SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.
For - Pratt Institute
Open Access Plus 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 100%	Your plan pays 80%
Maximum Reimbursable Charge	Not Applicable	80th Percentile
Calendar Year Deductible	Individual: None Family: None	Individual: $500 Family: $1,000

- 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 (^)

Plan Highlights	In-Network	Out-of-Network
Calendar Year Out-of-Pocket Maximum	Individual: $1,200 Family: $2,400	Individual: $1,200 Family: $2,400

- 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 $40 Specialist copay	Your plan pays 80% ^
Surgery Performed in Physician's Office	$25 PCP or $40 Specialist copay, then Plan pays 100%	Your plan pays 80% ^
Allergy Treatment/Injections	$25 PCP or $40 Specialist copay or actual charge (if less), then plan pays 100%	Your plan pays 80% ^
Allergy Serum Dispensed by the physician in the office	Your plan pays 100%	Your plan pays 80% ^
Cigna Telehealth Connection services	$25 copay	Not Covered
• 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). • Telehealth services rendered by providers that are not contracted medical telehealth providers (as described on myCigna.com) are covered at the same benefit level as the same services would be if rendered in-person.		
Preventive Care		
Preventive Care	Your plan pays 100%	Your plan pays 80% ^
• Includes well-baby, well-child, well-woman, and adult preventive care • Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.		
Immunizations	Your plan pays 100%	Your plan pays 80% ^
Mammogram, PAP, and PSA Tests	Your plan pays 100%	Your plan pays 80% ^
• 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.		
Inpatient		

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^)		
Inpatient Hospital Facility	$250 per admission copay, then your plan pays 100%	Your plan pays 80% ^
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 100%	Your plan pays 80% ^
Inpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Your plan pays 100%	Your plan pays 80% ^
Outpatient		
Outpatient Facility Services • Non-surgical treatment procedures are not subject to the facility per visit copay/benefit deductible	$125 per facility visit copay, then your plan pays 100%	Your plan pays 80% ^
Outpatient Professional Services • For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists	Your plan pays 100%	Your plan pays 80% ^
Short-Term Rehabilitation	$25 PCP or $40 Specialist copay, then Plan pays 100%	Your plan pays 80% ^
Calendar Year Maximums: • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy and Cardiac Rehabilitation – Unlimited days • Chiropractic 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.		
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private duty nursing subject to medical necessity) • Unlimited days maximum per Calendar Year • 16 hour maximum per day • Home Health Care deductible is $50 per individual per Calendar Year	Your plan pays 100%	Your plan pays 80% ^
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • Unlimited days maximum per Calendar Year	Your plan pays 100%	Your plan pays 80% ^
Durable Medical Equipment • Unlimited maximum per Calendar Year	Your plan pays 100%	Your plan pays 80% ^

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^)		
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 80% ^
External Prosthetic Appliances (EPA) • Unlimited maximum per Calendar Year	Your plan pays 100%	Your plan pays 80% ^
Routine Foot Disorders	Not Covered	Not Covered
Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.		
Hearing Aid • One hearing aid every 36 months	Your plan pays 100%	Your plan pays 80% ^

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	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%		Plan pays 100%	Plan pays 80% ^
Advanced Radiology Imaging	Plan pays 100%	Plan pays 80% ^	Not Applicable	Not Applicable	Plan pays 100%		Plan pays 100%	Plan pays 80% ^
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	$100 per visit (copay waived if admitted), then Plan pays 100%		Plan pays 100%		Plan pays 100%	
Urgent Care	$25 per visit (copay waived if admitted), then Plan pays 100%		Plan pays 100%		Plan pays 100%	
*Ambulance services used as non-emergency transportation (e.g., transportation from hospital back home) generally are not covered.						

Benefit	Inpatient Hospital and Other Health Care Facilities		Outpatient Services	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Hospice	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^
Bereavement Counseling	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^
Note: Services provided as part of Hospice Care Program				
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 $40 Specialist copay, then Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	$25 PCP or $40 Specialist copay, then Plan pays 100%	Plan pays 80% ^	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 $40 Specialist copay, then Plan pays 100%	Plan pays 80% ^	$250 per admission copay, then plan pays 100%	Plan pays 80% ^	$125 per facility visit copay, then plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^
Family Planning - Men's Services	$25 PCP or $40 Specialist copay then Plan pays 100%	Plan pays 80% ^	$250 per admission copay, then plan pays 100%	Plan pays 80% ^	$125 per facility visit copay, then plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^
Includes surgical services, such as vasectomy (excludes reversals)										
Family Planning - Women's Services	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^
Includes surgical services, such as tubal ligation (excludes reversals) Contraceptive devices as ordered or prescribed by a physician.										
Infertility	$25 PCP or $40 Specialist copay	Plan pays 80% ^	$250 per admission copay, then plan pays 100%	Plan pays 80% ^	$125 per facility visit copay, then plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^

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
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc. Injectable infertility drugs are covered under the medical plan instead of the prescription drug plan. • Unlimited Lifetime maximum										
Unlimited lifetime maximum										
TMJ, Surgical and Non-Surgical	$25 PCP or $40 Specialist copay, then Plan pays 100%	Plan pays 80% ^	$250 per admission copay, then plan pays 100%	Plan pays 80% ^	$125 per facility visit copay, then plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^
Services provided on a case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity.										
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	$250 per admission copay	$250 per admission copay, then plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 100%	Plan pays 80% ^
• Travel Lifetime Maximum - Lifesource Facility: In-Network: $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	$250 per admission copay, then plan pays 100%	Plan pays 80% ^	$40 copay, then Plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^
Substance Use Disorder	$250 per admission copay, then plan pays 100%	Plan pays 80% ^	$40 copay then plan pays 100%	Plan pays 80% ^	Plan pays 100%	Plan pays 80% ^
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, behavioral telehealth consultation and group therapy.

Mental Health and Substance Use Disorder Services

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

Cigna Total Behavioral Health - Inpatient and Outpatient Management

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

Pharmacy	In-Network	Out-of-Network
Cigna Pharmacy three-tier copay plan • Retail drugs may be obtained In-Network at a wide range of pharmacies across the nation. • Patient is responsible for the applicable copay based upon the tier of the dispensed medication. • Your pharmacy benefits have a combined out-of-pocket maximum with the medical/behavioral benefits. • Self Administered injectable and optional injectable drugs are covered - includes infertility drugs • Oral contraceptives included • Includes oral contraceptives - with specific products covered 100% • Lifestyle drugs included - limited to sexual dysfunction • Prescription diet drugs included • Prescription smoking cessation drugs included • Prescription vitamins included • Oral Fertility drugs included • Insulin, glucose test strips, lancets, insulin needles & syringes, insulin pens and cartridges included • Specialty medications are limited to a 90-day supply for Home Delivery • Specialty medications are limited to a 30-day supply at Retail	**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	Not Covered

Pharmacy Program Information

Pharmacy Clinical Management and Prior Authorization

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

Pharmacy Program Information

Prescription Drug List:

- Your Cigna Legacy 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

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 • Cigna Well Informed Program • Preference Sensitive care • Educate and Refer	Included
Healthy Pregnancies/Healthy Babies • Care Management outreach • Maternity Case Management • Neo-natal Case Management	$150 (1st trimester) / $75 (2nd trimester) - Option 3

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 percentile (80th) of charges made by health care professionals of such service or supply in the geographic area where it is received. These charges are compiled in a database selected by Cigna. 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.

Additional Information

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.

- The lesser of 50% or $500 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 - Continued Stay Review - PHS+ Outpatient Prior Authorization - required for selected outpatient procedures and diagnostic testing
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 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.

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 - 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

Exclusions and Expenses Not Covered

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this plan:

- Treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- Cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in functional defect.
- Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.
- Treatment provided in a government hospital.
- Benefits provided under Medicare or other governmental program (except Medicaid), any State or Federal workers' compensation, employers' liability or occupational disease law.
- Services rendered and separately billed by employees of hospitals, laboratories or other institutions.
- Services performed by a member of the covered person's immediate family.
- Dental care or treatment, except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly.
- Eyeglasses and examination for the prescription or fitting thereof.
- Rest cures and custodial care.
- Expenses incurred outside the United States, its possessions or the countries of Canada and Mexico, other than expenses for Medically Necessary urgent or emergent Care while temporarily traveling abroad.

Exclusions and Expenses Not Covered Unless Medically Necessary

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from 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.
- 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.
- 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.
- Dental implants for any condition.

Exclusions

- For or in connection with experimental, investigational or unproven services. However, Cigna will cover an experimental or investigational treatment approved by an external appeal agent. If the external appeal agent approved coverage of an experimental or investigational treatment that is part of a clinical trial, Cigna will only cover the costs of services required to provide treatment to you according to the design of the trial. Cigna shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or the costs which would not be covered under this plan for nonexperimental or noninvestigational treatments provided in such clinical trial.
- 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(s) of this plan; or
    - The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.
- Charges made for drugs and implanted/injected devices for contraception.
- 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.
- 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.

Limitations of Coverage

No payment will be made for expenses incurred for you or any one of your Dependents:

- 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.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, and elastic stockings.
- Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- Expenses denied by a Primary Plan because treatment was received from a nonparticipating provider.
- To the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- To the extent that payment is unlawful where the person resides when the expenses are incurred.
- For charges which would not have been made if the person had no insurance.
- Expenses for supplies, care, treatment, or surgery that are not Medically Necessary, except as specified in any certification requirement shown in this plan.

These are only the highlights

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

EHB State: NY