SUMMARY OF BENEFITS

Cigna Health and Life Insurance Co.
For - Accenture LLP
Open Access Plus Plan - Cigna PPO Plan

Selection of a Primary Care Provider - your plan allows 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. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.cigna.com/accenture 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.cigna.com/accenture 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	90th Percentile
Calendar Year Deductible	**Salary Under $100,000** Individual: $350 Family: $700 **Salary $100,000 to $250,000** Individual: $600 Family: $1,200 **Salary Over $250,000** Individual: $800 Family: $1,600	**All Salary Levels** Individual: $2,500 Family: $5,000

- 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 only counts toward your out-of-network deductible.
- 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	**Salary Under $100,000** Individual: $3,350 Family: $6,700 **Salary $100,000 to $250,000** Individual: $3,900 Family: $7,800 **Salary Over $250,000** Individual: $4,100 Family: $8,200	**All Salary Levels** Individual: $5,000 Family: $10,000

- Only the amount you pay for in-network covered expenses counts toward your in-network out-of-pocket maximum. Only the amount you pay for out-of-network covered expenses counts toward your out-of-network out-of-pocket maximum.
- All in-network deductibles contribute towards your in-network out-of-pocket maximum. All out-of-network deductibles contribute towards your out-of-network 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 in-network out-of-pocket maximum.

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	Your plan pays 80% ^	Your plan pays 60% ^
Surgery Performed in Physician's Office	Your plan pays 80% ^	Your plan pays 60% ^
Allergy Treatment/Injections	Your plan pays 80% ^	Your plan pays 60% ^
Allergy Serum Dispensed by the physician in the office	Your plan pays 80% ^	Your plan pays 60% ^
Preventive Care		
Preventive Care	Your plan pays 100%	Not Covered
• Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.		
Immunizations Includes travel immunizations	Your plan pays 100%	Not Covered
Flu Shots	Your plan pays 100%	Your plan pays 100%

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^)		
Mammogram, PAP, PSA Tests and Colonoscopies • Coverage includes the associated Preventive Outpatient Professional Services. • Associated wellness exam is covered in-network only. • Diagnostic-related services are covered at the same level of benefits as other x-ray and lab services, based on place of service.	Your plan pays 100%	Not covered
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 • When referred by an in-network provider, out-of-network services performed by Radiologists, Pathologists, and Anesthesiologists are covered at the in-network level.	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 • When referred by an in-network provider, out-of-network services performed by Radiologists, Pathologists, and Anesthesiologists are covered at the in-network level.	Your plan pays 80% ^	Your plan pays 60% ^
Short-Term Rehabilitation	Your plan pays 80% ^	Your plan pays 60% ^
Per Calendar Year Maximums: • Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy and Occupational Therapy - Unlimited days • Speech, developmental delay, physical, and/or occupational therapy for autism spectrum disorder is covered. • ABA Therapy - Unlimited days • Vision Therapy - Unlimited days • Cardiac Rehabilitation - 36 days • Chiropractic Care - 20 days Non-manipulative services do not contribute to the maximum. (ex. Labs, x-ray, etc.) Note: Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum. Autism Spectrum Disorder is treated by Short Term Rehab therapies, which are covered under the medical portion of the plan. It may also be treated by Applied Behavioral Analysis (ABA) Therapy, which is covered under the behavioral portion of the plan.		
Other Health Care Facilities/Services		

Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^)		
Home Health Care • 40 days maximum per Calendar Year • 16 hour maximum per day	Your plan pays 80% ^	Your plan pays 60% ^
Outpatient Private Duty Nursing • Unlimited maximum per Calendar Year	Your plan pays 80% ^	Your plan pays 60% ^
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility • 120 days 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 • Breast Pump rental for hospital grade breast pumps without medical necessity.	Your plan pays 100%	Not Covered
External Prosthetic Appliances (EPA) • Unlimited maximum per Calendar Year • Cranial banding is covered regardless of medical necessity.	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.		
Nutritional Evaluation • 3 days maximum per Calendar Year • Services for Diabetes education are unlimited and do not contribute to the day maximum.	Your plan pays 80% ^	Your plan pays 60% ^
Genetic Counseling • Unlimited maximum per Calendar Year	Your plan pays 80% ^	Your plan pays 60% ^
Hearing Aid • $2,500 maximum per unit, limited to one unit per ear every 3 Calendar Years	Your plan pays 80% ^	Your plan pays 60% ^
Wigs • $1,000 maximum per Lifetime • Coverage is only provided for loss of hair due to treatment of a malignancy or permanent hair loss due to accidental injury.	Your plan pays 80% ^	Your plan pays 60% ^

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 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	*Must meet the definition of an emergency Plan pays 80% ^		Plan pays 80% ^	Plan pays 60% ^
Advanced Radiology Imaging	Plan pays 80% ^	Plan pays 60% ^	Not Applicable	Not Applicable	*Must meet the definition of an emergency Emergency Room In and Out-of-Network Plan pays 80% ^ Urgent Care In-Network: Plan pays 80% ^ Out-of-Network: Plan pays 60% ^		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

- When referred by an in-network provider, out-of-network services are covered at the in-network level.

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	Plan pays 80% ^		Plan pays 80% ^		Plan pays 80% ^	
Urgent Care	In-Network: Plan pays 80% ^ Out-of-Network: Plan pays 60% ^		In-Network: Plan pays 80% ^ Out-of-Network: Plan pays 60% ^		Not Applicable	

- * Ambulance services used as non-emergency transportation, when provided by an out-of-network provider, are covered at 60% ^

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

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	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^
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)	Plan pays 80% ^	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% ^
Treatment of Gender Identity Disorder	Plan pays 80% ^	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% ^
• Covered according to WPATH Standards of Care. • Travel benefits for treatment of Gender Identity Disorder - Services are covered for travel and lodging when the customer resides at least 60 miles away from the treating facility, limited to $10,000 per Lifetime.										
Family Planning - Men'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 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 Services	Plan pays 80% ^	Plan pays 50% ^	Plan pays 80% ^	Plan pays 50% ^	Plan pays 80% ^	Plan pays 50% ^	Plan pays 80% ^	Plan pays 50% ^	Plan pays 80% ^	Plan pays 50% ^

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
Benefits will be provided the same as your benefits for any other condition for Covered Services rendered in connection with the diagnosis and/or treatment of infertility. Benefits for Artificial Reproductive Technologies (ART) and all related services and supplies are subject to a lifetime maximum of $20,000 for medical and prescription drugs combined across all Accenture medical plans. If you have Family Coverage, this is a family maximum. Services that apply to the lifetime maximum include, but not limited to in vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer, intracytoplamic sperm injection, and Cryopreservation and related services for egg, sperm and embryo. Please contact member services to authorize ART benefits or a $500 penalty will be applied to the claim.										
TMJ, Surgical and Non-Surgical	Plan pays 80% ^	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.										
Non Surgical: Unlimited maximum per lifetime										
Bariatric Surgery	Plan pays 80% ^	Not Covered	Plan pays 80% ^	Not Covered	Plan pays 80% ^	Not Covered	Plan pays 80% ^	Not Covered	Plan pays 80% ^	Not Covered
Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered. The following are excluded: • medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity. • weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision										
Note: 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: 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	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	Plan pays 60% ^
Substance Use Disorder	Plan pays 80% ^	Plan pays 60% ^	Plan pays 80% ^	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.

Pharmacy

Pharmacy benefits not provided by Cigna

Additional Information

Coverage While Traveling Abroad

Eligible expenses for services incurred while outside the United States covered at 60% ^. Emergency services incurred while outside the United States covered at 80% ^.

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.

Telephone or Video Consultations - Services Provided by Teladoc	$40 copay
Healthy Pregnancies/Healthy Babies • Care Management outreach • Maternity Case Management • Neo-natal Case Management	

Additional Information

Integrated Personal Health Team - A

- Your Health First Health and Wellness Coaching
- Cigna Well Informed Program
- Preference Sensitive Care
- Behavioral Health Case Management
- 24 hour Health Information Line Outreach
- Pre Admission Outreach
- Post Discharge Outreach
- Inpatient Advocacy
- Case Management - Short term and complex
- Healthy Steps to Weight Loss Lifestyle Management Program
- Quit Today Lifestyle Management Program
- Strength and Resilience Lifestyle Management Program
- Employee Assistance Program

Care Facility - Plano

Team Number - 471

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 (90th) 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.

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.

- $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.

- $500 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.

Definitions

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

Exclusions

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

- Care for health conditions that are required by state or local law to be treated in a public facility.
- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- Charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) you are required to pay for a Covered Service (as shown on the Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Service, or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a Non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.
- Charges arising out of or related to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- For or in connection with experimental, investigational or unproven services.
- Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
    - Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
    - Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
    - The subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section of this plan; or
    - The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the

Exclusions

"Clinical Trials" section(s) of this plan.

- Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance.
- The following services are excluded from coverage regardless of clinical indications: Abdominoplasty; Panniculectomy; 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.
- 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.
- Medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- Any 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, autism (except as may otherwise be covered under the plan) 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 except as provided under the Home Health Services provision.
- Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, and dentures.
- 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 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.
- 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

Exclusions

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 to protect against occupational hazards and risks.
- Cosmetics, dietary supplements and health and beauty aids.
- All nutritional supplements and formulae except when the attending physician diagnoses a failure to thrive.
- 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.
- 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.
- Massage therapy.

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

EHB State: UT