



CIGNA MEDICAL COVERAGE POLICY

The following Coverage Policy applies to all plans administered by CIGNA Companies including plans administered by Great-West Healthcare, which is now a part of CIGNA.

Subject Endovascular Repair of Abdominal Aortic Aneurysms

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Endovascular Repair of Thoracic Aortic Aneurysms

INSTRUCTIONS FOR USE

Coverage Policies are intended to provide guidance in interpreting certain **standard** CIGNA HealthCare benefit plans as well as benefit plans formerly administered by Great-West Healthcare. Please note, the terms of a participant's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a participant's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a participant's benefit plan document **always supercedes** the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable group benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. Proprietary information of CIGNA. Copyright ©2010 CIGNA

Coverage Policy

CIGNA covers endovascular repair of infrarenal abdominal aortic aneurysms and aortoiliac aneurysms using a U.S. Food and Drug Administration (FDA)-approved endoprosthesis as medically necessary.

CIGNA does not cover endovascular repair of abdominal aortic aneurysms involving visceral vessels using a fenestrated graft because it is considered experimental, investigational or unproven.

CIGNA does not cover placement of an implantable wireless pressure sensor during endovascular aneurysm repair because it is considered experimental, investigational or unproven.

CIGNA does not cover monitoring using an implantable wireless pressure sensor following endovascular aneurysm repair because it is considered experimental, investigational or unproven.

General Background

An aneurysm consists of focal enlargement of the aorta to 1.5 times its normal size, with involvement of all three layers of the arterial wall. Abdominal aortic aneurysms (AAAs) occur much more frequently than thoracic aortic aneurysms. Occurrence rates rise rapidly after age 55 in men and age 70 in women. Smoking is strongly associated with AAA; additional risk factors include male gender, age, hypertension, hyperlipidemia, and atherosclerosis. Marfan syndrome and Ehlers-Danlos syndrome have also been associated with AAA, although

to a lesser degree than is seen with thoracic aortic aneurysm. The overall incidence of AAA is significantly higher in men than in women, and men are much more likely to have an AAA of four centimeters (cm) or greater, although the risk of rupture is higher in women than in men. Most AAAs are asymptomatic and are discovered incidentally during evaluation for other indications. The majority of AAAs are infrarenal, arising below the renal arteries. A small percentage of AAAs are suprarenal, arising between the level of the diaphragm and the renal arteries. Rupture is unlikely in an aneurysm of 5.0 cm or less. The risk of rupture increases significantly in aneurysms 5.5 cm in diameter or greater, and rapid rate of aneurysm growth also increases the risk of rupture (Libby, 2007; Topol, 2007).

The conventional treatment for AAA has been open surgical repair. Open surgical repair involves transabdominal surgery, exposure of the aneurysm, cross-clamping the aorta, resection of the aneurysm, and placement of a graft prosthesis. Endovascular AAA repair developed as a minimally invasive alternative to open surgical repair in patients with suitable anatomy. In endovascular repair, a catheter is inserted in the femoral artery to deliver a tightly folded graft. Under fluoroscopic guidance, the graft is delivered to the affected section of the abdominal aorta and the catheter balloon is inflated, causing the graft to open and span the aneurysm. Fixation systems (e.g., stents or a supporting frame and hooks) are used to anchor the graft. The most significant risks and complications of endovascular AAA repair include device-related complications, graft migration and endoleak. Endoleak, a complication unique to endovascular aneurysm repair, is defined as blood flow within the aneurysm sac but outside the endoluminal graft. Endoleak can lead to aneurysm enlargement and rupture. Long-term screening with computed tomography (CT) and duplex ultrasound is generally performed to monitor for these complications (ECRI, 2008).

U.S. Food and Drug Administration (FDA)

A number of devices have received approval through the FDA Premarket Approval (PMA) process for endovascular treatment of AAA, including the following:

- AneuRx[®] Stent Graft System (Medtronic Vascular, Santa Rosa, CA)
- Zenith[®] AAA Endovascular Graft and H&L-B One-Shot[™] Introduction System (Cook Incorporated, Bloomington, IN)
- EXCLUDER[™] Bifurcated Endoprosthesis (W.L. Gore & Associates, Inc., Flagstaff, AZ)
- Endologix PowerLink[®] System (Endologix, Inc., Irvine, CA).
- Talent[™] Abdominal Stent Graft System (Medtronic Vascular, Santa Rosa, CA)

Literature Review

The Dutch Randomized Endovascular Aneurysm Management (DREAM) trial, conducted by Prinssen et al. for the DREAM Trial Group (2004), was a randomized, multicenter controlled trial (n=345) comparing open AAA repair (n=174) with endovascular repair (n=171). All patients had been diagnosed with AAA of at least 5 cm in diameter and were considered suitable candidates for both techniques. Operative mortality was 4.6% in the open repair group and 1.2% in the endovascular repair group. The combined rates of operative mortality and severe complications were 9.8% in the open repair group and 4.7% in the endovascular group. The authors concluded that endovascular repair is preferable to open repair in patients with an AAA of at least 5 cm in diameter, but that long-term follow-up was needed to determine whether this advantage is sustained.

In a subsequent study, Blankensteijn et al. for the DREAM Trial Group (2005) investigated whether the advantage of endovascular repair was sustained beyond the perioperative period. Two years after the initial randomization, the cumulative survival rates were 89.6% for open repair and 89.7% for endovascular repair. The cumulative rates of aneurysm-related death were 5.7% for open repair and 2.1% for endovascular repair. The rate of survival free of moderate or severe complications was also similar at two years: 65.9% for open repair and 65.6% for endovascular repair. The authors concluded that the perioperative survival advantage of endovascular repair compared to open repair is not sustained after the first postoperative year.

Long-term outcomes of the DREAM trial were published by De Bruin et al. for the DREAM Trial Group (2010). Six years after randomization, the cumulative survival rates were 69.9% for open repair and 68.9% for endovascular repair (p=0.97). The cumulative rates of freedom from secondary interventions were 81.9% for open repair and 70.4% for endovascular repair (p=0.03).

Endovascular Aneurysm Repair (EVAR) Trial 1 (EVAR Trial Participants, 2005), a multicenter, randomized controlled trial, included 1082 patients with AAA of at least 5.5 cm in diameter who had been referred to one of 34 hospitals proficient in the endovascular technique. The trial was conducted to compare endovascular repair with open repair in terms of mortality, durability, health-related quality of life (HRLQ), postoperative complications, and hospital costs. Patients who were anatomically suitable for endovascular repair and also fit for open repair were randomly assigned to endovascular repair (n=543) or open repair (n=539). Four years after randomization, all-cause mortality was similar in both groups at approximately 28%. Postoperative complications were seen four years after randomization in 41% of patients in the endovascular group and 9% in the open repair group. There was little difference in HRQL between the two groups at 12 months. The authors concluded that compared to open repair, endovascular repair offers no advantage in terms of all-cause mortality and HRQL and leads to a greater number of complications and re-interventions, but does result in a 3% better aneurysm-related survival.

Long-term outcomes of the EVAR 1 Trial were published by the EVAR Trial Investigators in 2010. Patients were followed until 2009; a minimum of 5 years and maximum of 10 years. The early benefit of endovascular repair in terms of aneurysm-related mortality was lost by the end of the study, due in part to fatal endograft ruptures (p=0.73). By the end of follow-up there was no significant difference between the two groups in the rate of death from any cause (p=0.72). The rates of graft-related complications and reinterventions were higher with endovascular repair, with new complications occurring up to eight years after randomization.

EVAR Trial 2 (EVAR Trial Participants, 2005), a multicenter, randomized controlled trial, included 338 patients with AAA of at least 5.5 cm who had been referred to one of 31 hospitals. EVAR 2 was conducted to identify whether endovascular repair improves survival compared to no intervention in patients unfit for open repair. The 30-day operative mortality in the endovascular repair group (n=166) was 9%, and the no-intervention group had a rupture rate of nine per 100 person-years. Overall mortality after four years was 64%. There was no significant difference between the endovascular repair group and the no-intervention group for all-cause mortality, and there was no difference in aneurysm-related mortality.

Lederle et al., for the Open Versus Endovascular Repair (OVER) Veterans Affairs Cooperative Study Group, published two year results an interim report of a planned nine year randomized multicenter trial (n=881). The OVER trial is designed to compare postoperative outcomes following elective endovascular (n=444) or open (n=437) repair of AAA. Perioperative mortality was lower for endovascular repair than for surgical repair (0.5% vs. 3.0%, p=.004), but did not significantly differ at two years (7.0% vs. 9.8%, p=.13). The median procedure time was lower in the endovascular group than in the open surgery group (2.9 vs. 3.7 hours). Patients in the endovascular group also had reduced blood loss (200 vs. 2000 milliliters), transfusion requirement (0 vs. 1 unit), duration of mechanical ventilation (3.6 vs. 5.0 hours), hospital stay (3 vs. 7 days), and intensive care unit stay (1 vs. 4 days). Substantial exposure to fluoroscopy and contrast was required for patients in the endovascular group, however. There was no difference between the groups in major morbidity, procedure failure, secondary therapeutic procedures, aneurysm-related hospitalizations, health-related quality of life, or erectile function. At a mean follow-up of 1.8 years, the early advantage of endovascular repair was thus not offset by increased morbidity and mortality. The authors noted, however, that longer-term outcome data are needed to fully assess the relative merits of the two procedures.

Systematic Reviews, Meta-Analyses, Technology Assessments

Lovegrove et al. (2008) conducted a meta-analysis to compare operative outcomes, postoperative complications, ten-day mortality and long-term patient survival following elective open and endovascular approaches of AAA repair. Forty-two studies involving 21,178 patients were included (10,855 open, 10,323 endovascular). With elective procedures, the endovascular method was associated with a shorter stay in intensive care (p< 001), and a shorter total postoperative stay (p<0.001). Cardiac and respiratory complications were more common after open surgery (p=0.002 and p< 0.001, respectively). Endovascular repair was associated with an increased risk of graft thrombosis (p=0.004), however. Thirty-day mortality was lower in the endovascular group (p< 0.001), and endovascular repair was associated with improved long-term aneurysm-related mortality (p< 0.001). With ruptured AAA (463 patients), endovascular repair was associated with a reduced intensive care stay (p=0.005) and a lower 30-day mortality (p=0.005). Endovascular repair did not influence long-term all-cause mortality (p=0.520).

Franks et al. (2007) conducted a systematic review and meta-analysis of endovascular AAA repair based on 163 studies (28,862 patients). The pooled estimate for operative mortality was 3.3%. The pooled estimate of

type 2 endoleaks was 10.5%, with an annual rate of 8.4%. The pooled estimate of type 2, 3, and 4 endoleaks was 13.7%, with an annual rate of 10.2%. The pooled estimate for primary conversion to open repair was 3.8%, and for postoperative rupture was 1.3%, with an annual rupture rate of 0.6%. Rates of operative mortality, postoperative rupture, and total number of endoleaks fell significantly over time ($p < 0.05$).

A Cochrane systematic review (Dillon, et al., 2007) was conducted to compare the advantages and disadvantages of endovascular treatment compared to open surgical repair for the treatment of ruptured AAA. No randomized controlled trials meeting the inclusion criteria were found. The authors stated that there is no high-quality evidence to support the use of endovascular repair of ruptured AAA. Results of available studies cannot be interpreted confidently because of the nature of the studies. Evidence from prospective controlled studies, prospective studies, and retrospective case series, however, suggest that endovascular repair is feasible in selected patients, with outcomes comparable to best conventional open surgical repair. In selected patients, endovascular repair may be associated with a trend toward reduction in blood loss, duration of intensive care treatment, and mortality.

An Agency for Healthcare Research and Quality (AHRQ) evidence report/technology assessment (Wilt et al., 2006) compared endovascular and open surgical repairs for AAA. Randomized controlled trials of open surgical repair, endovascular repair, or active surveillance; systematic reviews; nonrandomized U.S. trials; and national registries were used to assess clinical outcomes. The assessment concluded that for AAA < 5.5 cm in diameter, active surveillance with delayed open surgical repair results in equivalent mortality, but less morbidity, due to fewer interventions, compared to immediate open surgical repair. Endovascular repair of aneurysms ≥ 5.5 cm has not been shown to improve long-term survival or health status compared to open surgical repair, although perioperative outcomes are improved. The assessment also stated that endovascular repair does not improve survival in patients who are medically unfit for open surgical repair. Endovascular repair is associated with more complications, need for reintervention, and monitoring compared to open surgical repair or no intervention. The AHRQ report recommended U.S. randomized controlled trials be conducted with approved endovascular repair devices to evaluate patient outcomes.

National Institute for Health and Clinical Excellence (NICE) (United Kingdom)

NICE Interventional Procedures Guidance (2006) states that current evidence on the efficacy and short-term safety of stent-graft placement in AAA appears adequate to support the use of this procedure provided that the normal arrangements are in place for consent, audit and clinical governance.

Fenestrated Endovascular Grafts

Aneurysm anatomic criteria, including proximal and distal neck diameter, length, angulation and shape, are important considerations in patient selection for endovascular aneurysm repair. The Zenith[®] Fenestrated AAA Endovascular Graft (Cook, Inc., Bloomington, IN) has been evaluated in several studies for the treatment of patients with anatomic contraindications to standard endovascular repair. The Zenith Fenestrated Graft has tailored openings or scallops (i.e., fenestrations) and is custom-made based on the patient's anatomy. The self-expanding stent graft is designed to treat aneurysms that extend close to the renal and superior mesenteric arteries. These arteries are then stented to maintain vital organ perfusion. In addition to preserving blood flow to renal or visceral vessels, inserting stents into side branches is intended to enhance stability. The Zenith fenestrated graft is currently not FDA approved (Sun et al., 2006, Muhs et al., 2006, Cook, Inc. website).

The use of fenestrated grafts may become an alternative for patients who are not suitable candidates for traditional surgical repair or endovascular repair using currently approved devices. Additional evidence is needed, however, to demonstrate the safety, efficacy, and long-term outcomes of the use of fenestrated endovascular grafts.

Implanted Wireless Pressure Sensor

The CardioMEMS EndoSure[™] Wireless AAA Pressure Measurement System was approved for marketing through the 510(k) process on October 12, 2006 for the measurement of intrasac pressure during endovascular AAA repair and for use as an adjunctive tool in the detection of intraoperative leaks.

According to the 510(k) summary, the sensor is implanted in the aneurysm sac during stent graft deployment and is left in place in the excluded portion of the aneurysm as a permanent implant. The main body of the sensor is composed of fused silica coated in silicone. Nitinol loops extend from and surround the sensor body. The sensor is interrogated using the antenna of the EndoSure Electronics System. Once the signal is acquired,

a pressure waveform and numerical pressure data are displayed on the touch-screen, and a printout of the data and waveform is generated.

Published evidence on the use of the CardioMEMS system consists of several diagnostic cohort studies with short-term preliminary results (Hoppe et al., 2008, n=12; Silveira et al., 2008, n=25; Ohki et al., 2007, n=76). The safety and clinical utility of this technology in the intraoperative or long-term monitoring of patients following endovascular aortic aneurysm repair has not been established.

Professional Societies/Organizations

The Society for Vascular Surgery Practice Guidelines, The Care of Patients with an Abdominal Aortic Aneurysm (Chaikoff et al., 2009) state that endovascular aneurysm repair (EVAR) has rapidly expanded and is progressively replacing open surgical repair for the treatment of infrarenal AAA. The guideline also states that generally, only aneurysms with adverse neck anatomy not suitable for EVAR undergo standard open surgical repair. Specific recommendations for EVAR vs. open repair are not included for all situations. The guideline includes the following recommendations;

- Repair is recommended for patients that present with an AAA and abdominal or back pain. (Level of recommendation: Strong, Quality of evidence: High)
- Elective repair is recommended for patients that present with a fusiform AAA 5.5 cm in maximum diameter, in the absence of significant co-morbidities. (Level of recommendation: Strong, Quality of evidence: High)
- Elective repair is suggested for patients that present with a saccular aneurysm. (Level of recommendation: Weak, Quality of evidence: Low)
- Young, healthy patients, and especially women, with AAA between 5.0 cm and 5.4 cm in maximum diameter may benefit from repair. (Level of recommendation: Weak, Quality of evidence: Low)
- Immediate repair is recommended for patients that present with documented aneurysm rupture. (Level of recommendation: Strong, Quality of evidence: High)
- Emergent EVAR should be considered for treatment of a ruptured AAA, if anatomically feasible. (Level of recommendation: Strong, Quality of evidence: Moderate)
- EVAR may be considered for high-risk patients unfit for surgical repair. (Level of recommendation: Weak, Quality of evidence: Low)

The American College of Cardiology (ACC)/American Heart Association (AHA) Guidelines for the Management of Patients with Peripheral arterial Disease (Hirsch et al., 2005) include recommendations for the management of AAA. Recommendations are classified as Class I, Class IIa, Class IIb, and Class III. Class I is defined as conditions for which there is evidence and/or general agreement that a given procedure or treatment is beneficial, useful and effective; Class II is defined as conditions for which there is conflicting evidence and/or a divergence of opinion about the usefulness/efficacy of a procedure or treatment. Class II recommendations are further defined as IIa, for which the weight of evidence/opinion is in favor of usefulness/efficacy, and Class IIb, for which the usefulness/efficacy is less well-established by evidence/opinion. Class III is defined as conditions for which there is evidence and/or general agreement that a procedure/treatment is not useful/effective and in some cases may be harmful. The ACC/AHA guideline provides the following recommendations for the management of AAA:

Class I

1. Open repair of infrarenal AAAs and/or common iliac aneurysms is indicated in patients who are good or average surgical candidates.
2. Periodic long-term surveillance imaging should be performed to monitor for an endoleak, to document shrinkage or stability of the excluded aneurysm sac, and to determine the need for further intervention in patients who have undergone endovascular repair of infrarenal aortic and/or iliac aneurysms.

Class IIa

Endovascular repair of infrarenal aortic and/or common iliac aneurysms is reasonable in patients at high risk of complications from open operations because of cardiopulmonary or other associated diseases.

Class IIb

Endovascular repair of infrarenal aortic and/or common iliac aneurysms may be considered in patients at low or average surgical risk.

Summary

Endovascular repair of infrarenal abdominal or aortoiliac abdominal aortic aneurysms (AAA) has demonstrated reduced rates of perioperative mortality and morbidity compared to open surgical repair, with equivalent long-term aneurysm-related mortality. Endovascular repair is associated with higher rates of reintervention, however, and requires long-term radiological monitoring. Endovascular repair may be a reasonable option for selected patients with suitable anatomy for whom the risk/benefit ratio favors endovascular repair. The use of fenestrated grafts (e.g., Zenith® Fenestrated AAA Endovascular Graft) has been investigated for the treatment of patients with AAA involving the visceral arteries. Additional evidence is needed to demonstrate the safety, efficacy, and long-term outcomes of this procedure. In addition, no fenestrated grafts have received U.S. Food and Drug Administration (FDA) approval.

Implantable wireless pressure sensor monitoring (e.g., CardioMEMS EndoSure™ Wireless AAA Pressure Measurement System) has been suggested as a method to provide intraoperative and long-term monitoring of pressure within the aneurysm in conjunction with endovascular AAA repair. The safety and clinical utility of this technology has not been established.

Coding/Billing Information

Note: This list of codes may not be all-inclusive.

Covered when medically necessary:

CPT®* Codes	Description
34800	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis
34802	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (one docking limb)
34803	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (two docking limbs)
34804	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using unibody bifurcated prosthesis
34805	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-uniiliac or aorto-unifemoral prosthesis
34808	Endovascular placement of iliac artery occlusion device (List separately in addition to code for primary procedure)
34812	Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral
34813	Placement of femoral-femoral prosthetic graft during endovascular aortic aneurysm repair (List separately in addition to code for primary procedure)
34820	Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral
34825	Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; initial vessel
34826	Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection;

	each additional vessel (List separately in addition to code for primary procedure)
34830	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; tube prosthesis
34831	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bi-iliac prosthesis
34832	Open repair of infrarenal aortic aneurysm or dissection, plus repair of associated arterial trauma, following unsuccessful endovascular repair; aorto-bifemoral prosthesis
34833	Open iliac artery exposure with creation of conduit for delivery of infrarenal aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral
34834	Open brachial artery exposure to assist in the deployment of infrarenal aortic or iliac endovascular prosthesis by arm incision, unilateral
36200	Introduction of catheter, aorta
36245	Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family
75952	Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation
75953	Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal aortic or iliac artery aneurysm, pseudoaneurysm, or dissection, radiological supervision and interpretation

ICD-9-CM Diagnosis Codes	Description
441.4	Abdominal aneurysm without mention of rupture
441.9	Aortic aneurysm of unspecified site without mention of rupture

Experimental/Investigational/Unproven/Not Covered:

CPT* Codes	Description
34806	Transcatheter placement of wireless physiologic sensor in aneurysmal sac during endovascular repair, including radiological supervision and interpretation, instrument calibration, and collection of pressure data (List separately in addition to code for primary procedure)
93982	Noninvasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report
0078T	Endovascular repair using prosthesis of abdominal aortic aneurysm, pseudoaneurysm or dissection, abdominal aorta involving visceral branches (superior mesenteric, celiac and/or renal artery(s))
0079T	Placement of visceral extension prosthesis for endovascular repair of abdominal aortic aneurysm involving visceral vessels, each visceral branch (List separately in addition to code for primary procedure)
0080T	Endovascular repair of abdominal aortic aneurysm, pseudoaneurysm or dissection, abdominal aorta involving visceral vessels (superior mesenteric, celiac or renal), using fenestrated modular bifurcated prosthesis (two docking limbs), radiological supervision and interpretation
0081T	Placement of visceral extension prosthesis for endovascular repair of abdominal aortic aneurysm involving visceral vessels, each visceral branch, radiological supervision and interpretation (List separately in addition to code for primary procedure)

ICD-9-CM Diagnosis Codes	Description
	All codes

*Current Procedural Terminology (CPT®) ©2010 American Medical Association: Chicago, IL.

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Policy History

Pre-Merger Organizations	Last Review Date	Policy Number	Title
CIGNA HealthCare	10/15/2008	0208	Endovascular Repair of Abdominal Aortic Aneurysms
Great-West Healthcare	02/22/2008	06.336.02	Endovascular Repair of Abdominal Aortic Aneurysms (AAA)

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Connecticut General Life Insurance Company has acquired the business of Great-West Healthcare from Great-West Life & Annuity Insurance Company (GWLA). Certain products continue to be provided by GWLA (Life, Accident and Disability, and Excess Loss). GWLA is not licensed to do business in New York. In New York, these products are sold by GWLA’s subsidiary, First Great-West Life & Annuity Insurance Company, White Plains, N.Y.