# SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.

*This is a summary of benefits for your Open Access Plus plan. All deductibles and plan out-of-pocket maximums cross accumulate between in- and out-of-network unless otherwise noted. Plan maximums will cross accumulate between in- and out-of-network. Service-specific maximums (dollar and occurrence) cross-accumulate between in- and out-of-network unless otherwise noted. Pharmacy plan deductibles, out-of-pocket maximums, copays and annual maximums do not integrate with the employer medical program.*

## *BorgWarner Inc.*
## *Core Open Access Plus Copay Plan*
## *Pre-Medi Retirees - OAPR*
## *Effective 1/1/2019*

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***PPACA Status*** | Exempt | |
| ***MH/SUD Parity Status*** | Exempt | |
| ***Lifetime Maximum*** | Unlimited | |
| ***Coordination of Benefits Administration*** | Maintenance of Benefits | |
| ***Coinsurance Levels*** | 80% | 60% of Maximum Reimbursable Charge (AKA Reasonable & Customary) |
| ***Maximum Reimbursable Charge***<br>Determined based on the lesser of:<br>•The provider's normal charge for a similar service or supply<br>or<br>•A percentile of charges made by providers of such service or supply in the geographic area where it is received. These charges are compiled in a database selected by Cigna.<br><br>Note: The provider may bill the customer the difference between the provider's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles, co-payments, and coinsurance. | Not applicable | 90th percentile |
| ***Calendar Year Deductible*** | | |
| *Individual* | $400 per person | $800 per person |
| *Family Maximum* | $800 per family | $1,600 per family |
| ***Deductible Accumulators*** | Cross accumulation between In-network & Out-of-network deductibles | |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Out-of-Pocket Maximum*** | | |
| *Individual* | $3,000 per person | $6,000 per person |
| *Family Maximum* | $6,000per family | $12,000 per family |
| *Includes Deductible* | Yes | Yes |
| *Includes Copays* | No | No |
| *Does not apply to* | Non-compliance penalties, copays | Non-compliance penalties, or charges in excess of Reasonable and Customary |
| Benefits for accident or sickness are paid at 100% once an individual's out-of-pocket max has been reached. | | |
| ***Out-of-Pocket Maximum Accumulators*** | Cross accumulation between In-network and Out-of-network Out-of-Pocket Maximums | |
| ***Automated Annual Reinstatement*** | Not Applicable | |
| ***Physician's Services*** | | |
| *Primary Care Physician's Office visit* | No charge after $20 PCP per office visit copay; No charge after the PCP per office visit copay if only x-ray and/or lab services performed and billed. | 60% after plan deductible |
| *Specialty Care Physician's Office Visit*<br>*Office Visits, Consultant and Referral Physician's Services*<br>**Note:** OB-GYN visits will be subject to either the PCP or Specialist copay depending on how the provider calendars with CIGNA (i.e. as a PCP or as a Specialist). | No charge after $40 Specialist per office visit copay; No charge after the Specialist per visit copay if only x-ray and/or lab services performed and billed. | 60% after plan deductible |
| *Surgery Performed In the Physician's Office* | No charge after PCP or Specialist per office visit copay | 60% after plan deductible |
| *Second Opinion Consultations (services will be provided on a voluntary basis)* | No charge after PCP or Specialist per office visit copay | 60% after plan deductible |
| *Cigna Telehealth Connection services*<br>**Note**: Includes charges for 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). | No charge after PCP per office visit copay | Not Covered |
| *Allergy Testing/ Treatment/Injections* | No charge after PCP or Specialist per office visit copay, or actual charge, whichever is less | 60% after plan deductible |
| *Allergy Serum (dispensed by the physician in the office)* | No charge | 60% after plan deductible |
| ***Preventive Care***<br>*Routine Preventive Care (Well-Baby, Well-Child and Adult Preventive Care)*<br>*Preventive Care Maximum: $Unlimited*<br>*Including, but not limited to: Physician's office visit, immunizations, routine screenings, mammogram, pap smear and PSA* | 100%, no deductible regardless of the place of service | 60% after plan deductible |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Inpatient Hospital - Facility Services*** | 80% after plan deductible | 60% after plan deductible<br>Precertification required |
| *Semi Private Room and Board* | Limited to semi-private room negotiated rate | Limited to semi-private room rate |
| *Private Room* | Limited to semi-private room negotiated rate | Limited to semi-private room rate |
| *Special Care Units (ICU/CCU)* | Limited to negotiated rate | Limited ICU/CCU daily room rate |
| ***Outpatient Facility Services***<br>*Operating Room, Recovery Room, Procedure Room, Treatment Room and Observation Room* | 80% after plan deductible | 60% after plan deductible |
| ***Inpatient Hospital Physician's Visits/Consultations*** | 80% after plan deductible | 60% after plan deductible |
| ***Inpatient Hospital Professional Services***<br>*Surgeon*<br>*Radiologist*<br>*Pathologist*<br>*Anesthesiologist* | 80% after plan deductible | 60% after plan deductible |
| ***Multiple Surgical Reduction*** | Multiple surgeries performed during one operating session result in payment reduction of 50% of charges to the surgery of lesser charge. The most expensive procedure is paid as any other surgery. | |
| ***Outpatient Professional Services***<br>*Surgeon*<br>*Radiologist*<br>*Pathologist*<br>*Anesthesiologist* | 80% after plan deductible | 60% after plan deductible |
| ***Emergency and Urgent Care Services***<br>*Physician's Office* | No charge after PCP or Specialist per office visit copay | Same as in-network |
| *Hospital Emergency Room* | 80% after plan deductible | Same as in-network |
| *Outpatient Professional services (radiology, pathology and ER Physician)* | 80% after plan deductible | Same as in-network |
| *Urgent Care Facility or Outpatient Facility* | $40 per visit copay, then 80% no deductible | Same as in-network |
| *Ambulance* | 80% after plan deductible | Same as in-network |
| ***Inpatient Services at Other Health Care Facilities***<br>*Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities*<br>Maximum per calendar year: Unlimited | 80% after plan deductible | 60% after plan deductible |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Laboratory and Radiology Services (includes pre-admission testing)*** | | |
| *Physician's Office* | No charge after PCP or Specialist per office visit copay | 60% after plan deductible |
| *Outpatient Hospital Facility* | 80% after plan deductible | 60% after plan deductible |
| *Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)* | 80% after plan deductible | Same as in-network |
| *Independent X-ray and/or Lab facility* | 80% after plan deductible | 60% after plan deductible |
| *Independent X-ray and/or Lab Facility in conjunction with an ER visit* | 80% after plan deductible | Same as in-network |
| ***Advanced Radiological Imaging (i.e. MRI's, MRAs, CAT Scans and PET Scans, etc.)*** | | |
| *Inpatient Facility* | 80% after plan deductible | 60% after plan deductible |
| *Outpatient Facility* | 80% after plan deductible | 60% after plan deductible |
| *Emergency Room/Urgent Care Facility (billed by the facility as part of the ER visit)* | 80% after plan deductible | Same as in-network |
| *Physician's Office* | 80% after plan deductible | 60% after plan deductible |
| **Notes**:<br>• Scans are subject to the applicable place of service coinsurance and plan deductible. | | |
| ***Outpatient Short-Term Rehabilitative Therapy and Cardiac Rehabilitation***<br>Maximum per calendar year : Unlimited<br><br>Includes:<br>Physical Therapy<br>Speech Therapy<br>Occupational Therapy<br>Pulmonary Rehab<br>Cognitive Therapy<br>Cardiac Rehab | 80% after plan deductible<br><br>**Note:** Outpatient Short Term Rehab copay applies, regardless of place of service, including the home.<br><br>**Note:** Therapy days, provided as part of an approved Home Health Care plan, accumulate to the Outpatient Short Term Rehab Therapy maximum. If multiple outpatient services are provided on the same day, they constitute one day, but separate copay will apply to the services provided by each Participating provider. | 60% after plan deductible |
| ***Chiropractic Care Services*** (includes Chiropractors)<br>$500 combined maximum per calendar year | 80% after plan deductible | 60% after plan deductible |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Home Health Care***<br>120 days maximum per calendar year (includes outpatient private duty nursing when approved as medically necessary)<br><br>**Note:** The maximum number of hours per day is limited to 16 hours. Multiple visits can occur in one day; with a visit defined as a period of 2 hours or less (e.g. maximum of 8 visits per day). | 80% after plan deductible | 60% after plan deductible |
| ***Hospice*** | | |
| *Inpatient Services* | 80% after plan deductible | 60% after plan deductible |
| *Outpatient Services* | 80% after plan deductible | 60% after plan deductible |
| ***Bereavement Counseling*** | | |
| *Services provided as part of Hospice Care* | | |
| *Inpatient* | 80% after plan deductible | 60% after plan deductible |
| *Outpatient* | 80% after plan deductible | 60% after plan deductible |
| *Services provided by Mental Health Professional* | Covered under Mental Health benefit | Covered under Mental health benefit |
| ***Maternity Care Services*** | | |
| *Initial Visit to Confirm Pregnancy*<br>**Note:** OB-GYN visits will be subject to either the PCP or Specialist copay depending on how the provider calendars with CIGNA (i.e. as a PCP or as a Specialist). | No charge after PCP or Specialist per office visit copay; No charge after PCP or Specialist per visit copay if only x-ray and/or lab services are performed and billed. | 60% after plan deductible |
| *All Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges (i.e. global maternity fee)* | 80% after plan deductible | 60% after plan deductible |
| *Office Visits in addition to the global maternity fee when performed by an OB or Specialist* | No charge after PCP or Specialist per office visit copay; No charge after PCP or Specialist per visit copay if only x-ray and/or lab services are performed and billed | 60% after plan deductible |
| *Delivery – Facility (Inpatient Hospital, Birthing Center)* | 80% after plan deductible | 60% after plan deductible |
| ***Abortion***<br>*Includes non-elective procedures* | | |
| *Inpatient Facility* | 80% after plan deductible | 60% after plan deductible |
| *Outpatient Surgical Facility* | 80% after plan deductible | 60% after plan deductible |
| *Physician's Office* | No charge after PCP or Specialist per office visit copay | 60% after plan deductible |
| *Professional Services* | 80% after plan deductible | 60% after plan deductible |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Family Planning Services*** | | |
| *Office Visits, Lab and Radiology Tests and Counseling*<br><br>**Note:** The standard benefit will include coverage for contraceptive devices (e.g. Depo-Provera and Intrauterine Devices (IUDs). Diaphragms will also be covered when services are provided in the physician's office. | No charge after PCP or Specialist per office visit copay; No charge after PCP or Specialist per visit copay if only x-ray and/or lab services are performed and billed.<br><br>**Note:** Charges billed by an independent x-ray/lab facility or outpatient hospital will be covered under the plan's x-ray/lab benefit. | 60% after plan deductible |
| *Surgical Sterilization* Procedure *for Vasectomy/Tubal Ligation (excludes reversals)* | | |
| *Inpatient Facility* | 80% after plan deductible | 60% after plan deductible |
| *Outpatient Facility* | 80% after plan deductible | 60% after plan deductible |
| *Physician's Services* | 80% after plan deductible | 60% after plan deductible |
| *Physician's Office* | No charge after PCP or Specialist per office visit copay; No charge after PCP or Specialist per visit copay if only x-ray and/or lab services are performed and billed. | 60% after plan deductible |
| ***Infertility Treatment*** | | |
| *Office Visit (tests, counseling)*<br><br>*Coverage will be provided for the following services:*<br>• *Testing and treatment services performed in connection with an underlying medical condition.*<br>• *Testing performed specifically to determine the cause of infertility.*<br>• *Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).*<br><br>*Services to induce pregnancy are not covered, such as, In-vitro, Artificial Insemination, GIFT, ZIFT, etc.* | No charge after PCP or Specialist per office visit copay; No charge after PCP or Specialist per visit copay if only x-ray and/or lab services are performed and billed | 60% after deductible |
| *Inpatient Facility* | 80% after deductible | 60% after deductible |
| *Outpatient Facility* | 80% after deductible | 60% after deductible |
| *Physician's Services* | 80% after deductible | 60% after deductible |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Organ Transplant*** | | |
| *Includes all medically appropriate, non-experimental transplants* | | |
| *Organ Transplant Lifetime Maximum (combined)* | $1,000,000 | $1,000,000 |
| *Office Visit* | No charge after PCP or Specialist per office visit copay; No charge after PCP or Specialist per visit copay if only x-ray and/or lab services are performed and billed. | 60% after plan deductible |
| *Inpatient Facility* | 100%, no deductible at Lifesource center , otherwise 80% after plan deductible | 60% after plan deductible |
| *Physician's Services* | 100%, no deductible at Lifesource center , otherwise 80% after plan deductible | 60% after plan deductible |
| *Travel Services Maximum- only available for Lifesource facilities* | $10,000 per transplant, per lifetime | Does not apply |
| ***Durable Medical Equipment*** Unlimited maximum per calendar year | 80% after plan deductible | 60% after plan deductible |
| ***Breast Feeding Equipment and Supplies*** ***Limited to the rental of one breast pump per birth as lered or prescribed by a physician*** | 80% after plan deductible | 60% after plan deductible |
| ***External Prosthetic Appliances*** Unlimited maximum per calendar year | 80% after plan deductible | 60% after plan deductible |
| ***Routine Foot Disorders*** | Not covered except for services associated with foot care for diabetes and peripheral vascular disease when medically necessary. | Not covered except for services associated with foot care for diabetes and peripheral vascular disease when medically necessary. |
| ***Dental Care*** *Limited,to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.* | | |
| *Doctor's Office* | No charge after PCP or Specialist per office visit copay; No charge after PCP or Specialist per visit copay if only x-ray and/or lab services are performed | 60% after plan deductible |
| *Inpatient Facility* | 80% after plan deductible | 60% after plan deductible |
| *Outpatient Surgical Facility* | 80% after plan deductible | 60% after plan deductible |
| *Physician's Services* | 80% after plan deductible | 60% after plan deductible |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***TMJ – Surgical*** | | |
| *Provided on a limited, case by case basis. Always exclude appliances and orthodontic treatment. Subject to medical necessity.* | | |
| *Doctor's Office* | No charge after PCP or Specialist per office visit copay; No charge after PCP or Specialist per visit copay if only x-ray and/or lab services are performed | 60% after plan deductible |
| *Inpatient Facility* | 80% after plan deductible | 60% after plan deductible |
| *Outpatient Surgical Facility* | 80% after plan deductible | 60% after plan deductible |
| *Physician's Services* | 80% after plan deductible | 60% after plan deductible |
| ***Oral Surgery for removal of impacted teeth*** | | |
| *Limited to removal of impacted teeth, ADA codes 07220, 07230, 07240, 07241* | | |
| *Physician's Office* | No charge after PCP or Specialist per office visit copay; No charge after PCP or Specialist per visit copay if only x-ray and/or lab services are performed | 60% after plan deductible |
| *Inpatient Facility* | 80% after plan deductible | 60% after plan deductible |
| *Outpatient Surgical Facility* | 80% after plan deductible | 60% after plan deductible |
| *Physician's Services* | 80% after plan deductible | 60% after plan deductible |
| ***Prescription Drugs*** | | |
| *Cigna Pharmacy*<br>*3-tier Coinsurance Mandatory Generic*<br>• *Retail – up to 90-day supply (except Specialty up to 30-day supply)*<br>• *Home Delivery – up to 90-day supply (except Specialty up to 30-day supply)* | **Retail**: (30-day supply, up to 100 tablets/capsules)<br>Generic: $8<br>Preferred Brand: $8 then 30%<br>Non-Preferred Brand: $8 then 50%<br>**Retail & Home Delivery**: (90-day supply)<br>Generic: $16<br>Preferred Brand: 30% up to $150<br>Non-Preferred Brand: 50%<br>**Specialty Drugs – Retail (first fill only) & Home Delivery** (30-day supply)<br>Preferred Brand: 30% up to $50<br>Non-Preferred Brand: 50% up to $100 | In-network coverage only |
| ***Pharmacy Deductible*** | None | None |
| ***Pharmacy Out of Pocket Maximum*** | None | None |
| ***Pharmacy Annual Maximum*** | None | None |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-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.<br>• Cigna 90 Now Program: You can choose to fill your medications in a 30- or 90-day supply. If you choose to fill a 30-day prescription, it can be filled at any network retail pharmacy or Cigna Home Delivery. If you choose to fill a 90-day prescription, it must be filled at a 90-day network retail pharmacy or Cigna Home Delivery to be covered by the plan.<br>• This plan will not cover out-of-network pharmacy benefits.<br>• 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 require special handling and close supervision when being administered.<br>• Mandatory Generic: Patient pays the brand cost share plus the ocst difference between the brand and generic drugs up to the cost of the brand drug.<br>• Exclusive specialty home delivery: Specialty medications must be filled through home delivery; otherwise you pay the entire cost of the prescription after 1 Retail fill.<br>• 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. | | |
| ***Specialty Pharmacy*** | | |
| *Clinical Program* | Prior authorization required on specialty medications and quantity limits may apply.<br>TheraCare® Program | |
| ***Clinical Outcome Cost Management Programs:***<br>*Complex Psych Case Management*<br>*Narcotic Therapy Management* | <br>Included<br>Included | |
| **Buy-Up Options** | | |
| Injectables | | |
| Self-Administered | Included | In-Network coverage only |
| Optional | Included | In-Network coverage only |
| Oral Contraceptives/Devices | Included | In-Network coverage only |
| Oral fertility | Included with prior authorization if medically necessary to maintain pregnancy only | In-Network coverage only |
| Prescription Diet Drugs | Included | In-Network coverage only |
| Prescription Smoking Cessation | Included through mail order only for a 90 day supply. | In-Network coverage only |
| Insulin | Preferred or Non-preferred Brand copay/coinsurance, based on the formulary | In-Network coverage only |
| Diabetic Supplies ie: all syringes, including non-insulin syringes, needles, insulin injectable devices, swabs, blood monitors (eg: glucometers) and kits, urine test strips, lancets and lancet devices. | No charge if purchased with Insulin; otherwise, the generic copay applies. | In-Network coverage only |
| Prescription Vitamins | Included | In-Network coverage only |
| Lifestyle Drugs (injectable only) | Included | In-Network coverage only |
| ***Additional Comments*** | • Exclude Flumist<br>• Step Therapy applies to: ACEI/ARB (High Blood Pressure class), PPI (Heartburn/Ulcer class), Statin (Cholesterol Lowering class) | In-Network coverage only |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Mental Health/Substance Abuse (Alcohol & Drug)*** | | |
| ***Mental Health*** | | |
| *MH Inpatient* | 80% after plan deductible | 60% after plan deductible |
| *MH Outpatient Physician's Office* | No charge after $20 PCP/$40 Specialist office visit copay | 60% after plan deductible |
| *MH Outpatient Hospital Facility* | 80% after plan deductible | 60% after plan deductible |
| *Note: Outpatient Care includes Individual, Group and Intensive Outpatient* | | |
| ***Substance Abuse Rehabilitation*** | | |
| *SA Inpatient* | 80% after plan deductible | 60% after plan deductible |
| *SA Outpatient Physician's Office* | No charge after $20 PCP/$40 Specialist office visit copay | 60% after plan deductible |
| *SA Outpatient Hospital Facility* | 80% after plan deductible | 60% after plan deductible |
| *Note: Outpatient Care includes Individual and Intensive Outpatient* | | |
| ***MH/SA Service Specific Administration*** | Partial Hospitalization, Residential Treatment and Intensive Outpatient Programs:<br><br>The following administration will apply:<br>• ***Partial Hospitalization and Residential Treatment***: Covered as inpatient Mental Health and/or Substance Abuse<br>• ***Intensive Outpatient Program (IOP):*** Covered as outpatient Mental Health and/or Substance Abuse. Coverage only if approved through CHS (CIGNA Health Solutions) Case Management. | |
| ***MH/SA Utilization Review & Case Management*** | CHS Inpatient Management (FFS):<br>• CHS provides utilization review and case management for In-network and Out-of-network Inpatient Management Services. | |
| ***Pre-existing Condition Limitation (PCL)*** | Applies to any injury or sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a physician during the 90 days before the earlier of the date a person begins an eligibility waiting period or becomes insured for these benefits. Coverage for the pre-existing condition is excluded until one year of being continuously insured and/or is satisfying a waiting period.<br><br>Usually the PCL is waived for the initial group, but if not, the insured will receive credit for any portion of the PCL waiting period that was satisfied under the previous plan if they are enrolled in the subsequent plan within 63 days (or the applicable timeframe required per state law). | |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Pre-Admission Certification - Continued Stay Review (PHS)***<br><br>*CIGNA's PAC/CSR is not necessary for Medicare Primary individuals<br><br>*Inpatient Pre-Admission Certification* - Continued Stay Review (required for all inpatient admissions) | Coordinated by Provider/PCP | **Mandatory**: Employee is responsible for contacting CIGNA Healthcare. Penalties for non-compliance:<br>– 50% penalty applied to hospital inpatient charges for failure to contact CIGNA Healthcare to precertify admission.<br>– Benefits are denied for any admission reviewed by CIGNA Healthcare and not certified.<br>– Benefits are denied for any additional days not certified by CIGNA Healthcare. |
| ***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. | |
| ***Health Advisor-A***<br>*Support for healthy and at-risk individuals to help them stay healthy*<br><br>• *Health and Wellness Coaching*<br>• *Gaps in Care coaching for select conditions*<br>• *Preference Sensitive Care/Treatment Decision Support Coaching* | Included | |
| ***Your Health First – 200***<br>*Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:*<br><br>• *Condition Management*<br>• *Medication adherence*<br>• *Risk factor management*<br>• *Lifestyle issues*<br>• *Health & Wellness issues*<br>• *Pre/post-adminssion*<br>• *Treatment decision support*<br>• *Gaps in care* | Holistic health support for the following chronic health conditions:<br><br>• Heart Disease<br>• Coronary Artery Disease<br>• Angina<br>• Congestive Heart Failure<br>• Acute Myocardial Infarction<br>• Peripheral Arterial Disease<br>• Asthma<br>• Chronic Obstructive Pulmonary Disease (Emphysema and Chronic Bronchitis)<br>• Diabetes Type 1<br>• Diabetes Type 2<br>• Metabolic Syndrome/Weight Complications<br>• Osteoarthritis<br>• Low Back Pain<br>• Anxiety<br>• Bipolar Disorder<br>• Depression | |

## Medical Benefit Exclusions (*by way of example but not limited to*):

Your plan provides coverage for medically necessary services. Your plan does not provide coverage for the following except as required by law:

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public school system or school district.
3. Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
4. Treatment of an illness or injury which is due to war, declared or undeclared.
5. Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
6. 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.
7. Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be: Not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or The subject of review or approval by an Institutional Review Board for the proposed use, except as provided in the "Clinical Trials" section of "Covered Services and Supplies;" or The subject of an ongoing phase I, II or III clinical trial, except as provided in the " Clinical Trials" section of "Covered Services and Supplies."
8. Cosmetic Surgery and Therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
9. The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; 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.
10. Non-Surgical treatment of TMJ disorder.
11. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, surgery for impacted teeth, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within 6 months of the 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.
12. Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, including clinically severe (morbid) obesity, including: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.
13. Unless otherwise covered as a basic benefit, 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.
14. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under "Covered Services and Supplies."
15. Infertility services, 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 are also excluded from coverage.
16. Reversal of male and female voluntary sterilization procedures.
17. Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
18. Any services, supplies, medications or drugs 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.

19. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
20. Non-medical 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 non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
21. 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.
22. 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 "Inpatient Hospital Services," "Outpatient Facility Services," "Home Health Services," or "Breast Reconstruction and Breast Prostheses" sections of the "Covered Services and Supplies."
23. Private hospital rooms and/or private duty nursing except as provided in the Home Health Services section of "Covered Services and Supplies."
24. 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 illness or injury.
25. Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
26. 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.
27. 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.
28. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
29. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
30. Treatment by acupuncture.
31. All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Covered Services and Supplies."
32. 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.
33. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
34. Genetic screening or pre-implantation 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.
35. Dental implants for any condition.
36. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
37. Blood administration for the purpose of general improvement in physical condition.
38. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
39. Cosmetics, dietary supplements and health and beauty aids.
40. All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
41. Expenses incurred for medical treatment by a person age 65 or older, who is covered under this Agreement as a retiree, or his Dependents, when payment is denied by the Medicare plan because treatment was not received from a Participating Provider of the Medicare plan.
42. Expenses incurred for medical treatment when payment is denied by the Primary Plan because treatment was not received from a Participating Provider of the Primary Plan.
43. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.

44. 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. Telephone, e-mail & Internet consultations and telemedicine.
45. 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, see your employer's 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.