

SUMMARY OF BENEFITS



**Cigna Health and Life Insurance Co.
For - Montgomery College
Network POS Open Access 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 90%	Your plan pays 70%
Maximum Reimbursable Charge	Not Applicable	80th Percentile
Calendar Year Deductible	Individual: \$300	Individual: \$600
<ul style="list-style-type: none"> The amount you pay for all 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. <p>Note: Services where plan deductible applies are noted with a caret (^)</p>		
Calendar Year Out-of-Pocket Maximum	Individual: \$3,000 Family: \$7,800	Individual: \$6,000 Family: \$15,600
<ul style="list-style-type: none"> The amount you pay for all covered expenses counts toward both your in-network and out-of-network out-of-pocket maximums. 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. In-Network covered expenses that count towards your out-of-pocket maximum include the plan deductible, member paid coinsurance and copays. Out-of-Network covered expenses that count towards your out-of-pocket maximum include the plan deductible, member paid coinsurance and benefit deductibles. Non-compliance penalties or charges in excess of Maximum Reimbursable Charge do not contribute towards the out-of-pocket maximum. 		

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Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^)		
Physician Services		
Physician Office Visit <ul style="list-style-type: none"> All services including Lab & X-ray Plan pays 100% after you pay copay 	\$20 Primary Care Physician (PCP) copay or \$40 Specialist copay	Your plan pays 70% ^
Cigna Telehealth Connection Services <ul style="list-style-type: none"> 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) 	\$20 Primary Care Physician (PCP) copay	Not Covered
Surgery Performed in Physician's Office	\$20 PCP or \$40 Specialist copay	Your plan pays 70% ^
Allergy Treatment/Injections	\$20 PCP or \$40 Specialist copay or actual charge (if less)	Your plan pays 70% ^
Allergy Serum Dispensed by the physician in the office	Your plan pays 100%	Your plan pays 70% ^
Preventive Care		
Preventive Care <ul style="list-style-type: none"> Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit. 	Your plan pays 100%	Your plan pays 70% ^
Immunizations	Your plan pays 100%	Your plan pays 70% ^
Mammogram, PAP, and PSA Tests <ul style="list-style-type: none"> 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. 	Your plan pays 100%	Your plan pays 70% ^
Inpatient		
Inpatient Hospital Facility	Your plan pays 90% ^	Your plan pays 70% ^
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 90% ^	Your plan pays 70% ^
Inpatient Professional Services <ul style="list-style-type: none"> For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists 	Your plan pays 90% ^	Your plan pays 70% ^
Outpatient		
Outpatient Facility Services	Your plan pays 90% ^	Your plan pays 70% ^
Outpatient Professional Services <ul style="list-style-type: none"> For services performed by Surgeons, Radiologists, Pathologists and Anesthesiologists 	Your plan pays 90% ^	Your plan pays 70% ^

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Benefit	In-Network	Out-of-Network
Note: Services where plan deductible applies are noted with a caret (^)		
Short-Term Rehabilitation Calendar Year Maximums: <ul style="list-style-type: none"> Pulmonary Rehabilitation, Cognitive Therapy, Physical Therapy, Speech Therapy, Occupational Therapy, Cardiac Rehabilitation and Chiropractic Care – 60 days in-network and 60 days out-of-network Note: <ul style="list-style-type: none"> Therapy days, provided as part of an approved Home Health Care plan, accumulate to the applicable outpatient short term rehab therapy maximum. In-Network days count towards both In-Network and Out-of-Network Maximums 	\$40 Specialist copay	Your plan pays 70% ^
Other Health Care Facilities/Services		
Home Health Care (includes outpatient private duty nursing subject to medical necessity) <ul style="list-style-type: none"> Unlimited days maximum in-network per Calendar Year and 40 days maximum out-of-network per Calendar Year. Maximums cross-accumulate. 16 hour maximum per day 	Your plan pays 100%	Your plan pays 70% ^
Skilled Nursing Facility, Rehabilitation Hospital, Sub-Acute Facility <ul style="list-style-type: none"> 60 days maximum per Calendar Year 	Your plan pays 90% ^	Your plan pays 70% ^
Durable Medical Equipment	Your plan pays 100% Unlimited maximum per Calendar Year	Your plan pays 70% ^ Unlimited maximum per Calendar Year
Breast Feeding Equipment and Supplies <ul style="list-style-type: none"> 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 70% ^
External Prosthetic Appliances (EPA)	\$200 EPA annual deductible Your plan pays 100% Unlimited maximum per Calendar Year	\$200 EPA annual deductible Your plan pays 70% ^ Unlimited maximum per Calendar Year
Routine Foot Disorders	Not Covered	Not Covered
Note: Services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.		
Acupuncture <ul style="list-style-type: none"> Unlimited days maximum per Calendar Year 	\$20 PCP or \$40 Specialist copay	Your plan pays 70% ^

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 70% ^	Plan pays 100%	Plan pays 70% ^	Plan pays 100%		Plan pays 90% ^	Plan pays 70% ^
Advanced Radiology Imaging	Plan pays 100%	Plan pays 70% ^	Not Applicable	Not Applicable	Plan pays 100%		Plan pays 90% ^	Plan pays 70% ^

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)		Plan pays 100%		Plan pays 90% ^	
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 90% ^	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^
Bereavement Counseling	Plan pays 90% ^	Not Covered	Plan pays 100%	Not Covered

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	\$20 PCP or \$40 Specialist copay	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	\$20 PCP or \$40 Specialist copay	Plan pays 70% ^	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
Note: Services where plan deductible applies are noted with a caret (^)										
Abortion (Elective and non-elective procedures)	\$20 PCP or \$40 Specialist copay	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	\$0 per facility visit copay, then plan pays 90% ^	\$0 per facility visit deductible, then plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^
Family Planning - Men's Services	\$20 PCP or \$40 Specialist copay	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^
Includes surgical services, such as vasectomy (excludes reversals)										
Family Planning - Women's Services	Plan pays 100%	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^
Includes surgical services, such as tubal ligation (excludes reversals) Contraceptive devices as ordered or prescribed by a physician.										
Infertility	\$20 PCP or \$40 Specialist copay	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^	Plan pays 90% ^	Plan pays 70% ^
Infertility covered services: lab and radiology test, counseling, surgical treatment, includes artificial insemination, in-vitro fertilization, GIFT, ZIFT, etc. Unlimited lifetime maximum										
TMJ, Surgical and Non-Surgical	\$20 PCP or \$40 Specialist copay	Not Covered	Plan pays 90% ^	Not Covered	\$0 per facility visit copay, then plan pays 90% ^	Not Covered	Plan pays 90% ^	Not Covered	Plan pays 90% ^	Not Covered
Services provided on a case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity.										
Bariatric Surgery	\$20 PCP or \$40 Specialist copay	Not Covered	Plan pays 90% ^	Not Covered	Plan pays 90% ^	Not Covered	Plan pays 90% ^	Not Covered	Plan pays 90% ^	Not Covered
Surgeon Charges Lifetime Maximum: Unlimited										

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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

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

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

Benefit	Inpatient Hospital Facility		Inpatient Professional Services	
	LifeSOURCE Facility In-Network	LifeSOURCE Facility Out-of-Network	LifeSOURCE Facility In-Network	LifeSOURCE Facility Out-of-Network
Organ Transplants	Plan pays 90% ^	Not Covered	Plan pays 90% ^	Not Covered

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 90% ^	Plan pays 70% ^	\$20 copay	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^
Substance Use Disorder	Plan pays 90% ^	Plan pays 70% ^	\$20 copay	Plan pays 70% ^	Plan pays 100%	Plan pays 70% ^

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.

Pharmacy

Pharmacy benefits not provided by Cigna

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KitTrak: CSM10929

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.

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.

Multiple Surgical Reduction

In-Network - does not apply.

Out-of-Network - 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.

Personal Health Team - A

Client specific team of clinical specialists who provide support for healthy, at-risk and acute care individuals to help them stay healthy

- 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

Care Facility

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-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.

1/1/2017

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Network Point of Service - Open Access Hospital & Physician Copay/Coinsurance - Montgomery College Network POS - 5315768. Version# 7

KitTrak: CSM10929

Additional Information

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

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.

1/1/2017

ASO

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KitTrak: CSM10929

Exclusions

- 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:
 - o Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
 - o Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
 - o 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
 - o The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" 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: Rhinoplasty; Blepharoplasty; Acupressure; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; 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.
- 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

1/1/2017

ASO

Network Point of Service - Open Access Hospital & Physician Copay/Coinsurance - Montgomery College Network POS - 5315768. Version# 7

KitTrak: CSM10929

Exclusions

safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or intellectual disabilities.

- 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.
- 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 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.
- 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.

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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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