

## SUMMARY OF BENEFITS



**Cigna Health and Life Insurance Co.**  
**For - Manchester Town and Board of Education**  
**Open Access Plus IN Plan OAP45 Library Basic \$20 Copay**

**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](http://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](http://www.mycigna.com) or contact customer service at the phone number listed on the back of your ID card.

Plan Highlights	In-Network
<b>Lifetime Maximum</b>	Unlimited
<b>Coinsurance</b>	Your plan pays 100%
<b>Calendar Year Deductible</b>	Individual: None Family: None
<ul style="list-style-type: none"> <li>After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan.</li> </ul>	
<b>Calendar Year Out-of-Pocket Maximum</b>	Individual: \$5,100 Family: \$10,200
<ul style="list-style-type: none"> <li>Plan deductible does not contribute towards your out-of-pocket maximum.</li> <li>All copays and benefit deductibles contribute towards your out-of-pocket maximum.</li> <li>Mental Health and Substance Use Disorder covered expenses contribute towards your out-of-pocket maximum.</li> <li>After each eligible family member meets his or her individual out-of-pocket maximum, the plan will pay 100% of their covered expenses. Or, after the family out-of-pocket maximum has been met, the plan will pay 100% of each eligible family member's covered expenses.</li> </ul>	
Benefit	In-Network
<b>Note: Services where plan deductible applies are noted with a caret (^)</b>	
<b>Physician Services</b>	
<b>Physician Office Visit</b>	\$20 Primary Care Physician (PCP) copay or \$20 Specialist copay
<ul style="list-style-type: none"> <li>All services including Lab &amp; X-ray</li> <li>Plan pays 100% after you pay copay</li> </ul>	
<b>Surgery Performed in Physician's Office</b>	Your plan pays 100%

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Benefit	In-Network
<b>Note: Services where plan deductible applies are noted with a caret (^)</b>	
<b>Allergy Serum</b> Dispensed by the physician in the office	Your plan pays 100%
<b>Cigna Telehealth Connection services</b> <ul style="list-style-type: none"> <li>Includes charges for the delivery of medical and health-related consultations via secure telecommunications technologies, telephones and internet only when delivered by contracted medical telehealth providers (see details on myCigna.com).</li> </ul>	\$20 copay
<b>Allergy Treatment/Injections</b>	Your plan pays 100%
<b>Preventive Care</b>	
<b>Preventive Care</b> <ul style="list-style-type: none"> <li>Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.</li> <li>Includes well-baby, well-child, well-woman, and adult preventive care</li> </ul>	Your plan pays 100%
<b>Immunizations - Includes travel related immunizations</b>	Your plan pays 100%
<b>Mammogram, PAP, and PSA Tests</b> <ul style="list-style-type: none"> <li>Coverage includes the associated Preventive Outpatient Professional Services.</li> <li>Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.</li> </ul>	Your plan pays 100%
<b>Inpatient</b>	
<b>Inpatient Hospital Facility</b>  <b>Semi-Private Room:</b> Limited to the semi-private negotiated rate <b>Private Room:</b> Limited to the semi-private negotiated rate <b>Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):</b> Limited to the negotiated rate	\$200 per admission copay, then your plan pays 100%
<b>Inpatient Hospital Physician's Visit/Consultation</b>	Your plan pays 100%
<b>Inpatient Professional Services</b> <ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>	Your plan pays 100%
<b>Outpatient</b>	
<b>Outpatient Facility Services</b> <ul style="list-style-type: none"> <li>Non-surgical treatment procedures are not subject to the facility per visit copay/benefit deductible</li> </ul>	\$100 per facility visit copay, then your plan pays 100%
<b>Outpatient Professional Services</b> <ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>	Your plan pays 100%

Benefit	In-Network
<b>Note: Services where plan deductible applies are noted with a caret (^)</b>	
<b>Short-Term Rehabilitation</b>	\$20 PCP or \$20 Specialist copay
Calendar Year Maximums: <ul style="list-style-type: none"> <li>Includes Physical Therapy, Speech Therapy, Occupational Therapy, Pulmonary Rehabilitation, Cognitive Therapy, and Chiropractic Therapy</li> <li>60 days maximum per Calendar Year for all therapies combined</li> <li>Includes maintenance for Chiropractic Care</li> <li>Includes massage therapy when in conjunction with Physical Therapy or Chiropractic Care</li> <li>Speech, physical, and/or occupational therapy for autism spectrum disorder is covered on an unlimited basis</li> </ul> Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.	
<b>Cardiac Rehabilitation</b>	\$20 PCP or \$20 Specialist copay
<ul style="list-style-type: none"> <li>36 days maximum per occurrence</li> </ul>	
<b>Other Health Care Facilities/Services</b>	
<b>Home Health Care</b> (includes outpatient private duty nursing subject to medical necessity) <ul style="list-style-type: none"> <li>Unlimited days maximum per Calendar Year</li> <li>16 hour maximum per day</li> </ul>	Your plan pays 100%
<b>Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility</b> <ul style="list-style-type: none"> <li>180 days maximum per Calendar Year</li> </ul>	Your plan pays 100%
<b>Durable Medical Equipment</b> <ul style="list-style-type: none"> <li>Unlimited maximum per Calendar Year</li> </ul>	Your plan pays 100%
<b>Breast Feeding Equipment and Supplies</b> <ul style="list-style-type: none"> <li>Limited to the rental of one breast pump per birth as ordered or prescribed by a physician.</li> <li>Includes related supplies</li> </ul>	Your plan pays 100%
<b>External Prosthetic Appliances (EPA)</b> <ul style="list-style-type: none"> <li>Unlimited maximum per Calendar Year</li> </ul>	Your plan pays 100%
<b>Routine Foot Disorders</b>	Not Covered
Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.	
<b>Hearing Aid</b> <ul style="list-style-type: none"> <li>\$1,000 maximum In-Network per Calendar Year</li> <li>Includes testing and fitting of hearing aid devices.</li> <li>Coverage through age 12</li> </ul>	Your plan pays 100%
<b>Naturopath</b>	\$20 PCP or \$20 Specialist copay
<b>Osteopaths</b>	\$20 PCP or \$20 Specialist copay
<b>Diabetic Equipment and Supplies</b> <ul style="list-style-type: none"> <li>Includes glucometers, blood glucose monitors for the legally blind, insulin pumps, infusion devices and related accessories, including those adaptable for the legally blind; medically necessary</li> </ul>	Your plan pays 100%

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Benefit	In-Network
<b>Note: Services where plan deductible applies are noted with a caret (^)</b>	
<b>Diabetic Training - Diabetic Self Management Courses</b> <ul style="list-style-type: none"> <li>For Inpatient and Outpatient Training; including training conducted in group sessions, home visits and nutrition therapy; including needs assessment, education plan, education intervention, evaluation of learner outcomes, plan for follow up for continuing learning needs and documentation by the provider.\$1,000 maximum In-Network per 24 months</li> </ul>	\$20 PCP or \$20 Specialist copay
<b>Nutritional Formula</b> <ul style="list-style-type: none"> <li>Birth to 12 years of age</li> </ul>	Your plan pays 100%
<b>Wigs</b> <ul style="list-style-type: none"> <li>\$350 maximum per Calendar Year</li> </ul>	Your plan pays 100%
<b>Vision Care</b> <ul style="list-style-type: none"> <li>Eye exam once every 24 months</li> </ul>	Your plan pays 100%
<b>Oral Surgery - Impacted Wisdom Teeth</b>	Your plan pays 100%
<b>Early Childhood Intervention Service</b>	Your plan pays 100%
<b>Services covered for child or children's family from birth to age 3</b>	

### Place of Service - your plan pays based on where you receive services

Benefit	Physician's Office	Independent Lab	Emergency Room/ Urgent Care Facility	Outpatient Facility
	In-Network	In-Network	In-Network	In-Network
<b>Lab and X-ray</b>	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
<b>Advanced Radiology Imaging</b>	Plan pays 100%	Not Applicable	Plan pays 100%	Plan pays 100%

Advanced Radiology Imaging (ARI) includes MRI, MRA, CAT Scan, PET Scan, etc.

Note: All lab and x-ray services, including ARI, provided at Inpatient Hospital are covered under Inpatient Hospital benefit

- Non Par Labs paid according to in-network OV, OP, IP and Independent Lab places of service.

Benefit	Emergency Room / Urgent Care Facility	Outpatient Professional Services	*Ambulance
	In-Network	In-Network	In-Network
<b>Emergency Care</b>	\$75 per visit (copay waived if admitted)	Plan pays 100%	Plan pays 100%
<b>Urgent Care</b>	\$25 per visit (copay waived if admitted)	Plan pays 100%	Plan pays 100%

\*Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.

Benefit	Inpatient Hospital and Other Health Care Facilities	Outpatient Services
	In-Network	In-Network
<b>Hospice</b>	Plan pays 100%	Plan pays 100%

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Benefit	Inpatient Hospital and Other Health Care Facilities		Outpatient Services		
	In-Network		In-Network		
<b>Bereavement Counseling</b>	Plan pays 100%		Plan pays 100%		
Note: Services provided as part of Hospice Care Program					
Benefit	Initial Visit to Confirm Pregnancy	Global Maternity Fee (All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges)	Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)	Delivery - Facility (Inpatient Hospital, Birthing Center)	
	In-Network	In-Network	In-Network	In-Network	
<b>Maternity</b>	\$20 PCP or \$20 Specialist copay	Plan pays 100%	\$20 PCP or \$20 Specialist copay	Covered same as plan's Inpatient Hospital benefit	
Benefit	Physician's Office	Inpatient Facility	Outpatient Facility	Inpatient Professional Services	Outpatient Professional Services
	In-Network	In-Network	In-Network	In-Network	In-Network
<b>Abortion</b> (Elective and non-elective procedures)	\$20 PCP or \$20 Specialist copay	\$200 per admission copay, then plan pays 100%	\$100 per facility visit copay, then plan pays 100%	Plan pays 100%	Plan pays 100%
<b>Family Planning - Men's Services</b>	\$20 PCP or \$20 Specialist copay	\$200 per admission copay, then plan pays 100%	\$100 per facility visit copay, then plan pays 100%	Plan pays 100%	Plan pays 100%
Includes surgical services, such as vasectomy (excludes reversals)					
<b>Family Planning - Women's Services</b>	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Includes surgical services, such as tubal ligation (excludes reversals) Contraceptive devices as ordered or prescribed by a physician.					
<b>Infertility</b>	\$20 PCP or \$20 Specialist copay	\$200 per admission copay, then plan pays 100%	\$100 per facility visit copay, then plan pays 100%	Plan pays 100%	Plan pays 100%
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc. \$5,000 lifetime maximum					
<b>Dental Care</b>	\$20 PCP or \$20 Specialist copay	\$200 per admission copay, then plan pays 100%	\$100 per facility visit copay, then plan pays 100%	Plan pays 100%	Plan pays 100%
Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.					
<b>Bariatric Surgery</b>	\$20 PCP or \$20 Specialist copay	\$200 per admission copay, then plan pays 100%	\$100 per facility visit copay, then plan pays 100%	Plan pays 100%	Plan pays 100%

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Benefit	Physician's Office	Inpatient Facility	Outpatient Facility	Inpatient Professional Services	Outpatient Professional Services
	In-Network	In-Network	In-Network	In-Network	In-Network

Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered.

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.
- weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision

Benefit	Inpatient Hospital Facility		Inpatient Professional Services	
	Lifesource Facility In-Network	Non-Lifesource Facility In-Network	Lifesource Facility In-Network	Non-Lifesource Facility In-Network
<b>Organ Transplants</b>	\$200 per admission copay	\$200 per admission copay, then plan pays 100%	Plan pays 100%	Plan pays 100%

- Travel Maximum - Lifesource Facility: In-Network: \$10,000 maximum per Transplant

Benefit	Inpatient In-Network	Outpatient - Physician's Office In-Network	Outpatient - All Other Services In-Network
	<b>Mental Health</b>	\$200 per admission copay, then plan pays 100%	\$20 copay
<b>Substance Use Disorder</b>	\$200 per admission copay, then plan pays 100%	\$20 copay	Plan pays 100%

**Note:** Detox is covered under medical

- Unlimited maximum per Calendar Year
- Services are paid at 100% after you reach your out-of-pocket maximum.
- Inpatient includes Residential Treatment.
- Outpatient includes partial hospitalization and individual, intensive outpatient, behavioral telehealth consultation and group therapy.

## Mental Health and Substance Use Disorder Services

### Mental Health/Substance Use Disorder Utilization Review, Case Management and Programs

Cigna Total Behavioral Health - Inpatient and Outpatient Management

- Inpatient utilization review and case management
- Outpatient utilization review and case management
- Partial Hospitalization
- Intensive outpatient programs
- Changing Lives by Integrating Mind and Body Program
- Lifestyle Management Programs: Stress Management, Tobacco Cessation and Weight Management.

## Pharmacy

Pharmacy benefits not provided by Cigna

## Additional Information

### Case Management

Coordinated by Cigna HealthCare. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

### Medicare Coordination

Cigna will pay as the Secondary Plan to Medicare Part A and B **regardless if the person is actually enrolled in Medicare Part A and/or Part B as permitted by the Social Security Act of 1965** as follows:

- (a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent, who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);
- (b) an Employee, a former Employee, an Employee's Dependent, or former Employee's Dependent, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

Cigna will pay as the Secondary Plan to Medicare Part A and B **regardless if the person seeks care at a Medicare Provider or not for Medicare covered services.**

### Multiple Surgical Reduction

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.

**Pre-Certification - Continued Stay Review - PHS+ Inpatient** - required for all inpatient admissions

In Network: Coordinated by your physician

**Pre-Certification - Continued Stay Review - PHS+ Outpatient Prior Authorization** - required for selected outpatient procedures and diagnostic testing

In Network: Coordinated by your physician

**Pre-Existing Condition Limitation (PCL)** does not apply.

### Your Health First - 200

Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:

- Condition Management
- Medication adherence
- Risk factor management
- Lifestyle issues
- Health & Wellness issues
- Pre/post-admission
- Treatment decision support
- Gaps in care

Holistic health support for the following chronic health conditions:

- Heart Disease
- Coronary Artery Disease
- Angina
- Congestive Heart Failure
- Acute Myocardial Infarction
- Peripheral Arterial Disease
- Asthma
- Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)
- Diabetes Type 1
- Diabetes Type 2
- Metabolic Syndrome/Weight Complications
- Osteoarthritis
- Low Back Pain
- Anxiety
- Bipolar Disorder
- Depression

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## Definitions

**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.

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

**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.

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

**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.

## Exclusions

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

Your plan provides for most medically necessary services. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control. 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.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- 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. For example, if Cigna determines that a provider is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) you are required to pay for a Covered Service (as shown on the Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Service, or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a Non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.
- Charges arising out of or related to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- 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 use disorder or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
  - o 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;
  - o Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
  - o 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

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## Exclusions

- o The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.
- The following services are excluded from coverage regardless of clinical indications: Abdominoplasty; Panniculectomy; Rhinoplasty; Acupressure; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- Surgical or nonsurgical treatment of TMJ disorders.
- 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. 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 intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute guideline is covered if the services are demonstrated, through peer reviewed medical literature and scientifically based guidelines, to be safe and effective for treatment of the condition.
- 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.
- Any 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), anorgasmy, 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 intellectual disabilities.
- 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 and dentures.
- 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 eyeglasses or contact lenses for treatment of keratoconus or post cataract surgery).
- Eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Treatment by acupuncture.
- All non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered

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## Exclusions

drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.

- 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 to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- 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.
- Charges for the delivery of medical and health-related services via telecommunications technologies, including telephone and internet, unless provided as specifically described under the benefit section.
- Reversal of male and female voluntary sterilization.

### 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. This summary provides additional information not provided in the Summary of Benefits and Coverage document required by the Federal Government.

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