



CIGNA MEDICAL COVERAGE POLICY

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

Effective Date 1/15/2011
Next Review Date 1/15/2013
Coverage Policy Number 0269

Subject Nutritional Counseling

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Hyperlink to Related Coverage Policies

- Attention-Deficit/Hyperactivity Disorder (ADHD): Assessment and Treatment
- Bariatric Surgery
- Chronic Fatigue Syndrome: Diagnostic and Treatment Services
- Diabetes Self-Management Education
- Hospitalization for the Initiation of a Ketogenic Diet
- Nutritional Support

INSTRUCTIONS FOR USE

Coverage Policies are intended to provide guidance in interpreting certain **standard** CIGNA HealthCare benefit plans. Please note, the terms of a customer'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 customer'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 customer'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 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. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations. Proprietary information of CIGNA. Copyright ©2011 CIGNA

Coverage Policy

CIGNA does not cover individual nutritional counseling or nutrition classes under certain benefit plans because such counseling or classes are considered education and training in nature. Services that are education and training in nature are specifically excluded under many benefit plans. Even in the presence of coverage for nutritional counseling, certain plans limit the number of covered nutritional counseling visits. Please refer to the individual's applicable benefit plan document and schedules for the terms, conditions and limitations of coverage.

If coverage is available for nutritional evaluation and counseling, the following conditions of coverage apply.

CIGNA covers individualized nutritional evaluation and counseling as medically necessary for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program when prescribed by a physician or physician extender and provided by a licensed health-care professional (e.g., a registered dietician) covered under the plan. Conditions for which nutritional evaluation and counseling may be considered medically necessary include, but are not limited to, the following:

- anorexia nervosa/bulimia
- celiac disease
- cardiovascular disease
- Crohn's disease (CD)
- diabetes mellitus (DM)
- disorders of metabolism (e.g., inborn errors of metabolism, inherited metabolic diseases, amino acid disorders)
- hyperlipidemia
- hypertension
- liver disease
- malabsorption syndrome
- metabolic syndrome X
- multiple or severe food allergies
- nutritional deficiencies
- obesity (i.e., body mass index [BMI] ≥ 30 or $\geq 95^{\text{th}}$ percentile)*
- post-bariatric surgery*
- prediabetes
- renal failure
- ulcerative colitis (UC)

***Medical and surgical services intended for the treatment or control of obesity including clinically severe (morbid) obesity, are specifically excluded under many benefit plans. Please refer to the applicable benefit plan document to determine benefit availability and the terms and conditions of coverage. If coverage for medical and surgical services intended for the treatment or control of obesity is available, the stated medical necessity criteria for nutritional counseling apply.**

CIGNA does not cover individualized nutritional evaluation and counseling for the management of conditions where appropriate diet and eating habits have not been proven to be essential to the overall treatment program because they are not considered to be medically necessary. Conditions for which nutritional evaluation and counseling are not considered to be medically necessary include, but are not limited to, the following:

- attention-deficit/hyperactivity disorder (ADHD)
- chronic fatigue syndrome (CFS)
- idiopathic environmental intolerance (IEI)
- multiple food and chemical sensitivity

General Background

A registered dietitian provides nutritional counseling or medical nutrition therapy as prescribed by the primary care physician. The dietitian evaluates the patient's food intake, physical activity, course of any medical therapy, including medications, and any individual preferences. An initial nutritional evaluation and short-term nutritional counseling may be appropriate as part of the overall medical management of documented metabolic conditions such as diabetes or phenylketonuria (PKU). Typically, this can be accomplished in two to three visits. Short-term evaluation and counseling should include doing an initial dietary work-up, counseling the patient about sample menu planning and teaching him or her about the impact of diet on the disease or condition. The goals of medical nutrition therapy are to promote health, reduce the incidence of preventable disease and improve quality of life. Adherence to a medical nutrition plan of care and adaptation of other appropriate components of lifestyle changes may prevent or delay the need for pharmacotherapy or allow discontinuation of pharmacotherapy after a period of time.

Diseases associated with dietary excess and imbalance rank among the leading causes of illness and death in the United States. Obesity is currently a major public health problem. Body mass index (BMI) values for adults are as follows:

- overweight 25.0–29.9
- obese 30.0–39.9
- extremely obese 40.0 or higher

Scientific evidence has linked diet to coronary artery disease, some types of cancer and stroke. Associations have also been found between diet and prediabetes (i.e., impaired fasting glucose with a fasting glucose range of 100–125 or impaired glucose tolerance with a two-hour glucose tolerance test levels of 140–199), diabetes mellitus (DM), Crohn’s disease (CD), arteriosclerosis, hypertension, osteoporosis and diverticulitis. Lifestyle changes, which include diet modification, have also been found to play a role in the management of metabolic syndrome X. This syndrome is characterized by a cluster of lipid and nonlipid abnormalities including dyslipidemia, elevated fasting blood glucose, hypertension, and abdominal obesity (Berra, 2003). Whatever role diet may play in the prevention of these conditions is moderated by a combination of environmental, behavioral, social and genetic factors. Chronic disease and illness can be reduced through early identification of lifestyle risks.

Diet modification has also been proposed as an intervention for the management of attention-deficit/hyperactivity disorder (ADHD), chronic fatigue syndrome (CFS), and idiopathic environmental intolerance (IEI). IEI, also known as multiple chemical sensitivity, is a chronic, polysymptomatic condition that cannot be attributed to organic disease. IEI is characterized by multiple functional symptoms in relation to environmental exposures. The more common environmental chemicals cited for triggering symptoms include car exhaust, perfumes, cigarette smoke and pesticides. Although allergic, immunotoxic, neurotoxic, cytotoxic, psychologic, sociologic, and iatrogenic theories have been proposed for both etiology and production of symptoms of IEI, there is an absence of scientific evidence to establish any of these mechanisms as definitive (American Academy of Allergy Asthma and Immunology [AAAAI], 1996, 2008).

Literature Review

The body of evidence demonstrating the effectiveness of nutritional counseling includes a number of randomized controlled trials (RCTs) with patient populations ranging from 50–257. Available studies have explored the role of nutritional counseling in the prevention and management of multiple conditions including impaired glucose tolerance, diabetes, chronic kidney disease, cardiovascular disease, hypertension, and overweight and obesity (Molenaar, et al., 2010; Keyserling, et al., 2008; Sartorelli, et al., 2005; Arcand, et al., 2005; Ravasco, et al., 2005; Tuomilehto, et al., 2002).

There is sufficient evidence in the published peer-reviewed medical literature to support the use of nutritional counseling in the treatment of chronic conditions and showing improvement of meaningful health outcomes.

There is insufficient evidence in the scientific medical literature to support the use of nutritional intervention for the treatment of either ADHD or CFS.

There is a lack of evidence in the published, peer-reviewed scientific literature demonstrating that nutritional counseling is effective in the treatment of IEI.

Professional Societies/Organizations

The USPSTF recommends that children aged six years and older be screened for obesity and offered or referred to comprehensive, intensive behavioral interventions to promote improvement in weight status. According to the USPSTF, effective comprehensive weight-management programs have incorporated counseling and other interventions that targeted diet and physical activity (USPSTF, 2010). The USPSTF recommends dietary counseling for individuals with known risk factors for diet-related chronic diseases and concludes that such counseling is likely to improve health outcomes (USPSTF, 2003).

According to the American Dietetic Association (ADA) position statement on medical nutrition therapy and pharmacotherapy, the use of medical nutrition therapy and lifestyle counseling is an essential component of the medical treatment of specific disease states (e.g., diabetes, hypertension, cardiovascular disease, obesity) and should be the initial step in the management of these conditions (McCabe-Sellers, et al., 2010; ADA, 2003). The ADA position on nutrition intervention in the treatment of eating disorders states that nutrition intervention which includes nutritional counseling by a registered dietitian is an integral component of the treatment of patients with anorexia nervosa, bulimia nervosa, and other eating disorders during assessment and treatment across the

continuum of care. The registered dietitian is uniquely qualified to provide medical nutrition therapy for the normalization of eating patterns and nutritional status (ADA, 2006).

The Institute for Clinical Systems Improvement (ICSI) guideline for the diagnosis and management of Type 2 DM in adults states that treatments for individuals diagnosed with prediabetes should include “intensive lifestyle behavioral change including a nutrition and activity plan by a registered dietitian, health educator or other qualified health professional. Ongoing support of behavioral change is necessary” (ICSI, 2010).

The AAAAI states that “a causal connection between environmental chemicals, foods, and/or drugs and the patient’s symptoms continues to be speculative and cannot be based on the results of currently published scientific studies” (AAAAI, 2008; 1996).

The American College of Endocrinology (ACE) consensus statement on the diagnosis and management of prediabetes reiterates that lifestyle is a fundamental management approach to prevent or delay progression from prediabetes to diabetes as well as to reduce both micro- and macrovascular risks. This guideline further states that even modest weight loss (7–10% of body weight) results in decreased fat mass, blood pressure, glucose, low-density lipoprotein, and triglyceride levels. These benefits can also translate into improved long-term outcome, especially if weight loss and lifestyle alterations are maintained (ACE, 2008).

The American Association of Clinical Endocrinologists (AACE) states that prediabetes, which includes states of impaired fasting glucose or impaired glucose tolerance, often progresses to Type 2 DM in the absence of intervention. The AACE recommends lifestyle modification as an intervention for the prevention of Type 2 DM. Lifestyle modification should include referral to a registered dietitian or credible weight loss program/service for counseling in energy intake reduction and nutritional strategies with a weight reduction goal of 5–10% of total body weight (AACE Diabetes Mellitus Clinical Practice Guidelines Task Force, 2007).

In 2005, the American Heart Association (AHA)/National Heart, Lung, and Blood Institute (NHLBI) published a scientific statement on the diagnosis and management of the metabolic syndrome. This document states that although many people may be genetically susceptible to the metabolic syndrome, rarely does it become clinically manifested in the absence of some degree of obesity and physical inactivity. Therefore, the prime emphasis in management of the metabolic syndrome is to lessen the effects of the modifiable, underlying risk factors (obesity, physical inactivity, and atherogenic diet) through lifestyle changes (AHA/ NHLBI, et al., 2005).

Summary

Nutritional counseling is appropriate only for the management of conditions for which nutritional intervention has been demonstrated to result in positive net health outcomes (e.g., prediabetes, diabetes, eating disorders, cardiovascular and renal diseases). The role of nutritional counseling has not been established in the management of conditions that are not nutritionally related, such as chronic fatigue syndrome, attention-deficit/hyperactivity disorder (ADHD), and idiopathic environmental intolerances/multiple food and chemical sensitivities.

Coding/Billing Information

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

Covered when medically necessary:

CPT[®]* Codes	Description
97802	Medical nutrition therapy; initial assessment and intervention, individual, face to face with the patient, each 15 minutes
97803	Medical nutrition therapy; re-assessment and intervention, individual, face to face with the patient, each 15 minutes

HCPCS Codes	Description
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G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes
S9465	Diabetic management program, dietitian visit
S9470	Nutrition counseling, dietitian visit

ICD-9-CM Diagnosis Codes	Description
042	Human immunodeficiency virus [HIV] disease
140.0-208.92	Malignant neoplasms
209.00- 209.36	Malignant neuroendocrine tumors
249.00- 249.91	Secondary diabetes mellitus
270.0 – 270.9	Disorders of amino-acid transport and metabolism
272.0 – 272.4	Disorders of lipid metabolism
275.01 – 275.9	Disorders of mineral metabolism
276.0 – 276.9	Disorders of fluid, electrolyte and acid-base balance
277.00 – 277.89	Other and unspecified disorders of metabolism
278.01	Morbid obesity
281.2	Folate deficiency anemia
281.8	Anemia associated with other specified nutritional deficiency
281.9	Unspecified deficiency anemia
307.1	Anorexia nervosa
307.51	Bulimia nervosa
401.0 – 405.99	Hypertensive disease
411.0 – 414.9	Ischemic heart disease
428.0 – 428.9	Heart failure
531.00- 531.91	Gastric ulcer
532.0-532.91	Duodenal ulcer
533.00- 533.91	Peptic ulcer, site unspecified
534.00- 534.91	Gastrojejunal ulcer
535.00- 535.71	Gastritis and duodenitis
536.0-536.9	Disorders of function of stomach
537.0-537.9	Other disorders of stomach and intestine
555.0 – 555.9	Regional enteritis
556.0 – 556.9	Ulcerative colitis
558.1-558.9	Other and unspecified noninfectious gastroenteritis and colitis
571.1 – 571.9	Chronic liver disease and cirrhosis
579.0-579.9	Intestinal malabsorption
580.0-599.9	Nephritis, nephrotic syndrome and nephrosis
648.80 – 648.84	Abnormal maternal glucose tolerance, complicating pregnancy, childbirth, or the puerperium
790.21 – 790.29	Abnormal glucose
V15.01	Personal history of allergy to peanuts
V15.02	Personal history of allergy to milk products

V15.03	Personal history of allergy to eggs
V15.04	Personal history of allergy to seafood
V15.05	Personal history of allergy to other foods
V45.86	Bariatric surgery status
V65.3	Dietary surveillance and counseling
V85.30 – V85.39	Body Mass Index between 30-39, adult
V85.41 – V85.45	Body Mass Index 40 and over, adult
	Multiple/Varied

Experimental/Investigational/Unproven/Not Covered:

ICD-9-CM Diagnosis Codes	Description
314.00 – 314.01	Attention deficit disorder of childhood
692.0 – 692.9	Contact dermatitis and other eczema
693.8	Dermatitis due to other specified substances taken internally
693.9	Dermatitis due to unspecified substance taken internally
780.71	Chronic fatigue syndrome

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

References

1. AACE Diabetes Mellitus Clinical Practice Guidelines Task Force. American Association of Clinical Endocrinologists medical guidelines for clinical practice for the management of diabetes mellitus. *Endocr Pract.* 2007 May-Jun;13 Suppl 1:1-68.
2. American Academy of Allergy Asthma and Immunology (AAAAI). Position Statement. Idiopathic environmental intolerances. © 1996–2008 Accessed Dec 8, 2008. Available at URL address: http://www.aaaai.org/members/academy_statements/position_statements/ps35.asp
3. http://www.aaaai.org/members/academy_statements/position_statements/ps35.asp
4. American Academy of Family Physicians, American Dietetic Association. Nutrition Screening Initiative. A physician's guide to nutrition in chronic disease management for older adults. Accessed Dec 3, 2004; Nov 27, 2007. Available at URL: http://www.aafp.org/PreBuilt/NSI_newbookletSMALLER.pdf
5. American Academy of Family Physicians. American Dietetic Association. Nutrition Screening Initiative. Congestive heart failure. Nutrition management for older adults. Accessed Nov 27, 2007. Available at URL address: http://www.aafp.org/PreBuilt/NSI_CHF.pdf
6. American College of Endocrinology Task Force on Pre-diabetes. American College of Endocrinology Consensus Statement on the Diagnosis and Management of Pre-diabetes in the Continuum of Hyperglycemia – When do the Risks of diabetes Begin? Jul 2008. Accessed Dec 2, 2008. Available at URL address: <http://www.aace.com/meetings/consensus/hyperglycemia/hyperglycemia.pdf>
7. American Diabetes Association. Pre-Diabetes. Accessed Dec 2, 2008. Available at URL address: <http://www.diabetes.org/pre-diabetes.jsp>
8. American Dietetic Association. Medical nutrition therapy and pharmacotherapy. *J Am Diet Assoc.* 1999;99:227-30.

9. American Dietetic Association. Position of the American Dietetic Association: integration of medical nutrition therapy and pharmacotherapy. *J Am Diet Assoc.* 2003 Oct;103(10):1363-70.
10. American Dietetic Association. Position of the American Dietetic Association: nutrition intervention in the treatment of anorexia nervosa, bulimia nervosa, and eating disorders not otherwise specified (EDNOS). *J Am Diet Assoc.* 2001 Jul;101(7):810-9.
11. American Dietetic Association. Position of the American Dietetic Association: Nutrition intervention in the treatment of anorexia nervosa, bulimia nervosa, and other eating disorders. *J Am Diet Assoc.* 2006 Dec;106(12):2073-82.
12. American Dietetic Association. Disorders of lipid metabolism evidence-based nutrition practice guideline. Chicago (IL): American Dietetic Association; 2005 Aug. 17 p. Accessed Nov 28, 2006. Available at URL address: http://www.guideline.gov/summary/summary.aspx?ss=15&doc_id=9533&nbr=5083
13. American Heart Association; National Heart, Lung, and Blood Institute, Grundy SM, Cleeman JI, Daniels SR, Donato KA, et al. Diagnosis and management of the metabolic syndrome. An American Heart Association/National Heart, Lung, and Blood Institute Scientific Statement. Executive summary. *Cardiol Rev.* 2005 Nov-Dec;13(6):322-7.
14. Arcand JA, Brazel S, Joliffe C, Choleva M, Berkoff F, Allard JP, et al. Education by a dietitian in patients with heart failure results in improved adherence with a sodium-restricted diet: a randomized trial. *Am Heart J.* 2005 Oct;150(4):716.
15. Bailer J, Witthoft M, Paul C, Bayerl C, Rist F. Evidence for overlap between idiopathic environmental intolerance and somatoform disorders. *Psychosom Med.* 2005 Nov-Dec;67(6):921-9.
16. Berra K. Treatment options for patients with the metabolic syndrome. *J Am Acad Nurse Pract.* 2003 Aug;15(8):361-70.
17. Bossola M, Muscaritoli M, Tazza L, Giungi S, Tortorelli A, Fanelli FR, et al. Malnutrition in hemodialysis patients: what therapy? *Am J Kidney Dis.* 2005 Sep;46(3):371-86.
18. Centers for Disease Control (CDC). National Center for Chronic Disease Prevention and Health Promotion. Diabetes Public Health Resource. Frequently Asked Questions. Prediabetes. Last modified: July 8, 2008. Accessed Dec 5, 2008. Available at URL address: <http://www.cdc.gov/diabetes/faq/prediabetes.htm>
19. Das-Munshi J, Rubin GJ, Wessely S. Multiple chemical sensitivities: review. *Curr Opin Otolaryngol Head Neck Surg.* 2007 Aug;15(4):274-80.
20. Diabetes Mellitus Clinical Practice Guidelines Task Force. AACE diabetes mellitus guidelines. Prevention of type 2 diabetes mellitus. *Endocr Pract.* 2007 May-Jun;13 Suppl 1:1-68.
21. Institute for Clinical Systems Improvement (ICSI). Diagnosis and Management of Type 2 Diabetes Mellitus in Adults, Fourteenth Edition. January 2010. Accessed Dec 9, 2010. Available at URL address: http://www.icsi.org/diabetes_mellitus__type_2/management_of_type_2_diabetes_mellitus__9.html
22. Israili ZH, Lyoussi B, Hernández-Hernández R, Velasco M. Metabolic syndrome: treatment of hypertensive patients. *Am J Ther.* 2007 Jul-Aug;14(4):386-402.
23. Keyserling TC, Samuel Hodge CD, Jilcott SB, Johnston LF, Garcia BA, Gizlice Z, et al. Randomized trial of a clinic-based, community-supported, lifestyle intervention to improve physical activity and diet: the North Carolina enhanced WISEWOMAN project. *Prev Med.* 2008 Jun;46(6):499-510. Epub 2008 Feb 15.

24. McCabe-Sellers BJ, Skipper A; American Dietetic Association. Position of the American Dietetic Association: integration of medical nutrition therapy and pharmacotherapy. *J Am Diet Assoc.* 2010 Jun;110(6):950-6.
25. Molenaar EA, van Ameijden EJ, Vergouwe Y, Grobbee DE, Numans ME. Effect of nutritional counselling and nutritional plus exercise counselling in overweight adults: a randomized trial in multidisciplinary primary care practice. *Fam Pract.* 2010 Apr;27(2):143-50. Epub 2009 Dec 21.
26. Ravasco P, Monteiro-Grillo I, Vidal PM, Camilo ME. Dietary counseling improves patient outcomes: a prospective, randomized, controlled trial in colorectal cancer patients undergoing radiotherapy. *J Clin Oncol.* 2005 Mar 1;23(7):1431-8.
27. Ravasco P, Monteiro Grillo I, Camilo M. Cancer wasting and quality of life react to early individualized nutritional counselling! *Clin Nutr.* 2007 Feb;26(1):7-15. Epub 2006 Dec 12.
28. Roblin L. Childhood obesity: food, nutrient, and eating-habit trends and influences. *Appl Physiol Nutr Metab.* 2007 Aug;32(4):635-45.
29. Sartorelli DS, Sciarra EC, Franco LJ, Cardoso MA. Beneficial effects of short-term nutritional counselling at the primary health-care level among Brazilian adults. *Public Health Nutr.* 2005 Oct;8(7):820-5.
30. Shephard RJ. Chronic fatigue syndrome. A brief review of functional disturbances and potential therapy. *J Sports Med Phys Fitness.* 2005 Sep;45(3):381-92.
31. Sherwin RS, Anderson RM, Buse JB, Chin MH, Eddy D, Fradkin J, et al. Prevention or delay of type 2 diabetes. *Diabetes Care.* 2004 Jan;27 Suppl 1:S47-54.
32. Spahn JM, Reeves RS, Keim KS, Laquatra I, Kellogg M, Jortberg B, et al. State of the evidence regarding behavior change theories and strategies in nutrition counseling to facilitate health and food behavior change. *J Am Diet Assoc.* 2010 Jun;110(6):879-91.
33. Tabi M, Vogel RL. Nutritional counselling: an intervention for HIV-positive patients. *J Adv Nurs.* 2006 Jun;54(6):676-82.
34. Tuomilehto J, Lindström J, Eriksson JG, Valle TT, Hämäläinen H, Ilanne-Parikka P, et al. Prevention of type 2 diabetes mellitus by changes in lifestyle among subjects with impaired glucose tolerance. *N Engl J Med.* 2001 May 3;344(18):1343-50.
35. U.S. Preventive Services Task Force (USPSTF). Behavioral counseling in primary care to promote a healthy diet: recommendations and rationale. *Am Fam Physician.* 2003 Jun 15;67(12):2573-6.
36. U.S. Preventive Services Task Force (USPSTF). Screening for obesity in adults: recommendations and rationale. *Am Fam Physician.* 2004 Apr 15;69(8):1973-6.
37. U.S. Preventive Services Task Force (USPSTF). Screening for Obesity in Children and Adolescents. Recommendation Statement. January 2010. Accessed December 8, 2010. Available at URL address: <http://www.uspreventiveservicestaskforce.org/uspstf10/childobes/chobesrs.htm>

Policy History

<u>Pre-Merger Organizations</u>	<u>Last Review Date</u>	<u>Policy Number</u>	<u>Title</u>
CIGNA HealthCare	1/15/2008	0269	Nutritional Counseling

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