SUMMARY OF BENEFITS

Cigna General Life Insurance Co.
For – Howard University and Hospital
Open Access Plus IN Plan

This plan contains a higher level of In-Network benefits for a Howard University Hospital Provider as shown in the column labeled "HUH".
The HUH network is defined by the Client.

Plan Highlights	HUH	In-Network
Lifetime Maximum	Unlimited	Unlimited
Coinsurance	Your plan pays 100%	Your plan pays 90%
Maximum Reimbursable Charge	Not Applicable	Not Applicable
Calendar Year Deductible	Individual: None Family: None	Individual: $400 Family: $800
Calendar Year Out-of-Pocket Maximum	Individual: $650 Family: $1,500	Individual: $2,500 Family: $5,000

Benefit	HUH	In-Network
Physician Office Visit • All services including Lab & X-ray • Your plan pays 100% after you pay copay	$0 Primary Care Physician (PCP) copay or $0 Specialist copay	$20 Primary Care Physician (PCP) copay or $50 Specialist copay
Surgery Performed in Physician's Office	$0 PCP copay or $0 Specialist copay	$25 PCP copay or $50 Specialist copay
Allergy Treatment/Injections	$0 PCP or $0 Specialist copay or actual charge (if less)	Lesser of $25 PCP or $50 Specialist copay or actual charge, then the plan pays at 100%
Allergy Serum Dispensed by the physician in the office	Your plan pays 100%	Your plan pays 100%
Preventive Care	Your plan pays 100%	Your plan pays 100%
Immunizations	Your plan pays 100%	Your plan pays 100%
Mammogram, PAP, PSA Tests	Your plan pays 100%	Your plan pays 100%
Inpatient		
Inpatient Hospital Facility	$0 per admission copay, then your plan pays 100% ^	$500 per admission copay, then your plan pays 90% ^
Semi-Private Room: Limited to the semi-private negotiated rate **Private Room:** Limited to the semi-private negotiated rate **Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):** Limited to the negotiated rate		
Inpatient Hospital Physician's Visit/Consultation	Your plan pays 100% ^	Your plan pays 90% ^
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Your plan pays 100% ^	Your plan pays 90% ^

Benefit	HUH	In-Network
Note: Services where plan deductible applies are noted with a caret (^)		
Outpatient		
Outpatient Facility Services • Non-surgical treatment procedures are not subject to the facility per visit copay/benefit deductible	$10 per facility visit copay, then your plan 100% ^	Your plan pays 90% ^
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Your plan pays 100% ^	Your plan pays 90% ^
Short-Term Rehabilitation	$0 PCP copay or $0 Specialist copay	$25 PCP copay or $50 Specialist copay
Calendar Year Maximums: • Includes physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation, and cognitive therapy • 90 days maximum per Calendar Year for all therapies combined • Therapy days, provided as part of an approved Home Health Care plan, accumulate to the outpatient short term rehabilitation therapy maximum **Speech, Physical and Occupational Therapy for Autism Spectrum Disorder** • Unlimited days maximum per Calendar Year Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.		
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private duty nursing subject to medical necessity) • Unlimited days maximum per Calendar Year • 16 hour maximum per day	Your plan pays 100% ^	Your plan pays 90% ^
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • Unlimited days maximum per Calendar Year	Your plan pays 100% ^	Your plan pays 90% ^
Durable Medical Equipment • Unlimited maximum per Calendar Year	Your plan pays 100% ^	Your plan pays 90% ^

Benefit	HUH	In-Network
Note: Services where plan deductible applies are noted with a caret (^)		
Outpatient		
Breast Feeding Equipment and Supplies • Limited to the rental of one breast pump per birth as ordered or prescribed by a physician. • Includes related supplies	Your plan pays 100%	Your plan pays 100%
External Prosthetic Appliances (EPA) • Unlimited maximum per Calendar Year	Your plan pays 100% ^	Your plan pays 90% ^

Benefit	HUH	In-Network
Note: Services where plan deductible applies are noted with a caret (^)		
Other Health Care Facilities/Services		
Routine Foot Disorders	Not Covered	Not Covered
Acupuncture/Acupressure • Unlimited days maximum per Calendar Year	$0 Specialist copay	$50 Specialist copay
Hearing Exam • Includes diagnostic and preventive exams at the HUH level only	Plan pays 100%	Not Covered
Wigs • $150 maximum per Calendar Year	Plan pays 100%	Plan pays 100%

Place of Service - You pay based on where you receive services.

Note: Services where plan deductible applies are noted with a caret (^)

Benefit	Physician's Office	Independent Lab	Emergency Room/ Urgent Care Facility	Outpatient Facility
	In-Network	**In-Network**	**In-Network**	**In-Network**
Lab and X-ray	$25 PCP copay or $50 Specialist copay	Plan pays 90% ^	Plan pays 100%	Plan pays 90% ^
Advanced Radiology Imaging (MRI, MRA, CAT Scan, PET Scan, etc.)	Plan pays 100%	Not Applicable	Plan pays 100% ^	Plan pays 90% ^

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

NOTE: **Services obtained at HUH are covered at 100%**

Place of Service - You pay based on where you receive services.			
Note: Services where plan deductible applies are noted with a caret (^)			
Benefit	**Emergency Room / Urgent Care Facility**	**Outpatient Professional Services**	***Ambulance**
	In-Network	**In-Network**	**In-Network**
Emergency Care	$125 per visit (copay waived if admitted) ^	Plan pays 100% ^	Plan pays 100% ^
Urgent Care	$50 per visit (copay waived if admitted) ^	Plan pays 100% ^	Not applicable
*Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.			
NOTE: **Higher levels of In-Network benefits will apply for HUH as shown previously in this summary.** **- This includes an Urgent Care Facility copay of $25 (copay waived if admitted) and an Ambulance coinsurance of 100%.**			

Place of Service - You pay based on where you receive services.		
Benefit	**Inpatient Hospital and Other Health Care Facilities**	**Outpatient Services**
	In-Network	**In-Network**
Hospice	Plan pays 90% ^	Plan pays 90% ^
Bereavement Counseling	Plan pays 90% ^	Plan pays 90% ^
Note: Services provided as part of Hospice Care Program		
Note: Services where plan deductible applies are noted with a caret (^)		
NOTE: **Services obtained at HUH are covered at 100%**		

Place of Service - You pay based on where you receive services.				
	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)**
Benefit	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Maternity	$25 PCP or $50 Specialist copay	Plan pays 90%^	$25 PCP or $50 Specialist copay	Covered same as plan's Inpatient Hospital benefit
NOTE: Physician's Office, Inpatient Facility and Professional Services at HUH are covered at 100%. Outpatient Facility is covered at $10 per visit.				

Place of Service - You pay based on where you receive services.					
Note: Services where plan deductible applies are noted with a caret (^)					
Benefit	**Physician's Office**	**Inpatient Facility**	**Outpatient Facility**	**Inpatient Professional Services**	**Outpatient Professional Services**
	In-Network	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Abortion (Elective and non-elective procedures)	$25 PCP or $50 Specialist copay	$500 per admission copay, then plan pays 90% ^	Plan pays 90% ^	Plan pays 90% ^	Plan pays 90% ^
NOTE: Physician's Office, Inpatient Facility and Professional Services at HUH are covered at 100%. Outpatient Facility is covered at $10 per visit.					

Place of Service - You pay based on where you receive services.					
Note: Services where plan deductible applies are noted with a caret (^)					
Benefit	**Physician' s Services - Office Visit**	**Inpatient Hospital Facility**	**Outpatient Facility Services**	**Inpatient Professional Services**	**Outpatient Professional Services**
	In-Network	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Family Planning - Men's Services	$25 PCP or $50 Specialist copay	$500 per admission copay, then plan pays 90% ^	Plan pays 90% ^	Plan pays 90% ^	Plan pays 90% ^
Includes surgical services, such as vasectomy (excludes reversals).					
NOTE: **Physician's Office, Inpatient Facility and Professional Services at HUH are covered at 100%. Outpatient Facility is covered at $10 per visit.**					

Place of Service - You pay based on where you receive services.					
Note: Services where plan deductible applies are noted with a caret (^)					
Benefit	**Physician' s Services - Office Visit**	**Inpatient Hospital Facility**	**Outpatient Facility Services**	**Inpatient Professional Services**	**Outpatient Professional Services**
	In-Network	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Family Planning - Women's Services	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.					
NOTE: **Services obtained at HUH are covered at 100%**					

Place of Service - You pay based on where you receive services.					
Note: Services where plan deductible applies are noted with a caret (^)					
Benefit	**Physician' s Services - Office Visit**	**Inpatient Hospital Facility**	**Outpatient Facility Services**	**Inpatient Professional Services**	**Outpatient Professional Services**
	In-Network	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Infertility	$25 PCP or $50 Specialist copay	$500 per admission copay, then plan pays 90% ^	Plan pays 90%^	Plan pays 90% ^	Plan pays 90% ^
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc. $10,000 lifetime maximum					
NOTE: **Physician's Office, Inpatient Facility and Professional Services at HUH are covered at 100%. Outpatient Facility is covered at $10 per visit.**					

Place of Service - You pay based on where you receive services.					
Note: Services where plan deductible applies are noted with a caret (^)					
Benefit	**Physician' s Services - Office Visit**	**Inpatient Hospital Facility**	**Outpatient Facility Services**	**Inpatient Professional Services**	**Outpatient Professional Services**
	In-Network	**In-Network**	**In-Network**	**In-Network**	**In-Network**
Bariatric Surgery	$25 PCP or $50 Specialist copay	$500 per admission copay, then plan pays 90% ^	Plan pays 90% ^	Plan pays 90% ^	Plan pays 90% ^
Surgeon Charges Lifetime Maximum: $30,000					
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					
NOTE: **Physician's Office, Inpatient Facility and Professional Services at HUH are covered at 100%. Outpatient Facility is covered at $10 per visit.**					

Place of Service - You pay based on where you receive services.				
Note: Services where plan deductible applies are noted with a caret (^)				
	Inpatient Hospital Facility		Inpatient Professional Services	
Benefit	**Lifesource Facility In-Network**	**Non-Lifesource Facility In-Network**	**Lifesource Facility In-Network**	**Non-Lifesource Facility In-Network**
Organ Transplants	Plan pays 100%	$500 per admission copay, then plan pays 90% ^	Plan pays 100%	Plan pays 90% ^
Travel Lifetime Maximum - LifeSOURCE Facility: In-Network: $10,000 maximum per Transplant per Lifetime				

Place of Service - You pay based on where you receive services.			
Note: Services where plan deductible applies are noted with a caret (^)			
Benefit	**Inpatient**	**Outpatient - Physician's Office**	**Outpatient – All Other Services**
	In-Network	**In-Network**	**In-Network**
Mental Health	$500 per admission copay, then plan pays 90% ^	Plan pays 90%	Plan pays 90%
NOTE: **Services obtained at HUH are covered at 100%**			

Place of Service - You pay based on where you receive services.			
Note: Services where plan deductible applies are noted with a caret (^)			
Benefit	**Inpatient**	**Outpatient - Physician's Office**	**Outpatient – All Other Services**
	In-Network	**In-Network**	**In-Network**
Substance Use Disorder	$500 per admission copay, then plan pays 90% ^	Plan pays 90%	Plan pays 90%

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 and group therapy.

NOTE: **Services obtained at HUH are covered at 100%**

Mental Health and Substance Use Disorder Services

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

Cigna Behavioral Advantage - 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.
- Narcotic Therapy Management
- Complex Psychiatric Case Management

Pharmacy	In-Network	Out-of-Network
Cigna Pharmacy three-tier coinsurance plan • Generic push • Self Administered injectable and optional injectable drugs - excludes infertility drugs • Oral contraceptive drugs (excludes contraceptive devices) • Oral Contraceptives included; specific products covered at 100% • Lifestyle drugs included - limited to sexual dysfunction • Prescription smoking cessation drugs included • Prescription vitamins included • Oral Fertility drugs included • Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges included • Travel Immunizations • Retail and home delivery RX costs contribute to the combined Medical/Pharmacy Out of Pocket	**Retail** - 34 day supply Generic: You pay $5 Preferred Brand: You Pay $50 Non-Preferred Brand: You pay 30% ($150 max) **Home delivery** - 90 day supply Generic: You pay $10 Preferred Brand: You pay $100 Non-Preferred Brand: You pay 30% (%150 max)	**Retail** Not covered **Home Delivery** Not covered

Pharmacy Program Information

Pharmacy Clinical Management and Prior Authorization

- Your plan is subject to refill-too-soon and other clinical edits as well as prior authorization requirements.
- Plan exclusion edits are always included.
- Additional clinical management - Basic package - provides a limited set of clinical edits such as prior authorization, age edits and quantity limits for a specific list of prescription medications.

Prescription Drug List:

- Your Cigna Standard Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. To check which drugs are included in your plan, please log on to myCigna.com.

Specialty Pharmacy Management:

- Clinical Programs
  - Prior authorization is required on specialty medications but quantity limits may apply.
  - Theracare® Program
- Medication Access Option
  - Home Delivery

Pharmacy Cost Management Program

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.
- Some Step 3 (Non-Preferred Brand) medications are not covered and require the use of Generic or Preferred Brand products instead.

Pharmacy	In-Network	Out-of-Network

High Blood Pressure (ACEI/ARB)

- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 30 Days grace period
- First Fill Pay and Educate included

Cholesterol Lowering (STATIN)

- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 30 Days grace period
- First Fill Pay and Educate included

Heartburn/Ulcer (PPI)

- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 30 Days grace period
- First Fill Pay and Educate included

Bladder Problems (OAB)

- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 30 Days grace period
- First Fill Pay and Educate included

Osteoporosis (Bone)

- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 30 Days grace period
- First Fill Pay and Educate included

Sleep Disorders (HYPNOTICS)

- Generic or PB First One Step - Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication.
- 30 Days grace period
- First Fill Pay and Educate included

Allergy (Nasal Steroids)

- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 30 Days grace period
- First Fill Pay and Educate included

Depression (SSRI/SNRI)

- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 30 Days grace period

Pharmacy	In-Network	Out-of-Network

- First Fill Pay and Educate included

Skin Conditions (TI)

- Generic First One Step - Step 1 (Generic) medication(s) must be used prior to using a Step 2 (Preferred Brand) or Step 3 (Non-Preferred Brand) medication.
- 30 Days grace period
- First Fill Pay and Educate included

Mental Health (ATYPICAL_PSYCHS)

- Generic or PB First One Step - Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication.
- 30 Days grace period
- First Fill Pay and Educate included

Non-Narcotic Pain relievers (NSAID)

- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 30 Days grace period
- First Fill Pay and Educate included

ADD/ADHD (ADHD)

- Stacked Multidrug Prerequisite - Both Step 1 (Generic) and Step 2 (Preferred Brand) medications must be used, in either order, prior to using a Step 3 (Non-Preferred Brand) medication.
- 30 Days grace period
- First Fill Pay and Educate included

Asthma (ASTHMA)

- Generic or PB First One Step - Step 1 (Generic) or Step 2 (Preferred Brand) medication(s) must be used prior to using a Step 3 (Non-Preferred Brand) medication.
- 30 Days grace period
- First Fill Pay and Educate included

Narcotic Pain Relievers (NARCOTICS)

- Generic First One Step - Step 1 (Generic) medication(s) must be used prior to using a Step 2 (Preferred Brand) or Step 3 (Non-Preferred Brand) medication.
- 30 Days grace period
- First Fill Pay and Educate included

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.

eVisits
Provides an online consultation service, or “eVisit,” with doctors. The eVisit guides patients through an interactive interview that delivers to doctors the information they need to respond to non-urgent conditions. Individuals pay a predetermined copay or coinsurance based on their benefit plan design. After the eVisit is completed, a claim is automatically submitted to Cigna for reimbursement.

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-Existing Condition Limitation (PCL) does not apply.

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.
- 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:
    - 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 for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.
- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter 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; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; 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.

Exclusions

- Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance 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), 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, dentures and wigs.
- 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 for treatment of keratoconus or post cataract surgery).
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- All non-injectable 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.
- 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.

Exclusions

- All 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 or other services which under normal circumstances are expected to be provided through face-to-face clinical encounters, unless provided via an approved internet-based intermediary.
- 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. This summary provides additional information not provided in the Summary of Benefits and Coverage document required by the Federal Government.

EHB State: **UT**