SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.
For - City of North Port
Open Access Plus Base Plan

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

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

Plan Highlights	In-Network	Out-of-Network
Lifetime Maximum	Unlimited	Unlimited
Coinsurance	Your plan pays 80%	Your plan pays 60%
Maximum Reimbursable Charge	Not Applicable	110%
Calendar Year Deductible	Individual: $500 Family: $1,000	Individual: $1,000 Family: $2,000

- Only the amount you pay for in-network covered expenses counts toward your in-network deductible. The amount you pay for out-of-network covered expenses counts toward both your in-network and out-of-network deductibles.
- After each eligible family member meets his or her individual deductible, covered expenses for that family member will be paid based on the coinsurance level specified by the plan. Or, after the family deductible has been met, covered expenses for each eligible family member will be paid based on the coinsurance level specified by the plan.

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

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Plan Highlights	In-Network	Out-of-Network
Calendar Year Out-of-Pocket Maximum	Individual: $3,000 Family: $6,000	Individual: $6,000 Family: $12,000

- Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. The amount you pay for out-of-network covered expenses counts toward both your in-network and out-of-network out-of-pocket maximums.
- Plan deductible contributes towards your out-of-pocket maximum.
- All copays and benefit deductibles contribute towards your out-of-pocket maximum.
- Mental Health and Substance Use Disorder covered expenses contribute towards your out-of-pocket maximum.
- 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.
- This plan includes a combined Medical/Pharmacy out-of-pocket maximum.
- Retail and home delivery Pharmacy costs contribute to the combined Medical/Pharmacy out-of-pocket.

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^)		
Physician Services		
Physician Office Visit • All services including Lab & X-ray • Plan pays 100% after you pay copay	$25 Primary Care Physician (PCP) copay or $50 Specialist copay	Your plan pays 60% ^
Surgery Performed in Physician's Office	$25 PCP or $50 Specialist copay	Your plan pays 60% ^
Allergy Treatment	$25 PCP or $50 Specialist copay or actual charge (if less)	Your plan pays 60% ^
Allergy Serum Dispensed by the physician in the office	Your plan pays 100%	Your plan pays 60% ^
Allergy Injections	$5 copay	Your plan pays 60% ^
Preventive Care		
Preventive Care Birth through age 15 Ages 16 and older	Your plan pays 100% Your plan pays 100%	Your plan pays 60% Your plan pays 60% ^
• Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.		
Immunizations Birth through age 15 Ages 16 and older	Your plan pays 100% Your plan pays 100%	Your plan pays 60% Your plan pays 60% ^
Mammogram, PAP, and PSA Tests	Your plan pays 100%	Your plan pays 60% ^
• Coverage includes the associated Preventive Outpatient Professional Services. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.		

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Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^)		
Inpatient		
Inpatient Hospital Facility	Your plan pays 80% ^	Your plan pays 60% ^
Semi-Private Room: In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate **Private Room:** In-Network: Limited to the semi-private negotiated rate / Out-of-Network: Limited to semi-private rate **Special Care Units (Intensive Care Unit (ICU), Critical Care Unit (CCU)):** In-Network: Limited to the negotiated rate / Out-of-Network: Limited to ICU/CCU daily room rate		
Inpatient Hospital Physician's Visit/Consultation	Your plan pays 80% ^	Your plan pays 60% ^
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Your plan pays 80% ^	Your plan pays 60% ^
Outpatient		
Outpatient Facility Services	Your plan pays 80% ^	Your plan pays 60% ^
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Your plan pays 80% ^	Your plan pays 60% ^
Short-Term Rehabilitation	$25 copay	Your plan pays 60% ^
Calendar Year Maximums: • Speech Therapy, Occupational Therapy, Physical Therapy, Autism Therapy, and Spinal Manipulation Care – Unlimited days Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.		
Short-Term Rehabilitation	$25 PCP or $50 Specialist copay	Your plan pays 60% ^
Calendar Year Maximums: • Pulmonary Rehabilitation, Cognitive Therapy– Unlimited days Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum.		
Cardiac Rehabilitation	$50 Specialist copay	Your plan pays 60% ^
Calendar Year Maximums: • Cardiac Rehabilitation - 36 days 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) • 60 days maximum per Calendar Year • 16 hour maximum per day	Your plan pays 80% ^	Your plan pays 60% ^
Skilled Nursing Facility, Sub-Acute Facility • 60 days maximum per Calendar Year	Your plan pays 80% ^	Your plan pays 60% ^

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Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^)		
Inpatient Rehabilitation Facility • Unlimited day maximum per Calendar Year	Your plan pays 80% ^	Your plan pays 60% ^
Durable Medical Equipment • Unlimited maximum per Calendar Year	Your plan pays 80% ^	Your plan pays 60% ^
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 60% ^
External Prosthetic Appliances (EPA) • Unlimited maximum per Calendar Year	Your plan pays 80% ^	Your plan pays 60% ^
Routine Foot Disorders	Not Covered	Not Covered
Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.		

Place of Service - your plan pays 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	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Lab and X-ray	$25 PCP or $50 Specialist copay	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 100%		Plan pays 80% ^	Plan pays 60% ^
Advanced Radiology Imaging	Plan pays 100%	Plan pays 60% ^	Not Applicable	Not Applicable	Plan pays 100%		Plan pays 80% ^	Plan pays 60% ^

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

Benefit	Emergency Room / Urgent Care Facility		Outpatient Professional Services		*Ambulance	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Emergency Care	$300 per visit (copay waived if admitted)		Plan pays 100%		Plan pays 80% ^	
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.

Benefit	Inpatient Hospital and Other Health Care Facilities		Outpatient Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospice	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^
Bereavement Counseling	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^

Note: Services provided as part of Hospice Care Program

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Benefit	Inpatient Hospital and Other Health Care Facilities		Outpatient Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network

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

Benefit	Initial Visit to Confirm Pregnancy		Global Maternity Fee (All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges)		Office Visits in Addition to Global Maternity Fee (Performed by OB/GYN or Specialist)		Delivery - Facility (Inpatient Hospital, Birthing Center)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Maternity	$25 PCP or $50 Specialist copay	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	$25 PCP or $50 Specialist copay	Plan pays 60% ^	Covered same as plan's Inpatient Hospital benefit	Covered same as plan's Inpatient Hospital benefit

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	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Abortion (Elective and non-elective procedures)	$25 PCP or $50 Specialist copay	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^
Family Planning - Men's Services	$25 PCP or $50 Specialist copay	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^
Includes surgical services, such as vasectomy (excludes reversals)										
Family Planning - Women's Services	Plan pays 100%	Plan pays 60% ^	Plan pays 100%	Plan pays 60% ^	Plan pays 100%	Plan pays 60% ^	Plan pays 100%	Plan pays 60% ^	Plan pays 100%	Plan pays 60% ^
Includes surgical services, such as tubal ligation (excludes reversals) Contraceptive devices as ordered or prescribed by a physician.										
Infertility **Note:** 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.										
TMJ, Surgical and Non-Surgical	$25 PCP or $50 Specialist copay	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^
Services provided on a case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity.										

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Benefit	Physician's Office		Inpatient Facility		Outpatient Facility		Inpatient Professional Services		Outpatient Professional Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Unlimited maximum per lifetime										
Note: Services where plan deductible applies are noted with a caret (^)										

Benefit	Inpatient Hospital Facility			Inpatient Professional Services		
	Lifesource Facility In-Network	Non-Lifesource Facility In-Network	Out-of-Network	Lifesource Facility In-Network	Non-Lifesource Facility In-Network	Out-of-Network
Organ Transplants	Plan pays 100%	Plan pays 80% ^	Plan pays 60% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 60% ^
• Travel Lifetime Maximum - LifeSOURCE Facility $10,000 maximum per Transplant per Lifetime						
Note: Services where plan deductible applies are noted with a caret (^)						

Benefit	Inpatient		Outpatient - Physician's Office		Outpatient – All Other Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Mental Health	Plan pays 80% ^	Plan pays 60% ^	$50 copay	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^
Substance Use Disorder	Plan pays 80% ^	Plan pays 60% ^	$50 copay	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^
Note: Services where plan deductible applies are noted with a caret (^)						

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.

Mental Health and Substance Use Disorder Services

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

Cigna Total Behavioral Health - Inpatient and Outpatient Management

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

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Pharmacy	In-Network	Out-of-Network
Cigna Pharmacy Plus three-tier copay plan • Retail drugs may be obtained In-Network at a wide range of pharmacies across the nation. • When patient requests brand drug, patient pays the generic copay plus the cost difference between the brand and generic drugs up to the cost of the brand drug. • Your pharmacy benefits have a combined out-of-pocket maximum with the medical/behavioral benefits. • Self Administered injectable drugs - excludes infertility drugs • Includes oral contraceptives - with specific products covered 100% • Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges included • Prescription smoking cessation drugs included	**Retail** - 30 day supply Generic: You pay $15 Preferred Brand: You pay $30 Non-Preferred Brand: You pay $50 **Home delivery** - 90 day supply Generic: You pay $30 Preferred Brand: You pay $60 Non-Preferred Brand: You pay $100	You pay 50% Your plan pays 50%

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 - Enhanced package - a group of clinical medication management options that focus on various drug use management philosophies to help actively manage the pharmacy benefit include:
  - Benefits Exclusion - prior authorization, age edits and quantity over time edits.
  - Intensive Appropriateness of Use - duration of therapy edits, step therapy on new market entrants, and dose optimization edits.
  - Utilization and Unit Cost Management - prior authorization, quantity limits, maximum daily dose, and step therapy for limited class(es) of specific 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
  - Retail and/or Home Delivery

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.

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Additional Information

Maximum Reimbursable Charge
Out-of-Network services are subject to a Calendar Year deductible and maximum reimbursable charge limitations. Payments made to health care professionals not participating in Cigna's network are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a percentage (110%) of a fee schedule developed by Cigna that is based on a methodology similar to one used by Medicare to determine the allowable fee for the same or similar service in a geographic area. In some cases, the Medicare based fee schedule is not used, and the maximum reimbursable charge for covered services is determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or the amount charged for that service by 80% of the health care professionals in the geographic area where it is received. The health care professional may bill the customer the difference between the health care professional's normal charge and the Maximum Reimbursable Charge as determined by the benefit plan, in addition to applicable deductibles, co-payments and coinsurance.

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

- 50% 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-Existing Condition Limitation (PCL) does not apply.

Your Health First - 200
Individuals with one or more of the chronic conditions, identified on the right, may be eligible to receive the following type of support:

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

Holistic health support for the following chronic health conditions:

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

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Definitions

Coinsurance - After you've reached your deductible, you and your plan share some of your medical costs. The portion of covered expenses you are responsible for is called Coinsurance.
Copay - A flat fee you pay for certain covered services such as doctor's visits or prescriptions.
Deductible - A flat dollar amount you must pay out of your own pocket before your plan begins to pay for covered services.
Out-of-Pocket Maximum - Specific limits for the total amount you will pay out of your own pocket before your plan coinsurance percentage no longer applies. Once you meet these maximums, your plan then pays 100 percent of the "Maximum Reimbursable Charges" or negotiated fees for covered services.
Prescription Drug List - The list of prescription brand and generic drugs covered by your pharmacy plan.
Transition of Care - Provides in-network health coverage to new customers when the customer's doctor is not part of the Cigna network and there are approved clinical reasons why the customer should continue to see the same doctor.

Exclusions

What's Not Covered (not all-inclusive):
Your plan provides for most medically necessary services. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control. Examples of things your plan does not cover, unless required by law or covered under the pharmacy benefit, include (but aren't limited to):

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance 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 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 or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; 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.

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Exclusions

- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- For medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- 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 are also excluded from coverage.
- Reversal of male or female voluntary sterilization procedures.
- 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, or mental retardation.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- Aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses 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, 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.

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Exclusions

- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- Dental implants for any condition.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- 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, email, and Internet consultations, and telemedicine.
- Massage therapy.

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

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EHB State: FL

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