

## BENEFIT SUMMARY



**Cigna Health and Life Insurance Co.**  
**For - Equifax, Inc.**  
**Indemnity Plan**  
**PR**  
**Effective - 01/01/2021**

**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 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 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	Benefit Amount
<b>Lifetime Maximum</b>	Unlimited
<b>Plan Year Accumulation</b>	Your Plan's Deductibles, Out-of-Pockets and benefit level limits accumulate on a calendar year basis unless otherwise stated
<b>Plan Coinsurance</b>	Plan pays 90%
<b>Maximum Reimbursable Charge</b>	200%
<b>Plan Deductible</b>	Individual: None Family: None
<b>Plan Out-of-Pocket Maximum</b>	Individual: \$100 Family: \$200
<ul style="list-style-type: none"> <li>Covered expenses that count towards your out-of-pocket maximum include customer paid coinsurance and charges for Mental Health and Substance Use Disorder.</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> <li>This plan includes a combined Medical/Pharmacy out-of-pocket maximum.</li> </ul>	

Benefit	Benefit Amount
<b>Physician Services - Office Visits</b>	
<b>Primary Care Physician (PCP) Services/Office Visit</b>	Plan pays 90%
<b>Specialty Care Physician Services/Office Visit</b>	Plan pays 90%
<b>Surgery Performed in Physician's Office</b>	Plan pays 100%
<b>Allergy Treatment/Injections and Allergy Serum</b> Allergy serum dispensed by the physician in the office	Covered same as Physician Services - Office Visit
<b>Cigna Telehealth Connection Services</b>	Plan pays 90%
<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>	

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Benefit	Benefit Amount
<b>Preventive Care</b>	
<b>Preventive Care</b> <ul style="list-style-type: none"> <li>Annual Limit: Unlimited</li> </ul>	Plan pays 100%
<b>Immunizations</b>	Plan pays 100%
<b>Routine Mammogram, PAP, and PSA Tests</b> <ul style="list-style-type: none"> <li>Coverage includes the associated Preventive Outpatient Professional Services.</li> </ul>	Plan pays 100%
<b>Routine Colonoscopies/Sigmoidscopies</b> <ul style="list-style-type: none"> <li>Coverage includes the associated Preventive Outpatient Professional Services.</li> </ul>	Plan pays 100%
<b>Diagnostic Colonoscopies/Sigmoidscopies</b> <ul style="list-style-type: none"> <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>	Plan pays 90%
<b>Diagnostic Mammogram, PAP, and PSA Tests</b> <ul style="list-style-type: none"> <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>	Plan pays 90%
<b>Inpatient</b>	
<b>Inpatient Hospital Facility Services</b> <b>Note:</b> Includes all Lab and Radiology services, including Advanced Radiological Imaging as well as Medical Specialty Drugs	\$75 per admission copay, and plan pays 100%
<b>Inpatient Hospital Physician's Visit/Consultation</b>	Plan pays 90%
<b>Inpatient Professional Services</b> <ul style="list-style-type: none"> <li>For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists</li> </ul>	Plan pays 90%
<b>Outpatient</b>	
<b>Outpatient Facility Services</b>	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>	Plan pays 90%
<b>Emergency Services</b>	
<b>Emergency Room</b> <ul style="list-style-type: none"> <li>Includes Professional, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit.</li> <li>Per visit copay is waived if admitted.</li> </ul>	\$50 copay, and plan pays 100%
<b>Urgent Care Facility</b> <ul style="list-style-type: none"> <li>Includes Professional, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the urgent care visit.</li> </ul>	Plan pays 100%
<b>Ambulance</b> Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.	Plan pays 100%
<b>Inpatient Services at Other Health Care Facilities</b>	
<b>Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facilities</b> <ul style="list-style-type: none"> <li>Annual Limit: 120 days</li> </ul>	Plan pays 100%

Benefit	Benefit Amount
<b>Laboratory Services</b>	
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit
Independent Lab	Plan pays 75%
Outpatient Facility	Plan pays 75%
<b>Radiology Services</b>	
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit
Outpatient Facility	Plan pays 75%
<b>Advanced Radiological Imaging (ARI)</b>	
Includes MRI, MRA, CAT Scan, PET Scan, etc.	
Outpatient Facility	Plan pays 75%
Physician's Services/Office Visit	Covered same as Physician Services - Office Visit
<b>Outpatient Therapy Services</b>	
Outpatient Therapy Services	Covered same as Physician Services - Office Visit
<p>Annual Limits:</p> <ul style="list-style-type: none"> <li>Occupational Therapy, Physical Therapy and Speech Therapy - 60 days</li> <li>All other therapies - Includes Cardiac Rehabilitation, Cognitive Therapy and Pulmonary Rehabilitation - Unlimited days</li> <li>Limits are not applicable to mental health conditions for Physical, Speech and Occupational Therapies.</li> </ul> <p><b>Note:</b> Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient therapy services maximum.</p>	
<b>Chiropractic Services</b>	
Covered same as Physician Services - Office Visit	
Annual Limit:	
<ul style="list-style-type: none"> <li>Chiropractic Care - 20 days</li> </ul>	
<b>Hospice</b>	
Inpatient Facilities	Plan pays 100%
Outpatient Services	Plan pays 100%
<b>Note:</b> Includes Bereavement counseling provided as part of a hospice program.	
<b>Bereavement Counseling</b>	
Services Provided by a Mental Health Professional	Covered under Mental Health benefit
<b>Medical Specialty Drugs</b>	
Outpatient Facility	Plan pays 100%
Physician's Office	Plan pays 90%
<p><b>Note:</b> This benefit only applies to the cost of the Infusion Therapy drugs administered. This benefit does not cover the related Facility, Office Visit or Professional charges.</p>	

Benefit	Benefit Amount
<b>Home</b>	Plan pays 100%
<b>Maternity</b>	
<b>Initial Visit to Confirm Pregnancy</b>	Plan pays 100%
<b>All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges</b> (Global Maternity Fee)	Plan pays 100%
<b>Office Visits in Addition to Global Maternity Fee</b> (Performed by OB/GYN or Specialist)	Covered same as Physician Services - Office Visit
<b>Delivery - Facility</b> (Inpatient Hospital, Birthing Center)	Covered same as plan's Inpatient Hospital benefit
<b>Employee and Spouse only</b>	
<b>Abortion</b>	
<b>Abortion Services</b> <b>Note:</b> Elective and non-elective procedures	Coverage varies based on Place of Service
<b>Family Planning</b>	
<b>Women's Services</b> Includes contraceptive devices as ordered or prescribed by a physician and	Plan pays 100% surgical sterilization services, such as tubal ligation (excludes reversals)
<b>Men's Services</b> Includes surgical sterilization services, such as vasectomy (excludes reversals)	Coverage varies based on Place of Service
<b>Infertility</b>	
<b>Infertility Treatment</b> <b>Note:</b> Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.	
<b>Other Health Care Facilities/Services</b>	
<b>Home Health Care</b> • Annual Limit: 120 days (The limit is not applicable to mental health and substance use disorder conditions.)	Plan pays 100%
<b>Private Duty or Special Duty Nursing</b> • 70 days maximum per Calendar Year • 8 hour maximum per day • Covered as part of a Home Health Care or Hospice Care Plan	Plan pays 100%
<b>Organ Transplants</b> • Travel Maximum - Cigna LifeSOURCE Transplant Network® Facility	100% at LifeSOURCE Facility, Otherwise covered same as Inpatient benefit Only: \$10,000 maximum per Transplant per Lifetime
<b>Durable Medical Equipment</b> • Annual Limit: Unlimited	Plan pays 100%

Benefit	Benefit Amount
<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>	Plan pays 100%
<b>External Prosthetic Appliances (EPA)</b> <ul style="list-style-type: none"> <li>Annual Limit: Unlimited</li> </ul>	Plan pays 90%
<b>Oral Surgery - Impacted Wisdom</b>  Limited to charges made for extraction of bony, impacted teeth	Plan pays 90%
<b>Wigs</b> <ul style="list-style-type: none"> <li>Maximum of 1 wig per lifetime</li> <li>Covered for certain conditions in hair loss such as burns with resulting permanent alopecia; lupus; alopecia areata, alopecia totalis; alopecia univeralis; fungal injections; chemotherapy or radiation therapy.</li> </ul>	Plan pays 90%
<b>Temporomandibular Joint Disorder (TMJ) Surgical</b> <ul style="list-style-type: none"> <li>Unlimited lifetime maximum</li> </ul>	Coverage varies based on Place of Service
<b>Note:</b> Provided on a limited, case-by-case basis. Excludes appliances and orthodontic treatment. Subject to medical necessity. Includes dental and orthodontic treatment when needed to treat the condition, secondary to the dental plan coverage.	
<b>Bariatric Surgery</b>  Treatment of Clinically severe obesity, as defined by the body mass index (BMI) is covered only at approved facilities. The following are excluded: <ul style="list-style-type: none"> <li>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</li> <li>weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision</li> </ul>	Coverage varies based on Place of Service
<b>Routine Foot Care</b>	Not Covered
<b>Note:</b> Services associated with foot care for diabetes and peripheral vascular disease are covered when approved as medically necessary.	
<b>Mental Health and Substance Use Disorder</b>	
<b>Inpatient mental health</b>	\$75 per admission copay, and plan pays 100%
<b>Outpatient mental health – Physician’s Office</b>	Plan pays 90%
<b>Outpatient mental health – all other services</b>	Plan pays 100%
<b>Inpatient substance use disorder</b>	\$75 per admission copay, and plan pays 100%
<b>Outpatient substance use disorder – Physician’s Office</b>	Plan pays 90%
<b>Outpatient substance use disorder – all other services</b>	Plan pays 100%

**Benefit****Benefit Amount****Annual Limits:**

- Unlimited maximum

**Notes:**

- Inpatient includes Acute Inpatient and Residential Treatment.
- Outpatient - Physician's Office - may include Individual, family and group therapy, psychotherapy, medication management, etc.
- Outpatient - All Other Services - may include Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy), etc.
- Services are paid at 100% after you reach your out-of-pocket maximum.

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

- Inpatient utilization review and case management

**Pharmacy****In-Network****Cost Share and Supply****Cigna Pharmacy Cost Share**

- Retail – up to 90-day supply (except Specialty up to 30-day supply)
- Home Delivery – up to 90-day supply

**Retail (per 30-day supply):**

Generic: You pay \$5  
 Preferred Brand: You pay \$15  
 Non-Preferred Brand: You pay \$15

**Retail (per 90-day supply):**

Generic: You pay \$5  
 Preferred Brand: You pay \$15  
 Non-Preferred Brand: You pay \$15

**Home Delivery (per 90-day supply):**

Generic: You pay \$10  
 Preferred Brand: You pay \$30  
 Non-Preferred Brand: You pay \$30

## Pharmacy

## In-Network

- Retail drugs for a 30 day supply may be obtained In-Network at a wide range of pharmacies across the nation although prescriptions for a 90 day supply (such as maintenance drugs) will be available at select network pharmacies.
- Cigna 90 Now Program: For specified maintenance medications, you must obtain a 90-day prescription (filled at either a 90-day network retail pharmacy or network home delivery pharmacy) for the medication to be covered by the plan. Otherwise, after three 30-day fill(s), you pay the entire cost of the prescription.
- This plan will not cover out-of-network pharmacy benefits.
- Specialty medications are used to treat an underlying disease which is considered to be rare and chronic including, but not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis. Specialty Drugs may include high cost medications as well as medications that may require special handling and close supervision when being administered.
- If a generic is available, patient pays the brand cost share plus the cost difference between the brand and generic drugs up to the cost of the brand drug.
- Exclusive specialty home delivery: Specialty medications must be filled through home delivery; otherwise you pay the entire cost of the prescription upon your first fill. Some exceptions may apply.
- If you use a manufacturer coupon to pay for some or all of the cost of a medication, the value of the coupon may not apply towards meeting your plan deductible or out-of-pocket maximum, if any.
- **Saveon Specialty Program:** If you participate in the SaveonSP program, certain specialty pharmacy drugs may be considered non-essential health benefits and may fall outside of the deductible and out-of-pocket limits. In that case, manufacturer assistance may not be applied towards your deductible and out-of-pocket maximums.
- Your pharmacy benefits share an out-of-pocket maximum with the medical/behavioral benefits.
- If you receive a supply of 34 days or less at home delivery (including a Specialty Prescription Drug), the home delivery pharmacy cost share will be adjusted to reflect a 30-day supply.

## Drugs Covered

### Prescription Drug List:

Your Cigna Value Prescription Drug List includes a full range of drugs including all those required under applicable health care laws. Some of the more expensive drugs are excluded when there are less expensive alternatives. To check which drugs are included in your plan, please log on to myCigna.com.

Some highlights:

- Coverage includes Self Administered injectables and optional injectable drugs – but excludes infertility drugs.
- Contraceptive devices and drugs are covered with federally required products covered at 100%.
- Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges are covered.

## Pharmacy Program Information

### Pharmacy Clinical Management: Essential

Your plan features drug management programs and edits to ensure safe prescribing, and access to medications proven to be the most reliable and cost effective for the medical condition, including:

- Prior authorization requirements
- Step Therapy on select classes of medications and drugs new to the market
- Quantity limits, including maximum daily dose edits, quantity over time edits, duration of therapy edits, and dose optimization edits
- Age edits, and refill-too-soon edits
- Plan exclusion edits
- Current users of Step Therapy medications will be allowed one 30-day fill during the first three months of coverage before Step Therapy program applies.
- Your plan includes Specialty Drug Management features, such as prior authorization and quantity limits, to ensure the safe prescribing and access to specialty medications.
- For customers with complex conditions taking a specialty medication, we will offer Accredo Therapeutic Resource Centers (TRCs) to provide specialty medication and condition counseling. For customers taking a specialty medication not dispensed by Accredo, Cigna experts will offer this important specialty medication and condition counseling.

### Patient Assurance Program

Your plan includes the Patient Assurance Program, which waives the deductible and reduces the amount you owe for certain medications used to treat chronic conditions included in the program. Additionally:

- Any amount you pay for these medications only count toward meeting your out-of-pocket maximum.
- Any discount provided by a pharmaceutical manufacturer for these medications only count toward meeting your out-of-pocket maximum.

### Clinical Outcome Programs:

- Includes complex psychiatric case management
- Includes narcotic therapy management

## 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.

### Comprehensive Oncology Program

- Care Management outreach
- Case Management

Included

### Health Advisor - A

Support for healthy and at-risk individuals to help them stay healthy

- Health Assessments
- Health and Wellness Coaching
- Gaps in Care Coaching
- Treatment Decision Support
- Educate and Refer

Included

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## Additional Information

### Maximum Reimbursable Charge

The allowable covered expense for services is based on the lesser of the health care professional's normal charge for a similar service or a percentage of a fee schedule (200%) 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 based on the lesser of the health care professional's normal charge for a similar service or a percentile (80th) of charges made by health care professionals of such service or supply in the geographic area where it is received. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. Services are subject to a Calendar Year deductible and maximum reimbursable charge limitations.

### Medicare Coordination

In accordance with the Social Security Act of 1965, this plan will pay as the Secondary plan to Medicare Part A and B as follows:

- (a) a former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent, or an Employee's Domestic Partner 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.

When a person is eligible for Medicare A and B as described above, this plan 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 and 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.

### Premium Personal Health Team

The Premium Personal Health Team is a designated and integrated service delivery approach using a one health advocate model. Core functions include:

- Case Management - Short term and complex
- Inpatient Advocacy
- Pre Admission Outreach
- Post Discharge Outreach
- 24 hour Health Information Line Outreach

Care Facility - Plano

Program Name - beWell Personal Health Team

### Pre-Certification - Continued Stay Review - Preferred Care Management Inpatient

- required for all inpatient admissions

Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- \$150 penalty applied to hospital inpatient charges for failure to contact Cigna Healthcare to precertify admission.
- 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.

### Pre-Certification - Preferred Care Management Outpatient Prior Authorization

- required for selected outpatient procedures and diagnostic testing

Customer is responsible for contacting Cigna Healthcare. Subject to penalty/reduction or denial for non-compliance.

- \$150 penalty applied to outpatient procedures/diagnostic testing charges for failure to contact Cigna Healthcare and to precertify admission.
- Benefits are denied for any outpatient procedures/diagnostic testing reviewed by Cigna Healthcare and not certified.

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

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## Additional Information

### Treatment Decision Support

Treatment decision support for common health conditions. Cigna health advocates provide unbiased information and education on treatment options for common health conditions, including: back pain, coronary artery disease, osteoarthritis of the hip and knee, benign uterine conditions, breast cancer and prostate cancer.

Included

### 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

## Definitions

**Coinsurance** - 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.

**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.

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

**Professional Services** - Services performed by Surgeons, Assistant Surgeons, Hospital Based Physicians, Radiologists, Pathologists and Anesthesiologists

**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.
- 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 or Pharmacy 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 Expense (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 Expense, 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 or Pharmacy 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.
- Provided further, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a prescription medication or other product, Cigna may, in its sole discretion, reduce the benefits provided under the plan in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any plan Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Coinsurance you are required to pay.
- Charges arising out of or relating 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 or Biologic therapies or devices that are determined by the utilization review Physician to be:
  - o not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
  - 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 the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or
  - 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" sections of this plan.

## Exclusions

In determining whether any such technologies, supplies, treatments, drug or Biologic therapies or devices are experimental, investigational and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- The following services are excluded from coverage regardless of clinical indications: Panniculectomy; Abdominoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolwing; 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. Charges made for services or supplies provided for or in connection with an accidental Injury to teeth are covered provided a continuous course of dental treatment is started within six months of an accident.
- 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.
- Infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs is also excluded from coverage.
- Reversal of male or female voluntary sterilization procedures.
- 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), anorgasmia, 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.
- Non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.
- 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.

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## Exclusions

- 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 non-verbal communications, including but not limited to communication boards, pre-recorded 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.
- Treatment by acupuncture.
- All non-injectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription 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 for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- 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 Covered Expenses.
- 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, service agreement 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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