of charges*** |
| *Physician's Office – PCP or Specialist Physician* | $25 or $35 co-payment; No charge after office visit copay if only x-ray and/or lab services are performed and billed. | |
| *Hospital Emergency Room* | $150 copay, then 100%, no deductible (waived if admitted) | |
| *Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician)* | No charge after facility copay | |
| *Urgent Care Facility or Outpatient Facility* | $35 copay, then 100%, no deductible (waived if admitted) | |
| *Ambulance* | 20% of charges* | |
| ***Maternity Care Services*** | | |
| *Initial Office Visit to Confirm Pregnancy*<br>***Note:*** *A copayment applies for OB/GYN visits. If your doctor is listed as a PCP in the provider directory, you will pay a PCP copayment. If your doctor is listed as a specialist, you will pay the specialist copayment.* | $25 or $35 co-payment; No charge after office visit copay if only x-ray and/or lab services are performed and billed. | 40% of charges** |
| *All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (total maternity fee)* | 20% of charges* | 40% of charges** |
| *Office Visits not included in the total maternity fee performed by OB or Specialist Physician* | $25 or $35 co-payment; No charge after office visit copay if only x-ray and/or lab services are performed and billed. | 40% of charges** |
| *Delivery - Facility (Inpatient Hospital/Birthing Center Charges)* | 20% of charges* | 40% of charges*, precertification required |
| ***Inpatient Services at Other Health Care Facilities***<br>*Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities*<br>60 day maximum per calendar year combined for all facilities listed | 20% of charges* | 40% of charges** |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Home Health Services*** *– Includes outpatient private duty nursing when approved as medically necessary*<br>60 days maximum per calendar year; 16 hour maximum per day# | 20% of charges* | 40% of charges** |
| ***Bariatric Surgery - Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered. All services are subject to Medical Necessity Approval)***<br><br>*The following services are specifically 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*<br><br>*Physician's Office*<br><br>***Inpatient Facility***<br><br>***Outpatient Surgical Facility***<br><br>***Physician's Services*** | $25 or $35 co-payment; No charge after office visit copay if only x-ray and/or lab services are performed and billed<br><br>20% of charges*<br><br>20% of charges*<br><br>20% of charges* | In-network coverage only |
| ***Dental Care***<br><br>***Dental Care coverage under the medical plan is limited to:***<br><br>*Corrective treatment of an injury to a jaw or sound natural teeth due to an accident*<br>*Service that is for a covered dependent because of congenital disease or anomaly*<br>*The removal of impacted wisdom teeth when embedded in bone*<br>*Anesthesia expenses, hospital expenses and physician expenses associated with any inpatient or outpatient hospital dental procedure performed on a child 8 years of age or younger or a mentally disabled adult, if the procedure itself is a covered expense*<br><br>*Physician's Office*<br><br>*Inpatient Facility*<br><br>*Outpatient Surgical Facility*<br><br>*Physician's Services* | $25 or $35 co-payment; No charge after office visit copay if only x-ray and/or lab services are performed and billed<br><br>20% of charges*<br><br>20% of charges*<br><br>20% of charges* | 40% of charges**<br><br>40% of charges**<br><br>40% of charges**<br><br>40% of charges** |
| ***Vision Care***<br>*Eye exam every 12 months* | $10 copay for one exam per calendar year (hardware excluded) | In-network coverage only |

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|---|---|---|
| ***Family Planning Services***<br>*Office Visits (lab & radiology tests, counseling)*<br><br><br><br><br><br><br><br><br>***Vasectomy/Tubal Ligation (excludes reversals)***<br>*Inpatient Facility*<br>*Outpatient Facility*<br>*Physician's Services – Inpatient or Outpatient*<br>*Physician's Office* | $25 or $35 co-payment; No charge after office visit copay if only x-ray and/or lab services are performed and billed.<br><br>Note: charges billed by an independent x-ray/lab facility or out-patient hospital will be covered based on place of service under the plan's x-ray/lab benefit<br><br><br>20% of charges*<br>20% of charges*<br>20% of charges*<br>$25 or $35 co-payment; No charge after office visit copay if only x-ray and/or lab services are performed and billed. | In network coverage only.<br><br><br><br><br><br><br><br><br><br>40% of charges*, precertification required<br>40% of charges**<br>40% of charges**<br>40% of charges** |
| ***Infertility Services***<br>***Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.*** | Not covered | Not covered |
| ***TMJ - Surgical and Non-Surgical-case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity.***<br><br>*Physician's Office*<br><br><br><br>*Inpatient Facility*<br>*Outpatient Facility*<br>*Physician's Services* | <br><br><br><br>$25 or $35 co-payment; No charge after office visit copay if only x-ray and/or lab services are performed and billed.<br><br>20% of charges*<br>20% of charges*<br>20% of charges* | <br><br><br><br>40% of charges**<br><br><br><br>40% of charges**, precertification required<br>40% of charges**<br>40% of charges** |
| ***Mental Health***<br>***Inpatient*** - 30 days maximum per calendar year#<br>***Acute****:* Based on a ratio of 1:1<br>***Partial****:* Based on a ratio of 2:1<br>***Residential****:* Based on a ratio of 2:1<br><br>***Outpatient Individual*** –no visit maximum per calendar year#<br><br>***Group Therapy Mental Health*** –no visit maximum per calendar year#<br><br>***Intensive Outpatient Mental Health-*** no program maximum per calendar year# | <br>$75 per day deductible, then 20% of charges*<br><br><br><br><br>$35 office visit copay, then 100%<br><br>$15 office visit copay; 40 visits combined maximum per calendar year.<br><br>$50 per program copayment, plus 20% of charges; no plan deductible | <br>40% of charges*, precertification required<br><br><br><br><br>40% of charges**<br><br>40% of charges**<br><br><br>40% of charges** |
| ***Substance Abuse***<br>***Inpatient -*** 20 days maximum per calendar year#<br>***Acute Detox:*** Based on a ratio of 1:1 (requires 24 hour nursing)<br>***Acute Inpatient Rehab****:* Based on a ratio of 1:1 (requires 24 hour nursing)<br>***Partial***: Based on a ratio of 2:1<br>***Residential****:* Based on a ratio of 2:1<br><br>***Outpatient Individual*** - 20 visits combined maximum per calendar year#<br><br>***Intensive Outpatient Substance Abuse*** – up to 3 programs maximum per calendar year# based on a ratio of 1:1 with outpatient Substance Abuse visits | <br>$75 per day deductible, then 20% of charges*<br><br><br><br><br><br><br>$15 per visit copay for visits 1 and 2. $35 per visit copay for visits 3 through 20.<br><br>$50 per program copayment, plus 20% of charges; no plan deductible | <br>40% of charges*, precertification required<br><br><br><br><br><br><br>40% of charges**<br><br><br>$50 per program deductible, plus 40% of charges; no plan deductible |
| ***Durable Medical Equipment***<br>$5,000 maximum per calendar year | 20% of charges* | 40% of charges** |
| ***External Prosthetic Appliances***<br>$1,000 maximum per calendar year; separate $200 calendar year EPA deductible | 20% of charges* | 40% of charges** |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Prescription Drugs***<br>***CIGNA Pharmacy Retail Drug Program*** | | In-network coverage only. |
| ***Pharmacy calendar year deductible (retail only)*** | $100 per person/$200 per family (aggregate) | |
| *Generic*** drugs on the Prescription Drug List for a 30-day supply* | $10 co-payment per prescription/refill after pharmacy deductible | |
| *Brand Name*** drugs designated as preferred on the Prescription Drug List with no Generic equivalent for a 30-day supply* | $20 co-payment per prescription/refill after pharmacy deductible | |
| *Brand Name*** drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List for a 30-day supply* | $40 co-payment per prescription/refill after pharmacy deductible | |
| ***CIGNA Tel-Drug Mail Order Drug Program***<br>*Generic*** drugs on the Prescription Drug List for a 90-day supply* | $20 co-payment per prescription/refill | |
| *Brand Name*** drugs designated as preferred on the Prescription Drug List with no Generic equivalent for a 90-day supply)* | $40 copayment per prescription/refill | |
| *Brand Name*** drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List for a 90-day supply* | $80 copayment per prescription/refill | |
| *Prescription Preventive Maintenance Medications* | | |
| ***CIGNA Pharmacy Retail Drug Program***<br>*Generic*** Preventive Medications on the Prescription Drug List for a 30-day supply* | No deductible/no co-payment per prescription/refill | |
| *Brand Name*** Preventive Medications designated as preferred on the Prescription Drug List with no Generic equivalent for a 30-day supply* | No deductible/$20 co-payment per prescription/refill | |
| *Brand Name*** Preventive Medications with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List for a 30-day supply* | No deductible/$40 co-payment per prescription/refill | |
| ***CIGNA Tel-Drug Mail Order Drug Program***<br>*Generic*** Preventive Medications on the Prescription Drug List for a 90-day supply* | No copayment per prescription/refill | |
| *Brand Name*** Preventive Medications designated as preferred on the Prescription Drug List with no Generic equivalent for a 90-day supply)* | $40 copayment per prescription/refill | |
| *Brand Name*** Preventive Medications with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List for a 90-day supply* | $80 copayment per prescription/refill | |
| *Prescription Smoking Cessation Drugs* | | |
| *CIGNA Pharmacy Retail and* ***CIGNA Tel-Drug Mail Order Drug Programs*** | No deductible/no co-payment per prescription/refill | |
| ****Designated as per generally-accepted industry sources and adopted by CG* | | |

***Services are subject to calendar year deductible**
**** Services are subject to calendar year deductible and reasonable and customary charge/maximum reimbursable charge limitations.**
**# In-network and out-of-network services apply to the same treatment or dollar maximum.**

***Footnotes:***

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

- *Once the plan's out-of-pocket maximum is reached, the plan pays 100% of eligible charges for the remainder of the plan year, except for Substance Abuse which continue to be paid at the levels specified.*
- *Coverage for pre-existing conditions will not be covered under this plan unless continuously insured for one year.*

***Regarding In-Network Services:***

- *All services must be provided by one of the preferred providers on our list in order to be covered.*

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

- *Your out-of-pocket costs will be higher than with a preferred provider.*
- *All out-of-network hospital admissions and certain outpatient surgical and diagnostic procedures must be precertified and are subject to Continued Stay Review (CSR). A penalty applies to admissions which are not precertified. Non-approved admissions/days result in denial of benefits. The precertification penalty or cost of denied benefits does not apply to deductible or out-of-pocket maximum.*

## Case Management

Coordinated by CIGNA HealthCare. This is a service designed 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***)**:** **Y**our 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; 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, the following charges are eligible for coverage: made for services or supplies provided for or in connection with an accidental injury to the jaw or 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; service that is for the covered dependent because of a congenital disease or anomaly; the removal of impacted wisdom teeth when embedded in bone; anesthesia expenses, hospital expenses and physician expense associated with any inpatient or outpatient hospital dental procedure performed on a child 8 years of age or younger or a mentally disabled adult, if the procedure itself is a covered expense.
11. Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.
12. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
13. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under "Section IV. Covered Services and Supplies."
14. Infertility services, infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
15. Reversal of male and female voluntary sterilization procedures.

16. Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
17. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
18. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
19. Non-medical counseling or ancillary services, including, but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
20. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
21. Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Inpatient Hospital Services," "Outpatient Facility Services," "Home Health Services" or “Breast Reconstruction and Breast Prostheses” sections of "Section IV. Covered Services and Supplies."
22. Private hospital rooms and/or private duty nursing except as provided in the Home Health Services section of “Section IV. Covered Services and Supplies”.
23. Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
24. Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
25. Hearing aids, including, but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
26. Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
27. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
28. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
29. Treatment by acupuncture.
30. All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Section IV. Covered Services and Supplies.”
31. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
32. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
33. Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.
34. Dental implants for any condition.
35. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director’s opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
36. Blood administration for the purpose of general improvement in physical condition.
37. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
38. Cosmetics, dietary supplements and health and beauty aids.
39. All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
40. Expenses incurred for medical treatment by a person age 65 or older, who is covered under this Agreement as a retiree, or his Dependents, when payment is denied by the Medicare plan because treatment was not received from a Participating Provider of the Medicare plan.
41. Expenses incurred for medical treatment when payment is denied by the Primary Plan because treatment was not received from a Participating Provider of the Primary Plan.
42. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
43. Telephone, e-mail & Internet consultations and telemedicine.
44. Massage Therapy

**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.**