

SUMMARY OF BENEFITS Connecticut General Life Insurance Co.



Currituck County CIGNA Choice Fund Health Reimbursement Account Open Access Plus Coinsurance Plan

Health Reimbursement Account

Your employer has established a health reimbursement account that you can use to pay for eligible out-of-pocket expenses during the plan year.

Employer Contribution	Employee \$0	Employee + 1 \$0	Family \$0
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Annual deductibles and maximums	In-network	Out-of-network
Lifetime maximum	Unlimited	
Pre-Existing Condition Limitation (PCL)	Applies	Applies
Coinsurance	You pay 20% Plan pays 80% after the deductible is met	You pay 40% Plan pays 60% after the deductible is met
Maximum Reimbursable Charge <ul style="list-style-type: none"> Determined based on the lesser of: <ul style="list-style-type: none"> the health care professional's normal charge for a similar service; or a percentage of a fee schedule developed by CIGNA that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule will not be used and the maximum reimbursable charge for covered services is determined based on the lesser of: <ul style="list-style-type: none"> the health care professional's normal charge for a similar service or supply; or the amount charged for that service by 80% of the health care professionals in the geographic area where it is received. Out-of-network services are subject to a plan year deductible and maximum reimbursable charge limitations. 	N/A	110%
Plan year deductible <ul style="list-style-type: none"> The amount you pay for out-of-network services counts towards both your in-network and out-of-network deductibles. (One way accumulation). All family members contribute towards the family deductible. The plan cannot pay an individual's claims until the total family deductible has been met, even if he or she has met the individual deductible. This plan includes a combined Medical/Rx deductible. Out-of-network pharmacy deductible accumulates to the in-network pharmacy deductible. Mail order pharmacy costs contribute to the deductible. 	Employee \$1,500 Employee and Family \$3,000	Employee \$3,000 Employee and Family \$6,000
Plan year out-of-pocket maximum <ul style="list-style-type: none"> The amount you pay for out-of-network services counts towards both your in-network and out-of-network out-of-pocket maximums. (One way accumulation) 	Employee \$4,000	Employee \$8,000



Annual deductibles and maximums	In-network	Out-of-network
<ul style="list-style-type: none"> Deductibles do not contribute towards your out-of-pocket maximum. Copays do not contribute towards your out-of-pocket maximum Mental health and substance abuse services do not contribute towards your out-of-pocket maximum. All family members contribute towards the family out-of-pocket maximum. The plan cannot pay an individual's covered expenses at 100% until the total family out-of-pocket maximum has been reached. This plan includes a combined Medical/Rx out-of-pocket maximum. Out-of-network pharmacy out-of-pocket expenses accumulates to the in-network pharmacy out-of-pocket maximum. Mail order pharmacy costs contribute to the out-of-pocket maximum. 	<p>Employee and Family \$8,000</p>	<p>Employee and Family \$16,000</p>

Benefits	In-network	Out-of-network
Physician services		
<p>Office visit</p> <ul style="list-style-type: none"> Primary care physician and specialist office visits 	<p>You pay 20% Plan pays 80% after the deductible is met</p>	<p>You pay 40% Plan pays 60% after the deductible is met</p>
<p>Physician services (hospital)</p> <ul style="list-style-type: none"> In hospital visits and consultations Inpatient services Outpatient services 	<p>You pay 20% Plan pays 80% after the deductible is met</p>	<p>You pay 40% Plan pays 60% after the deductible is met</p>
<p>Surgery (in a physician's office)</p>	<p>You pay 20% Plan pays 80% after the deductible is met</p>	<p>You pay 40% Plan pays 60% after the deductible is met</p>
Preventive care		
<p>Preventive care</p> <ul style="list-style-type: none"> Includes well-baby, well-child, well-woman and adult preventive care In-network immunizations are included at no charge. Lab and x-ray billed outside the doctor's office do not count towards the plan year maximum. Mammograms do not count towards the plan year maximum. Unlimited plan year maximum 	<p>No charge</p>	<p>You pay 40% Plan pays 60% after the deductible is met</p>
<p>Mammogram, PSA, Pap Smear and Maternity Screening</p> <ul style="list-style-type: none"> Coverage includes the associated Preventive Outpatient Professional Services. Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service. 	<p>No charge, no deductible</p>	<p>You pay 40% Plan pays 60% after the deductible is met</p>



Benefits	In-network	Out-of-network
Inpatient hospital facility services		
Semi-private room and board and other non-physician services <ul style="list-style-type: none"> Inpatient room and board, pharmacy, x-ray, lab, operating room, surgery, etc. 	You pay 20% Plan pays 80% after the deductible is met	You pay 40% Plan pays 60% after the deductible is met
Inpatient Professional Services <ul style="list-style-type: none"> For services performed by surgeons, radiologists, pathologists and anesthesiologists 	You pay 20% Plan pays 80% after the deductible is met	You pay 40% Plan pays 60% after the deductible is met
Multiple surgical reduction <ul style="list-style-type: none"> 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. 	Included	Included
Outpatient services		
Outpatient surgery (facility charges)	You pay 20% Plan pays 80% after the deductible is met	You pay 40% Plan pays 60% after the deductible is met
Outpatient Professional Services <ul style="list-style-type: none"> For services performed by surgeons, radiologists, pathologists and anesthesiologists 	You pay 20% Plan pays 80% after the deductible is met	You pay 40% Plan pays 60% after the deductible is met
Physical, occupational, cognitive and speech therapy <ul style="list-style-type: none"> Limited to 60 days per plan year for all therapies combined Includes physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation and cognitive therapy Includes chiropractic therapy (includes chiropractors) Therapy days, provided as part of an approved Home Health Care plan, accumulate to the outpatient short term rehab therapy maximum. 	You pay 20% Plan pays 80% after the deductible is met	You pay 40% Plan pays 60% after the deductible is met
Cardiac rehabilitation <ul style="list-style-type: none"> Limited to 36 days per plan year 	You pay 20% Plan pays 80% after the deductible is met	You pay 40% Plan pays 60% after the deductible is met
Lab and X-ray		
Lab and X-ray <ul style="list-style-type: none"> Physician's office Outpatient hospital facility Independent lab & x-ray facility 	You pay 20% Plan pays 80% after the deductible is met	You pay 40% Plan pays 60% after deductible is met
Lab and X-ray, emergency room and urgent care <ul style="list-style-type: none"> Emergency room when billed by the facility as part of the emergency room visit Urgent care when billed by the facility as part of the urgent care visit. Independent x-ray and/or lab facility in conjunction with a emergency room visit 	You pay 20% Plan pays 80% after the deductible is met	



Benefits	In-network	Out-of-network
Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.) <ul style="list-style-type: none"> Physician's office Inpatient hospital facility Outpatient facility 	You pay 20% Plan pays 80% after the deductible is met	You pay 40% Plan pays 60% after the deductible is met
Advanced radiological imaging (MRI, MRA, CAT Scan, PET Scan, etc.) <ul style="list-style-type: none"> Emergency room Urgent care facility 	You pay 20% Plan pays 80% after the deductible is met	
Emergency and urgent care services		
Hospital emergency room <ul style="list-style-type: none"> Includes radiology, pathology and physician charges Out-of-network services are covered at the in-network rate. 	You pay 20% Plan pays 80% after the deductible is met	
Ambulance <ul style="list-style-type: none"> Out-of-network services are covered the same as in-network services. Note: Non-emergency transportation (e.g. from hospital back home) is generally not covered. 	You pay 20% Plan pays 80% after the deductible is met	
Urgent care services <ul style="list-style-type: none"> Out-of-network services are covered at the in-network rate. 	You pay 20% Plan pays 80% after the deductible is met	
Other health care facilities		
Skilled nursing facility, rehabilitation hospital and other facilities <ul style="list-style-type: none"> 60 days per plan year 	You pay 20% Plan pays 80% after the deductible is met	You pay 40% Plan pays 60% after the deductible is met
Home health care <ul style="list-style-type: none"> Unlimited days per plan year 	You pay 20% Plan pays 80% after the deductible is met	You pay 40% Plan pays 60% after the deductible is met
Hospice <ul style="list-style-type: none"> Inpatient services Outpatient services 	You pay 20% Plan pays 80% after the deductible is met	You pay 40% Plan pays 60% after the deductible is met
Other health care services		
Durable medical equipment <ul style="list-style-type: none"> Unlimited plan year maximum 	You pay 20% Plan pays 80% after the deductible is met	You pay 40% Plan pays 60% after the deductible is met
External prosthetic appliances (EPA) <ul style="list-style-type: none"> Unlimited plan year maximum 	You pay 20% Plan pays 80% after deductible is met	You pay 40% Plan pays 60% after deductible is met
TMJ <ul style="list-style-type: none"> Doctor's Office Inpatient Facility Outpatient Facility Physician's Services 	Cost and reimbursement vary based on the facility in which it is performed	Cost and reimbursement vary based on the facility in which it is performed.



Benefits	In-network	Out-of-network
Infertility (buy up option 1) <ul style="list-style-type: none"> Office visit for testing, treatment and artificial insemination Inpatient hospital facility Outpatient hospital facility Physician services Surgical treatment limited to procedures to correct infertility, excluding In-vitro, GIFT ZIFT, etc. 	Cost and reimbursement vary based on the facility in which it is performed	Cost and reimbursement vary based on the facility in which it is performed
Family planning <ul style="list-style-type: none"> Inpatient hospital facility Outpatient facility Physician services Surgical services such as tubal ligation or vasectomy are covered (excluding reversals). Includes contraceptive devices 	Cost and reimbursement vary based on the facility in which it is performed	Cost and reimbursement vary based on the facility in which it is performed
Mental health and substance abuse services		
Please note the following regarding Mental Health (MH) and Substance Abuse (SA) benefit administration: <ul style="list-style-type: none"> Substance Abuse includes Alcohol and Drug Abuse services. Transition of Care benefits are provided for a 90-day time period. 		
Inpatient mental health services <ul style="list-style-type: none"> Unlimited days per plan year Mental health services are paid at 100% after you reach your out-of-pocket maximum. 	You pay 20% Plan pays 80% after the medical plan deductible is met	You pay 40% Plan pays 60% after the medical plan deductible is met
Outpatient mental health services <ul style="list-style-type: none"> Unlimited visits per plan year Mental health services are paid at 100% after you reach your out-of-pocket maximum. This includes group therapy mental health, and intensive outpatient mental health 	You pay 20% Plan pays 80% after the medical plan deductible is met	You pay 40% Plan pays 60% after the medical plan deductible is met
Inpatient substance abuse services <ul style="list-style-type: none"> Unlimited days per plan year Substance abuse services are paid at 100% after you reach your out-of-pocket maximum. 	You pay 20% Plan pays 80% after the medical plan deductible is met	You pay 40% Plan pays 60% after the medical plan deductible is met
Outpatient substance abuse services <ul style="list-style-type: none"> Unlimited visits per plan year Substance abuse services are paid at 100% after you reach your out-of-pocket maximum. This includes intensive outpatient substance abuse 	You pay 20% Plan pays 80% after the medical plan deductible is met	You pay 40% Plan pays 60% after the medical plan deductible is met
Prescription Drugs		
CIGNA Pharmacy three-tier copay plan <ul style="list-style-type: none"> Generic push Self administered injectable– excludes infertility drugs Includes Oral Contraceptives 	Retail (30 day supply) <u>You pay:</u> Generic \$4 Preferred Brand \$30 Non-Preferred Brand \$45	You pay 30% Plan pays 70%



Benefits	In-network	Out-of-network
	<p>Home Delivery (90 day supply) <u>You pay:</u> Generic \$8 Preferred Brand \$60 Non-Preferred Brand \$90</p>	
<p>Pharmacy Clinical Management and Prior Authorization Your plan is subject to certain clinical edits and prior authorization requirements.</p>		
<p>Step Therapy</p> <ul style="list-style-type: none"> • Step Therapy is a prior authorization program that may require you to try other medications available to treat the same condition before the “Step Therapy” medication is covered. • All possible Step Therapy medications are identified on the CIGNA prescription drug list with an “ST” suffix. To determine if a specific drug is subject to Step Therapy for your plan, please call Customer Service at the phone number listed on your ID card or visit the Prescription Drug Price Quote tool on myCIGNA.com. 		
<p>Specialty Pharmacy</p> <ul style="list-style-type: none"> • Clinical Programs <ul style="list-style-type: none"> ○ Prior authorization required on specialty medications and quantity limits may apply. ○ TheraCare® Program • Medication Access Option: Retail and/or Home Delivery 		
<p>Vision care</p>	<p>Not covered</p>	



Definitions

Deductible – A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.

Coinsurance – After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called coinsurance.

Copay – A flat fee you pay for certain covered services such as doctor's visits or prescriptions.

Out-of-pocket Maximum – Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "maximum reimbursable charges" or negotiated fees for covered services.

Place of service – Your plan pays based on where you receive services. For example, for hospital stays, your coverage is paid at the inpatient level.

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

For children, you may designate a pediatrician as the primary care provider.

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

Pre-existing condition limitation – Not applicable to anyone under 19 years old. Applies to any injury or sickness that you are diagnosed with and receive treatment for, or incur expenses for during the 90 days before you are insured by these benefits or you begin an eligibility waiting period (whichever is earlier). Please refer to your plan documents for specific details.

Transition of Care – Provides in-network health coverage to new customers when the customer's doctor is not part of the CIGNA network and there are approved clinical reasons why the customer should continue to see the same doctor.

Prescription Drug List – The list of prescription brand and generic drugs covered by your pharmacy plan.

Maximizing your health care dollars

Log on to myCIGNA.com for resources to help you choose a health care professional or compare the cost and quality of medical services, medications and hospital care.

When you need a medical service or procedure, CIGNA offers you opportunities to save on prescription medicine, routine medical care, laboratory services, radiology scans, and outpatient surgery. Details are below:

CIGNA Home Delivery Pharmacy – You can save money and enjoy convenient home delivery by using CIGNA Home Delivery Pharmacy for your prescription medications. You can get up to a 90-day supply of your medication.

Lab – Save on lab services by using a free-standing laboratory instead of a hospital- or clinic-based lab.

Urgent Care – For non-emergency conditions that need attention before you can see your doctor, you can save money by going to an urgent care center instead of an Emergency Room (ER).

Convenience Care – For minor or routine conditions, go to a Convenience Care Clinic when your doctor is unavailable. Convenience Care Clinics are retail-based and often found in pharmacies or grocery stores.

Radiology – Costs for MRIs, PET, and CT scans can vary greatly. Non-hospital based outpatient radiology centers often cost much less than a hospital. CIGNA's network includes both hospitals and outpatient centers, so you can find a radiology center that's right for you.

Outpatient Surgery – Costs for colonoscopies, arthroscopies, and other outpatient procedures can vary greatly. Using a free-standing outpatient surgery center can save hundreds of dollars.



Exclusions

What's Not Covered (*not all-inclusive*):

Your plan provides coverage for most medically necessary services. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Services provided through government programs
- Services that aren't medically necessary
- Experimental, investigational or unproven services
- Services for an injury or illness that occurs while working for pay or profit including services covered by Worker's Compensation benefits
- Cosmetic services
- Dental care, unless due to accidental injury to sound natural teeth
- Reversal of sterilization procedures
- Genetic screenings
- Non-prescription and anti-obesity drugs
- Custodial and other non-skilled services
- Weight loss programs
- Hearing aids
- Acupuncture
- Treatment of sexual dysfunction
- Travel immunizations
- Telephone, email and internet consultations in the absence of a specific benefit
- Eyeglass lenses and frames, contact lenses and surgical vision correction

These are only the highlights

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

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Additional Information

Additional Benefit Information	In-network	Out-of-network
<p>Prescription Drug List:</p> <ul style="list-style-type: none"> • CIGNA Standard Prescription Drug List • 		
<p>Pharmacy Cost Management Program (Step Therapy)</p> <p><u>High Blood Pressure (ACEI/ARB)</u></p> <ul style="list-style-type: none"> • <i>Two-Step</i> – Both Step 1 (Generic) and then Step 2 (Preferred Brand) medications must be used, in that order, prior to using a Step 3 (Non-Preferred Brand) medication. • No Grace Period • First Fill Pay and Educate not included <p><u>Cholesterol Lowering (STATIN)</u></p> <ul style="list-style-type: none"> • <i>Two-Step</i> – Both Step 1 (Generic) and then Step 2 (Preferred Brand) medications must be used, in that order, prior to using a Step 3 (Non-Preferred Brand) medication. • No Grace Period • First Fill Pay and Educate not included <p><u>Heartburn/Ulcer (PPI)</u></p> <ul style="list-style-type: none"> • <i>Two-Step</i> – Both Step 1 (Generic) and then Step 2 (Preferred Brand) medications must be used, in that order, prior to using a Step 3 (Non-Preferred Brand) medication. • No Grace Period • First Fill Pay and Educate not included 		
<p>Pre-admission certification – continued stay review (PHS)</p> <ul style="list-style-type: none"> • Benefits are denied for any admission reviewed by CIGNA Healthcare and not certified. • Benefits are denied for any additional days not certified by CIGNA Healthcare. 	<p>Coordinated by provider/PCP</p>	<p>Employee is responsible for contacting CIGNA Healthcare. A 50% penalty is applied to hospital inpatient charges for failure to contact CIGNA Healthcare to pre-certify admission</p>
<p>Case Management</p>	<p>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.</p>	
<p>Mental health/Substance abuse utilization review, case management and programs</p>	<p>Capitation (CAP) - Inpatient and Outpatient Management</p> <ul style="list-style-type: none"> • Case Management and Utilization Review for Inpatient Services (In-Network, Out of Network) and Outpatient Services (In-Network only) Provided by CIGNA Behavioral Health (CBH). • Includes Lifestyle Management Programs: Stress management & Tobacco Cessation, Healthy Steps to Weight Loss.) 	



Additional Benefit Information	In-network	Out-of-network
MH/SA Service Specific Administration	The following administration applies for Partial Hospitalization, Residential Treatment, and Intensive Outpatient Programs: <ul style="list-style-type: none"> • <i>Partial Hospitalization and Residential Treatment:</i> Covered as inpatient Mental Health and/or Substance Abuse. • <i>Intensive Outpatient Program (IOP):</i> Covered as outpatient Mental Health and/or Substance Abuse 	
Annual Reinstatement	Not Included	
Allergy treatment/injections	You pay 20% Plan pays 80% after the deductible is met	You pay 40% Plan pays 60% after the deductible is met
Allergy serum (dispensed by the physician in the office)	You pay 20% Plan pays 80% after the deductible is met	You pay 40% Plan pays 60% after the deductible is met
Bereavement counseling - inpatient services	Paid the same as Inpatient Hospice Facility	Paid the same as Inpatient Hospice Facility
Bereavement counseling – outpatient services	Paid the same as outpatient Hospice Facility	Paid the same as outpatient Hospice Facility
Maternity Care Services <ul style="list-style-type: none"> • Federal Maternity - employee, all dependents 	Cost and reimbursement vary based on the facility in which it is performed	Cost and reimbursement vary based on the facility in which it is performed
Abortion <ul style="list-style-type: none"> • Provides elective and non-elective coverage 	Cost and reimbursement vary based on the facility in which it is performed	Cost and reimbursement vary based on the facility in which it is performed
Organ Transplant <ul style="list-style-type: none"> • Physician services: Covered at 100% at Lifesource center; otherwise 80% after plan deductible • Travel maximum \$10,000 per transplant (only available if using Lifesource facility) 	Cost and reimbursement vary based on the facility in which it is performed	Varies based on place of service with no transplant maximums
Dental Care <ul style="list-style-type: none"> • Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound natural teeth 	Cost and reimbursement vary based on the facility in which it is performed	Cost and reimbursement vary based on the facility in which it is performed
Obesity/Bariatric Surgery Rider <ul style="list-style-type: none"> • Subject to medical necessity and clinical guidelines • Lifetime Maximum \$8,000 • The following are excluded: Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity. • The following are excluded: Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision. 	Cost and reimbursement vary based on the facility in which it is performed	Cost and Reimbursement vary based on the facility in which it is performed.
Routine Foot Disorders	Not Covered	Not Covered



Additional Benefit Information	In-network	Out-of-network
Included Health and Wellness Programs		
Health Advisor <ul style="list-style-type: none"> Health Advisor Core/CIGNA Choice Fund Health Advisor CIGNA Well Informed included Preference Sensitive Care included 		Include
Chronic Condition Support (CCS) – Your Health First 300 <ul style="list-style-type: none"> Holistic health support for those with a chronic health condition. 		Included
eVisits		Not Included
Lifestyle Management Programs - included with CIGNA Behavioral Advantage <ul style="list-style-type: none"> Weight Management Tobacco Cessation Stress Management 		Included

Exclusions

What’s Not Covered (not all-inclusive):

Your plan provides coverage for most medically necessary services. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren’t limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- For or in connection with an Injury or Sickness which is due to war, declared or undeclared.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.

Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:

- Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
- Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
- The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the “Clinical Trials” section of this plan; or
- The subject of an ongoing phase I, II or III clinical trial, except as provided in the “Clinical Trials” section of this plan.
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one’s appearance.
- The following services are excluded from coverage regardless of clinical indications: macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty/panniculectomy; rhinoplasty; blepharoplasty; orthognathic surgeries, unless performed to correct a congenital defect; redundant skin surgery, unless performed to correct a congenital defect; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy, movement therapy; applied kinesiology;

Exclusions

- rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. 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 six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
 - For medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: 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.
 - Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
 - Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
 - Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
 - Any **medications, drugs**, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasm, and premature ejaculation.
 - Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
 - Nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
 - Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
 - Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
 - Private Hospital rooms and/or private duty nursing except as provided under the **Home Health Services** provision.
 - Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
 - Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
 - 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.
 - Aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
 - Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses that follows keratoconus or post-cataract surgery).
 - *Routine refractions*, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
 - Treatment by acupuncture.
 - All noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.

Exclusions

- *Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.*
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- Nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- Medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- Medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- Telephone, e-mail, and Internet consultations, and telemedicine.
- Massage therapy.

These are only the highlights

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