Wesleyan University

OPEN ACCESS PLUS
MEDICAL BENEFITS

(Coinsurance Plan)

EFFECTIVE DATE: January 1, 2008

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This document, printed in December, 2007, takes the place of any documents previously issued to you which described your benefits.

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Table of Contents

Important Information 5

Special Plan Provisions 8

Case Management 8
Additional Programs 9

Important Information About Your Medical Plan 9

Accident and Health Provisions 9

Eligibility – Effective Date 10

Employee Insurance 10
Dependent Insurance 10

Open Access Plus Medical Benefits 11

Certification Requirements 21
Prior Authorization/Pre-Authorized 21
Covered Expenses 21

Vision Benefits 28

The Schedule 28
Insuring Provisions 29
Limitations 29

Limitations and Exclusions 30

Coordination of Benefits 31

Medicare Eligibles 33

Expenses For Which A Third Party May Be Responsible 34

Payment of Benefits 35

Termination of Insurance 35

Employees 35
Dependents 36

Federal Requirements 36

Notice of Provider Directory/Networks 36
Qualified Medical Child Support Order (QMCSO) 36
Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA) 37
Effect of Section 125 Tax Regulations on This Plan 38
Eligibility for Coverage for Adopted Children 38
Federal Tax Implications for Dependent Coverage 38
Coverage for Maternity Hospital Stay 38
Women's Health and Cancer Rights Act (WHCRA) 39
Group Plan Coverage Instead of Medicaid 39
Obtaining a Certificate of Creditable Coverage Under This Plan 39
Requirements of Family and Medical Leave Act of 1993 (FMLA) 39
Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA) 39

Claim Determination Procedures Under ERISA 40
When You Have a Complaint or an Appeal 41
Arbitration 43
COBRA Continuation Rights Under Federal Law 43
ERISA Required Information 46

Definitions 48

Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET (OR IN ANY RIDER ATTACHED HEREUNTO) ARE SELF-INSURED BY **WESLEYAN UNIVERSITY,** WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CONNECTICUT GENERAL PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CONNECTICUT GENERAL. HOWEVER, BECAUSE THE PLAN IS NOT INSURED BY CONNECTICUT GENERAL, ALL REFERENCES TO INSURANCE HEREIN SHALL BE UNDERSTOOD TO BE REFERENCES TO A SELF-INSURED PLAN.

FOR EXAMPLE, REFERENCES TO "CG," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN "EMPLOYER"; AND "POLICY," TO MEAN "PLAN"; AND "INSURED," TO MEAN "COVERED"; AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE" OR "BENEFITS".

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Explanation of Terms

You will find terms starting with capital letters throughout this booklet. To help you understand your benefits, most of these terms are defined within the text, or in the "Definitions" section.

Unless the context dictates otherwise, use of the male pronoun in this certificate will be deemed to include the female.

The Schedule

The Schedule is a brief outline of the maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

Special Plan Provisions

When you receive care from a Participating Provider, this Plan pays a greater share of the cost for the services and supplies than if you receive that same care from a non-Participating Provider. Participating Providers include Physicians, Hospitals, and Other Health Care Professionals and Other Health Care Facilities. Consult your Physician Guide for a list of Participating Providers in your area. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

Services Available in Conjunction With Your Medical Plan

The following pages describe helpful services available in conjunction with your medical plan. You can access these services by calling the toll-free telephone number shown on the back of your benefit identification card.

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CIGNA'S Toll-Free Care Line

CIGNA's toll-free care line allows you to talk to a health care professional during normal business hours, Monday through Friday, simply by calling the toll-free telephone number shown on your benefit identification card.

CIGNA's toll-free care line personnel can provide you with the names of Participating Providers. If you or your Dependents need medical care, you may consult your Physician Guide, which lists the Participating Providers in your area, or call CIGNA's toll-free telephone number for assistance. If you or your Dependents need medical care while away from home, you may have access to a national network of Participating Providers through CIGNA's Away-From-Home Care feature. Call CIGNA's toll-free care line for the names of Participating Providers in other network areas. Whether you obtain the name of a Participating Provider from your Physician Guide or through the care line, it is recommended that, prior to making an appointment, you call the provider to confirm that he or she is a current participant in the Program.

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Case Management

Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible, whether at home, as an outpatient, or as an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family, and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area, such as trauma, high-risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine, and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your Dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

- You, your Dependent, or the attending Physician can request Case Management services by calling the toll-free telephone number shown on your benefit identification card during normal business hours, Monday through Friday. In addition, your Employer, a claim office or a utilization review program (see the Certification Requirements section in this certificate) may refer an individual for Case Management.
- The Review Organization assesses each case to determine whether Case Management is appropriate.
- You or your Dependent is contacted by an assigned Case Manager, who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.

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- Following an initial assessment, the Case Manager works with you, your family, and the Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
- The Case Manager also acts as a liaison between the insurer, the patient, his or her family, and the Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-

effective treatment alternatives, as well as provide assistance in obtaining necessary medical resources and ongoing family support in a time of need.

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Additional Programs

From time to time, CG may offer, or arrange for various entities to offer, discounts, benefits, or other considerations to Employees for the purpose of promoting their general health and well-being. Contact CG for details of these programs.

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Important Information About Your Medical Plan

Details of your medical benefits are described on the following pages.

Opportunity to Select a Primary Care Physician (Optional)

Choice of Primary Care Physician:

When you elect Medical Insurance, you *may* choose to select a Primary Care Physician for yourself and your Dependents from a list provided by CG. ***You are not required to do so.*** However, if you *do* choose to select a Primary Care Physician, the Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

Primary Care Physician's Role/Direct Access to Participating Physicians:

The Primary Care Physician's role is to provide or arrange for medical care for you and any of your Dependents.

However, you and your Dependents are allowed direct access to Participating Physicians for covered services. Even if you select a Primary Care Physician, there is no requirement to obtain an authorization of care from your Primary Care Physician for visits to the Participating Physician of your choice, including Participating Specialist Physicians, for covered services.

Changing Primary Care Physicians:

You may request a transfer from one Primary Care Physician to another by contacting us at the member services telephone number on your benefit identification card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician, if you choose.

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How To File Your Claim

When you or your Dependents receive care from a Participating Provider, you are only responsible for the applicable Copayment shown in The Schedule. You do not need to file a claim form.

If you or your Dependents receive care from a non-Participating Provider, you must submit a claim form to be reimbursed.

You may get the required claim forms from your benefit plan administrator. All fully-completed claim forms and bills should be sent directly to your servicing CG claim office.

Depending on your group insurance plan benefits, file your claim forms as described below.

Hospital Confinement

If possible, get your group Medical Insurance claim form before you are admitted to the Hospital. This form will make your admission easier and any cash deposit usually required will be waived.

If you have a benefit identification card, present it at the admissions office at the time of your admission. The card tells the Hospital to send its bills directly to CG.

Doctor's Bills and Other Medical Expenses

The first medical claim should be filed as soon as you have incurred Covered Expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT NUMBER (BOTH OF WHICH CAN BE FOUND ON YOUR BENEFIT IDENTIFICATION CARD) WHEN YOU FILE CG'S CLAIM FORMS, OR WHEN YOU CALL YOUR CG CLAIM OFFICE.
- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and imprisonment.

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Accident and Health Provisions

Notice of Claim

Written notice of claim must be given to CG within 30 days after the occurrence or start of the loss on which claim is based. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

Claim Forms

When CG receives the notice of claim, it will give to the claimant (or to the Employer for the claimant) the claim forms which it uses for filing proof of loss. If the claimant does not get these claim forms within 15 days after CG receives notice of claim, he will be considered to have met the proof of loss requirements under the plan if he submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character, and extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be given to CG within 90 days after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated or reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

Physical Examination

CG, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

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Eligibility – Effective Date

Eligibility For Employee Insurance

You will become eligible for insurance on your date of hire, if:

- you are an eligible, regularly-scheduled Employee; and
- you are in a Class of Eligible Employees.

Eligibility for Dependent Insurance

You will become eligible for Dependent Insurance on the later of:

- the date you become eligible for yourself; or
- the date you acquire your first Dependent.

Classes of Eligible Employees

Each Employee, as reported by the Employer to CG

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Employee Insurance

This plan is offered to you as an Employee. To be insured, you will have to pay part of the cost.

Effective Date of Your Insurance

You will become insured on the date you elect the insurance by signing an approved enrollment form authorizing a payroll deduction, but no earlier than the date you become eligible. If you do not elect the insurance within 30 days after the date you become eligible, you may be required to wait until the next Open Enrollment Period to elect insurance for yourself. You will not be denied enrollment for Medical Insurance due to your health status.

You will become insured as described above, if: (a) you are in Active Service on that date; or (b) if you are not in Active Service on that date due to your health status.

Open Enrollment Period

The term Open Enrollment Period means a period of time in each calendar year, as determined by the Employer, during which you may change your benefit elections

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Dependent Insurance

For your Dependents to be insured, you will have to pay part of the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved enrollment form authorizing a payroll deduction, but no earlier than the date you become eligible for Dependent Insurance. All of your Dependents as defined will be included, and will not be denied enrollment for Medical Insurance due to health status.

If you do not elect the insurance within 30 days after the date you become eligible for it, you may be required to wait until the next Open Enrollment Period to insure your Dependents.

Your Dependents will be insured only if you are insured.

Exception for Newborns

Any Dependent child born while you are insured for Medical Insurance for yourself, but not for your Dependents, will become insured for Medical Insurance on the date of his birth if you elect Dependent Medical Insurance no later than 31 days after his birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

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OPEN ACCESS PLUS MEDICAL BENEFITS

The Schedule

For You and Your Dependents

Open Access Plus Medical Benefits provide coverage for care In-Network and Out-of-Network. To receive Open Access Plus Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Deductible and Coinsurance.

If you are unable to locate an Participating Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the toll-free telephone number on the back of your benefit identification card to obtain authorization to receive the service or supply Out-of-Network (i.e., from a non-Participating Provider). If you obtain authorization to receive such services or supplies Out-of-Network, benefits for those services or supplies will be paid at the In-Network benefit level.

Deductibles

Deductibles are expenses to be paid by you or your Dependent before benefits for most In-Network or Out-of-Network care are payable. Deductibles are in addition to any Coinsurance.

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses incurred that an insured person is required to pay under this plan after any applicable deductible amounts have been satisfied.

Out of Pocket Expenses

Out-of-Pocket Expenses are charges incurred In-Network or Out-of-Network for which no payment is provided because of the Coinsurance. However, charges incurred: (a) due to non-compliance penalties; or (b) in excess of Maximum Reimbursable Charge levels, will not accumulate toward the Out-of-Pocket Maximums shown below.

Once the Out-of-Pocket Maximums shown in The Schedule have been satisfied in a calendar year, benefits for Covered Expenses incurred due to In-Network or Out-of-Network charges made during the remainder of that calendar year are payable at 100%.

Accumulation of Amounts

Both In-Network and Out-of-Network expenses incurred will apply toward satisfaction of the In-Network Plan Deductible and Out-of-Pocket Maximums, respectively. However, *only* amounts incurred Out-of-Network will apply toward satisfaction of the Out-of-Network Plan Deductible and Out-of-Pocket Maximums.

All benefit and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network, unless otherwise noted.

Multiple Surgical Reduction

Multiple surgeries performed during one operating session will result in a benefit reduction of 50% for the less-costly surgical procedure(s). The most expensive procedure will be paid according to the terms of this plan as described herein.

Assistant Surgeon/Co-Surgeon Limitation

Benefits payable for charges made by an assistant surgeon or co-surgeon are limited to 20 percent of the surgeon's allowable charge. (For the purposes of this limitation, "allowable charge" means the amount payable to the surgeons prior to any reductions due to coinsurance or deductible amounts.)

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	
Maximum Reimbursable Charge Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or A percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database we have selected. **Note:** The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles, copayments and coinsurance.	Not Applicable	80th Percentile
Plan Deductible		
Per Individual	$1,000 per calendar year	$2,000 per calendar year
Family Maximum	$2,000 per calendar year	$4,000 per calendar year
Out-of-Pocket Maximum		
Per Individual	$3,000 per calendar year	$ 6,000 per calendar year
Family Maximum	$6,000 per calendar year	$12,000 per calendar year
Physician's Services		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Primary Care Physician's Office visit	90% after plan deductible	70% after plan deductible
Specialty Care Physician's Office Visits Consultant and Referral Physician's Services **Note:** OB/GYN provider is considered a PCP.	90% after plan deductible	70% after plan deductible
Surgery Performed in Physician's Office	90% after plan deductible	70% after plan deductible
Second Opinion Consultations (provided on a voluntary basis)	90% after plan deductible	70% after plan deductible
Allergy Treatment/Injections	90% after plan deductible	70% after plan deductible
Allergy Serum (dispensed by the Physician in the office)	90% after plan deductible	70% after plan deductible
Preventive Care Routine Preventive Care Calendar Year Maximum (for persons through age 2): Unlimited Calendar Year Maximum (for persons aged 3 or older): Unlimited **Note:** *X-ray and/or lab services related to routine preventive care that are performed and billed by an independent diagnostic facility or outpatient Hospital are covered at no charge.*		
Physician's Office Visit	90% after plan deductible	70% after plan deductible
Immunizations	No Charge	70% after plan deductible
Mammograms, PSA, Pap Test		
Preventive Care	No Charge*	70% after plan deductible
Diagnostic	90% after plan deductible (if billed by an independent diagnostic facility or outpatient Hospital)	70% after plan deductible
* *Associated wellness exam is paid at 90% after plan deductible.*		
Inpatient Hospital - Facility Services	90% after plan deductible	70% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Covered Expense Daily Limit For:		
Semi-Private Room and Board	Limited to the negotiated rate	Limited to the semi-private room rate
Private Room	Limited to the negotiated rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	90% after plan deductible	70% after plan deductible
Inpatient Hospital Physician's Visits/Consultations	90% after plan deductible	70% after plan deductible
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	90% after plan deductible	70% after plan deductible
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	90% after plan deductible	70% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Emergency and Urgent Care Services		
Physician's Office Visit	90% after plan deductible	90% after plan deductible*
Hospital Emergency Room**	90% after plan deductible	90% after plan deductible*
Outpatient Professional Services (radiology, pathology, ER Physician)	90% after plan deductible	90% after plan deductible*
Urgent Care Facility or Outpatient Facility**	90% after plan deductible	90% after plan deductible*
X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	90% after plan deductible	90% after plan deductible*
Independent X-ray and/or Lab Facility in conjunction with an ER visit	90% after plan deductible	90% after plan deductible*
Ambulance	90% after plan deductible	90% after plan deductible*
** If not a true emergency, Out-of-Network charges for these services are paid at **70%** after plan deductible.*		
Inpatient Services at Other Health Care Facilities	90% after plan deductible	70% after plan deductible
Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities		
(No prior hospitalization required)		
Covered Expense Daily Limit:	Limited to the negotiated rate	Limited to the semi-private room rate
Calendar Year Maximum: 60 days		
Laboratory and Radiology Services (includes pre-admission testing)		
Advanced Radiological Imaging (i.e. MRIs, CAT Scans, PET Scans)	90% after plan deductible	70% after plan deductible
Other Laboratory and Radiology Services:		
Physician's Office Visit	90% after plan deductible	70% after plan deductible
Outpatient Hospital Facility	90% after plan deductible	70% after plan deductible
Independent X-ray and/or Lab Facility	90% after plan deductible	70% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Short-Term Rehabilitative Therapy Includes: Cardiac Rehabilitation Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehabilitation Cognitive Therapy Calendar Year Maximum: 60 days for all therapies combined	90% after plan deductible	70% after plan deductible
Home Health Care Calendar Year Maximum: 60 days *(includes outpatient private nursing when approved as Medically Necessary)*	90% after plan deductible	70% after plan deductible
Hospice		
Inpatient Services	90% after plan deductible	70% after plan deductible
<u>Covered Expense Daily Limit:</u>	Limited to the negotiated rate	Limited to the semi-private room rate
Outpatient Services	90% after plan deductible	70% after plan deductible
Bereavement Counseling Services provided as part of Hospice Care Program		
Inpatient	90% after plan deductible	70% after plan deductible
Outpatient	90% after plan deductible	70% after plan deductible
Services provided by Mental Health Professional	*Covered under Mental Health benefit*	*Covered under Mental Health benefit*

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Maternity Care Services Initial Visit to Confirm Pregnancy **Note:** OB/GYN provider will be considered a PCP.	90% after plan deductible	70% after plan deductible
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	90% after plan deductible	70% after plan deductible
Physician's Office Visits (in addition to the global maternity fee when performed by an OB/GYN or Specialist)	90% after plan deductible	70% after plan deductible
Delivery - Facility (Inpatient Hospital, Birthing Center)	90% after plan deductible	70% after plan deductible
Abortion (Includes elective and non-elective procedures)		
Physician's Office Visit	90% after plan deductible	70% after plan deductible
Inpatient Facility	90% after plan deductible	70% after plan deductible
Outpatient Facility	90% after plan deductible	70% after plan deductible
Physician's Services	90% after plan deductible	70% after plan deductible
Family Planning Services		
Office Visits, Lab and Radiology Tests and Counseling	90% after plan deductible	70% after plan deductible
Note: *Coverage will include contraceptive devices (e.g. Depo-Provera, Norplant and Intrauterine Devices (IUDs). Diaphragms also covered when services provided in Physician's office.*		
Surgical Sterilization Procedures for Vasectomy/Tubal Ligation (excludes reversals)		
Inpatient Facility	90% after plan deductible	70% after plan deductible
Outpatient Facility	90% after plan deductible	70% after plan deductible
Physician's Services	90% after plan deductible	70% after plan deductible
Physician's Office	90% after plan deductible	70% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Infertility Treatment Coverage will be provided for the following services: • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial Insemination, In-vitro Fertilization (IVF), GIFT, ZIFT.		
Physician's Office Visit (Lab and Radiology Tests, Counseling)	90% after plan deductible	70% after plan deductible
Inpatient Facility	90% after plan deductible	70% after plan deductible
Outpatient Facility	90% after plan deductible	70% after plan deductible
Physician's Services	90% after plan deductible	70% after plan deductible
Lifetime Maximum: $15,000 per person *Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility).*		
Organ Transplants Includes all medically appropriate, non-experimental transplants		
Office Visit	90% after plan deductible	*Not Covered*
Inpatient Facility	90% after plan deductible	*Not Covered*
Physician's Services	90% after plan deductible	*Not Covered*
Transplant Travel Services *(Covered only when transplant procedure is performed at a Lifesource facility)*	No Charge	*Not Covered*
Transplant Travel Benefit Maximum: $10,000 per transplant		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Durable Medical Equipment Calendar Year Maximum: $3,500	90% after plan deductible	70% after plan deductible
External Prosthetic Appliances Calendar Year Maximum: $1,500	90% after plan deductible	70% after plan deductible
Nutritional Evaluation		
Physician's Office	90% after plan deductible	70% after plan deductible
Calendar Year Maximum: 3 visits per person		
Dental Care (Limited to charges made for a continuous course of dental treatment started within six months of an Injury to sound, natural teeth)		
Physician's Office Visit	90% after plan deductible	70% after plan deductible
Inpatient Facility	90% after plan deductible	70% after plan deductible
Outpatient Facility	90% after plan deductible	70% after plan deductible
Physician's Services	90% after plan deductible	70% after plan deductible
Temporomandibular Joint Dysfunction (TMJ) (Surgical and Non-Surgical Treatment)		
Physician's Office Visit	90% after plan deductible	70% after plan deductible
Inpatient Facility	90% after plan deductible	70% after plan deductible
Outpatient Facility	90% after plan deductible	70% after plan deductible
Physician's Services	90% after plan deductible	70% after plan deductible
Hearing Aids *(for children through age 12)* Benefit Maximum: $1,000 every 24 months	90% after plan deductible	70% after plan deductible
Naturopathic Services Calendar Year Maximum: $500	90% (deductible waived)	90% (deductible waived)

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Mental Health		
Inpatient	90% after plan deductible	70% after plan deductible
Calendar Year Maximum: Unlimited		
Outpatient (Individual or Group Therapy)	90% after plan deductible	70% after plan deductible
Calendar Year Maximum: Unlimited		
Substance Abuse		
Inpatient	90% after plan deductible	70% after plan deductible
Calendar Year Maximum: Unlimited		
Outpatient (Individual or Group Therapy)	90% after plan deductible	70% after plan deductible
Calendar Year Maximum: Unlimited		
All Other Covered Expenses	90% after plan deductible	70% after plan deductible

Open Access Plus Medical Benefits

Certification Requirements

*(The inpatient certification requirements described in the following section apply to care received **Out-of-Network** only.)*

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your Dependent require treatment in a Hospital:

- as a registered bed patient;
- for Partial Hospitalization for the treatment of Mental Health or Substance Abuse;
- for the treatment of Mental Health or Substance Abuse in an intensive outpatient therapy program;
- for Mental Health or Substance Abuse Residential Treatment Services.

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested prior to the end of the certified length of stay for continued Hospital Confinement.

Benefits for Covered Expenses incurred for Hospital charges made for each separate admission to the Hospital will be reduced by 50%, unless PAC is received: (a) prior to the date of admission; or (b) in the case of an emergency admission, within 48 hours after the date of admission.

No benefits are payable for Covered Expenses incurred due to the charges listed below:

- Hospital charges for Bed and Board which are made for any day in excess of the number of days certified through PAC or CSR; and
- any Hospital charges for treatment listed above which was not certified as Medically Necessary.

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PAC and CSR are performed through a utilization review program by a Review Organization with which CG has contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

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Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy.

Services that require Prior Authorization:

- inpatient Hospital services;
- inpatient services at any participating Other Health Care Facility;
- residential treatment;
- intensive outpatient programs;
- advanced radiological imaging;
- non-emergency ambulance; or
- transplant services.

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Covered Expenses

The term Covered Expenses means expenses incurred by or on behalf of a person for the charges listed below if they are incurred after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are: (a) recommended by a Physician; and (b) Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by CG. **Any applicable Deductibles and Benefit Maximums are shown in The Schedule.**

Covered Expenses will include:

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; however, for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Hospital Bed and Board Daily Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf, for medical care and treatment.
- charges made by an Other Health Care Facility (including a Skilled Nursing Facility, a Rehabilitation Hospital, or a subacute facility), on its own behalf, for medical care and treatment; however, for any day of confinement in an Other Health Care Facility, Covered Expenses will not include that portion of charges in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.

- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.

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- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.

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- charges made every one to two years for a mammogram for women aged 35 to 69; or at any age for women at risk, when recommended by a Physician.
- charges made for an annual Papanicolaou ("Pap") laboratory screening test.
- charges made for an annual prostate-specific antigen (PSA) test.
- charges for appropriate counseling and medical services connected with surgical sterilization therapies, including vasectomy and tubal ligation.
- charges made for laboratory services, radiation therapy, and other diagnostic and therapeutic radiological procedures.
- charges made for Family Planning, including: medical history; physical exam; related laboratory tests; medical supervision in accordance with generally-accepted medical practices; other medical services, information, and counseling on contraception; and implanted/injected contraceptives.
- charges made for Routine Preventive Care for a Dependent child during the first two years of that child's life, including immunizations and all age-appropriate testing.
- charges made for Routine Preventive Care for persons aged 3 or older. Routine Preventive Care means health care assessments, wellness visits, immunizations, and related services.
- charges made for the services of a naturopath, subject to the maximum shown in The Schedule.

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- charges made for medical diagnostic services to determine the cause of erectile dysfunction. Penile implants are covered for an established medical condition that clearly is the cause of erectile dysfunction, such as postoperative prostatectomy and diabetes. Penile implants are not covered as treatment of psychogenic erectile dysfunction.
- surgical or non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ).
- hearing aids for Dependent children through age 12, 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.

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Clinical Trials

- charges made for routine patient services associated with cancer clinical trials approved and sponsored by the federal government. In addition the following criteria must be met:
  - the cancer clinical trial is listed on the NIH web site [www.clinicaltrials.gov] as being sponsored by the federal government;
  - the trial investigates a treatment for terminal cancer, and: (1) the person has failed standard therapies for the disease; (2) the person cannot tolerate standard therapies for the disease; or (3) no effective, non-experimental treatment for the disease exists;
  - the person meets all inclusion criteria for the clinical trial and is not treated "off-protocol";
  - the trial is approved by the Institutional Review Board of the institution administering the treatment; and
  - coverage will not be extended to clinical trials conducted at non-participating facilities if a person is eligible to participate in a covered clinical trial from a Participating Provider.

Routine patient services do not include, and reimbursement will not be provided for:

- the investigational service or supply itself;
- services or supplies listed herein as Exclusions;
- services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs);
- services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., a device, drug, item, or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

Genetic Testing

- charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:
  - a person has symptoms or signs of a genetically-linked inheritable disease;
  - it has been determined that a person is at risk for carrier status as supported by existing, peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or

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  - the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to

directly impact treatment options.

Pre-implantation genetic testing and genetic diagnosis prior to embryo transfer is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per calendar year for both pre- and post-genetic testing.

Nutritional Evaluation

- charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

Internal Prosthetic/Medical Appliances

- charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts. Medically Necessary repair, maintenance, or replacement of a covered appliance is also covered.

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Home Health Care Services

- charges made for Home Health Care Services when you:
  - require skilled care;
  - are unable to obtain the required care as an ambulatory outpatient; and
  - do not require confinement in a Hospital or Other Health Care Facility.

  Home Health Care Services are provided under the terms of a Home Health Care plan for the person named in that plan.

  If you are a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), Home Health Care Services will only be provided for you during times when there is a family member or care giver present in the home to meet your non-skilled care needs.

  Home Health Care Services are those skilled health care services that can be provided during intermittent visits of two hours or less by Other Health Care Professionals. Necessary consumable medical supplies, home infusion therapy, and Durable Medical Equipment administered or used by Other Health Care Professionals in providing Home Health Care Services are covered. Home Health Care Services do not include the services of a person who is a member of your family or your Dependent's family, or who normally resides in your home or your Dependent's home. Physical, occupational, and speech therapy provided in the home are subject to the benefit limitations described under "Short-Term Rehabilitative Therapy."

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Hospice Care Services

- charges made for a person who has been diagnosed as having six months or less to live due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
  - by a Hospice Facility, on its own behalf, for Bed and Board and Services and Supplies; however, for any day of such confinement, Covered Expenses will not include that portion of charges which is more than the Hospice Bed and Board Daily Limit shown in The Schedule;
  - by a Hospice Facility, for services provided on an outpatient basis;
  - by a Physician, for professional services;
  - by a Psychologist, social worker, family counselor, or ordained minister for individual and family counseling;
  - for pain relief treatment, including drugs, medicines,and medical supplies;
  - by an Other Health Care Facility for:
    - part-time or intermittent nursing care by or under the supervision of a Nurse;
    - part-time or intermittent services of an Other Health Care Professional;

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    - physical, occupational, and speech therapy;
    - medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the plan if the person had remained or been Confined in a Hospital or Hospice Facility.

  Charges for the following services and supplies are not covered as Hospice Care Services:

  - for the services of a person who is a member of your family or your Dependent's family, or who normally resides in your home or your Dependent's home;
  - for any period when you or your Dependent is not under the care of a Physician;
  - for services or supplies not listed in the Hospice Care Program;
  - for any curative or life-prolonging procedures;
  - to the extent that any other benefits are payable for those expenses under the plan;
  - for services or supplies that are primarily to aid you or your Dependent in daily living.

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Mental Health and Substance Abuse Services

Mental Health Services are services required to treat disorders that impair behavior, emotional reaction, or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Abuse.

Inpatient Mental Health Services

Services provided by a Hospital, while you or your Dependent are confined therein, for the treatment and evaluation of Mental Health. Inpatient Mental Health Services also include Partial Hospitalization, Residential Treatment Services, and Intensive Outpatient Therapy programs.

Partial Hospitalization sessions are periods of inpatient confinement of not less than 4 hours and not more than 12 hours in any 24-hour period.

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

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A **Mental Health Residential Treatment Center** is an institution which: (a) specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; (b) provides a subacute, structured, psychotherapeutic treatment program under the supervision of Physicians; (c) provides 24-hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate, legally-authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

Outpatient Mental Health Services

Services of providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis in an individual or group setting. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

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Inpatient Substance Abuse Rehabilitation Services

Services provided for rehabilitation while you or your Dependent is Confined in a Hospital, when required, for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Abuse Services include Partial Hospitalization sessions, Residential Treatment Services, and Intensive Outpatient Therapy programs.

Partial Hospitalization sessions are periods of inpatient confinement of not less than 4 hours and not more than 12 hours in any 24-hour period.

Substance Abuse Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Abuse conditions.

A **Substance Abuse Residential Treatment Center** is an institution which: (a) specializes in the treatment of psychological and social disturbances that are the result of Substance Abuse; (b) provides a subacute, structured, psychotherapeutic treatment program under the supervision of Physicians; (c) provides 24-hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate, legally-authorized agency as a residential treatment center.

A person is considered confined in a Substance Abuse Residential Treatment Center when she/he is a registered bed patient in a Substance Abuse Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Abuse Rehabilitation Services

Services provided on an outpatient basis for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, including outpatient rehabilitation in an individual or group setting.

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Substance Abuse Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. CG will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Exclusions

The following are specifically excluded from coverage as Mental Health and Substance Abuse Services:

- Any court-ordered treatment or therapy; or any treatment or therapy ordered as a condition of parole, probation, or

custody or visitation evaluations, unless Medically Necessary and otherwise covered under this plan.

- Treatment of conditions which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- Developmental disorders, including, but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders, or developmental articulation disorders.
- Counseling for activities of an educational nature.
- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness-raising.
- Vocational or religious counseling.
- I.Q. testing.
- Custodial care, including, but not limited to, geriatric day care.
- Psychological testing on children requested by or for a school system.
- Occupational/recreational therapy programs, even if combined with supportive therapy for age-related cognitive decline.

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Durable Medical Equipment

- charges made for the purchase or rental of Durable Medical Equipment which is ordered or prescribed by a Physician. Repair, replacement, or duplicate equipment is not covered, except when replacement or revision is necessary due to growth or a change in medical condition.

  Durable Medical Equipment is defined as items which: (a) are designed for, and able to withstand repeated use by, more than one person; (b) customarily serve a medical purpose; (c) generally are not useful in the absence of Injury or Sickness; (d) are appropriate for use in the home; and (e) are not disposable. Such equipment includes, but is not limited to, crutches, Hospital beds, wheel chairs, respirators, and dialysis machines.

  Unless covered in connection with the services described in another section of this booklet, the following are specifically excluded as Durable Medical Equipment:

  - Hygienic or self-help items or equipment;
  - Items or equipment that are primarily used for comfort or convenience, such as bathtub chairs, safety grab bars, stair gliders or elevators, over-the-bed tables, saunas, or exercise equipment;
  - Environmental control equipment, such as air purifiers, humidifiers, and electrostatic machines;
  - Institutional equipment, such as air-fluidized beds and diathermy machines;
  - elastic stockings and wigs;
  - Equipment used for the purpose of participation in sports or other recreational activities, including, but not limited to, orthotics, braces, and splints;
  - Items, such as auto-tilt chairs, paraffin bath units, and whirlpool baths, which are not generally accepted by the medical profession as being therapeutically effective;
  - Items which, under normal use, would constitute a fixture to real property, such as ramps, railings, and grab bars.

  Coverage is subject to the maximum shown in The Schedule.

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- charges made for the initial purchase and fitting of external prosthetic devices used as replacements or substitutes for missing body parts and necessary to alleviate or correct Sickness, Injury, or congenital defect; including only artificial arms and legs, and terminal devices such as hands or hooks. Replacement of such prostheses is covered only if needed due to normal anatomical growth.

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Infertility Services

- charges made for services related to the diagnosis and treatment of infertility. Services include, but are not limited to: Infertility drugs administered or provided by a Physician; approved surgeries and other therapeutic procedures that have been demonstrated, in existing, peer-reviewed, evidence-based, scientific literature, to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; artificial insemination (AI); diagnostic evaluations; gamete intrafallopian transfer (GIFT); in vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT); and the services of an embryologist.

Infertility is defined as the inability of opposite sex partners to achieve conception after one year of unprotected intercourse; or the inability of a woman to achieve conception after six trials of artificial insemination over a one-year period. This benefit includes diagnosis and treatment of both male and female infertility.

However, the following are specifically excluded from coverage as Infertility Services:

- reversal of male and female voluntary sterilization;
- any infertility services, when the infertility is caused by, or related to, voluntary sterilization;
- donor charges and services;
- cryopreservation of donor sperm and eggs; and
- any experimental, investigational, or unproven infertility procedures or therapies.

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Short-Term Rehabilitative Therapy and Chiropractic Care

- charges made for Short-Term Rehabilitative Therapy which is a part of a rehabilitation program, including physical, speech, occupational, cardiac, and pulmonary rehabilitation therapy, when provided in the most medically appropriate inpatient or outpatient setting. Also included are services that are provided by a chiropractic Physician when provided in an outpatient setting. Services of a chiropractic Physician include the management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment that is rendered to restore motion, reduce pain, and improve function.

The following limitations apply to Short-Term Rehabilitative Therapy and Chiropractic Care:

- Occupational therapy is provided only for the purpose of training members to perform the activities of daily living.
- Speech therapy is not covered when: (a) used to improve speech skills that have not fully developed; (b) considered custodial or educational; (c) intended to maintain speech communication; or (d) not restorative in nature.

Multiple services provided on the same day constitute one visit; however, a separate Copayment will apply to the services provided by each Physician.

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Transplant Services

- charges made for human organ and tissue transplant services, which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States. This coverage is subject to the following conditions and limitations.

  Transplant Services include the recipient’s medical, surgical, and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant Services are covered only if they are required to perform any of the following human-to-human organ or tissue transplants: allogeneic bone marrow/stem cell; autologous bone marrow/stem cell; corneal; heart/lung; kidney; kidney/pancreas; liver; lung; pancreas or intestine (which includes small bowel); liver; or multiple viscera.

  Transplant Services received from non-Participating Providers are not covered.

  All Transplant Services, other than corneal, must be received at a CIGNA LIFESOURCE Transplant Network® facility. Benefits are payable for corneal transplants when received from Participating Provider facilities other than CIGNA LIFESOURCE Transplant Network® facilities.

  Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal; organ transportation; and the transportation, hospitalization, and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of, a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant Travel Services

Charges made for reasonable travel expenses incurred in connection with a pre-approved organ/tissue transplant are covered, subject to the following conditions and limitations. Transplant travel benefits are not available for corneal transplants. Benefits for transportation, lodging, and food are available only if the insured is the recipient of a pre-approved organ/tissue transplant from a designated CIGNA LIFESOURCE Transplant Network® facility. The term "recipient" is defined to include a person receiving authorized transplant-related services during any of the following: (a) evaluation; (b) candidacy; (c) transplant event; or (d) post-transplant care. Travel expenses for the person receiving the transplant will include charges for: Transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); lodging while at, or traveling to and from, the transplant site; and food consumed while at, or traveling to and from, the transplant site.

In addition to the recipient's coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany the recipient. The term "companion" includes a spouse; a family member; a legal guardian; or any person not related to the recipient, but actively involved as caregiver. The following are specifically excluded from coverage as Transplant travel expenses:

> Travel costs incurred due to travel within 60 miles of your home; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits are only available when the covered person is the recipient of an organ transplant. No benefits are available when the covered person is a donor.

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Breast Reconstruction and Breast Prostheses

- charges made for reconstructive surgery following a mastectomy. Benefits are payable for:
  - surgical services for reconstruction of the breast on which surgery was performed;
  - surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance;

- postoperative breast prostheses; and
- mastectomy bras and external prosthetics, limited to the most cost-effective alternative available that meets external prosthetic placement needs.

During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Cosmetic Surgery

Charges made for cosmetic surgery or therapy to repair or correct severe facial disfigurements or severe physical deformities that are congenital, or that result from developmental abnormalities (other than abnormalities of the jaw or TMJ disorder), tumors, trauma, disease, or the complications of Medically Necessary non-cosmetic surgery.

Reconstructive surgery for correction of congenital birth defects or developmental abnormalities must be performed prior to a person's attainment of age 19. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement, as determined by CG.

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Vision Benefits

The Schedule

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Vision Benefits **For You and Your Dependents**	**You or Your Dependent Will Pay:**	**You or Your Dependent Will Pay:**
Eye Examinations: Benefit Maximum: One complete eye examination per calendar year	No Charge	No Charge
Eyeglass Lenses and Frames: Benefit Maximum: $75 maximum allowance per calendar year	No Charge	No Charge
Contact Lenses: Benefit Maximum: $75 maximum allowance per calendar year	No Charge	No Charge

Vision Benefits

Insuring Provisions

If you or any of your Dependents, while insured for Vision Benefits, incur expenses for:

- an eye examination by an Optometrist or an Ophthalmologist;
- lenses to correct vision; or
- eyeglass frames;

CG will pay you for such expenses, up to the Maximum Allowance shown in The Schedule.

No payment will be made for more than one examination during a 12-month period.

Limitations

No payment will be made for expenses incurred for:

- medical or surgical treatment of the eye.
- lenses which are not Medically Necessary and are not prescribed by an Optometrist or Ophthalmologist; or frames for such lenses.
- sunglasses, whether or not prescribed.
- replacement of lenses, unless an examination shows that, using the existing prescription, a visual defect equal to at least one-half of one diopter in strength exists; or a change of at least 10% in axis for astigmatism is required.
- services and supplies not listed in The Schedule;
- tinted lenses prescribed by the examiner when over Rose Tints No. 1 or No. 2; or
- charges for the excess cost of lenses over 65 millimeters in diameter.

Other limitations are shown in the **Limitations and Exclusions** section.

In addition, these benefits will be reduced so that the total payment made under :

- this plan; and
- any medical expense plan or prepaid treatment program sponsored or made available by your Employer;

will not be more than 100% of the charge made for the vision service.

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Limitations and Exclusions

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

- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- 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.
- charges made by a Hospital owned or operated by, or which provides care or performs services for, the United States Government, if such charges are directly related to a military service-connected Injury or Sickness.
- for or in connection with an Injury or Sickness which is due to war, declared or undeclared.
- charges which you are not obligated to pay; or for which you are not billed; or for which you would not have been billed, except that they were covered under this plan.
- assistance in the activities of daily living, including, but not limited to: eating; bathing; dressing or other Custodial Services or self-care activities; homemaker services; and services primarily for rest, domiciliary, or convalescent care.
- for or in connection with experimental, investigational, or unproven services.

  Experimental, investigational, and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse 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 as provided in the "Clinical Trials" section of this plan.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem; or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- regardless of clinical indication, for rhinoplasty; blepharoplasty; orthognathic surgeries; acupressure; dance therapy; movement therapy; applied kinesiology; rolfing; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- for or in connection with treatment of the teeth or periodontium, unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an Injury to sound, natural teeth; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; (c) charges made by a Free-Standing Surgical Facility or the outpatient department of a Hospital for or in connection with surgery.
- 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 under 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 otherwise covered under this plan.
- transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- medical and Hospital care and costs for the infant child of a Dependent, unless that child is otherwise eligible under this plan.
- non-medical counseling or ancillary services, including, but not limited to: Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety; and services, training, educational therapy, or other non-medical ancillary services for learning disabilities, developmental delays, autism, or mental retardation.
- 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, unless Medically Necessary.
- private duty nursing, except as provided under the "Home Health Services" provisions in **Covered Expenses**.
- 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.
- 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.
- charges made for or in connection with eye exercises; and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.
- treatment by acupuncture.
- all prescription and non-prescription drugs under this plan. *(Benefits for these expenses may be available under another plan sponsored by your Employer. See your Plan Administrator for details.)*
- 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-implantation genetic screening. General, population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.
- 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.
- nutritional supplements and formulae, except for infant formula needed for the treatment of inborn errors of metabolism.
- medical treatment for a person aged 65 or older who is covered under this plan as a retiree (or as a Dependent thereof), when payment is denied by Medicare because treatment was received from a non-participating provider.
- medical treatment, when payment is denied by a Primary Plan because treatment was received from a non-participating provider.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- telephone, e-mail, Internet consultations, and telemedicine.
- massage therapy.
- for charges which would not have been made if the person had no insurance.
- for Out-of-Network expenses, to the extent that the charges upon which they are based are more than Maximum Reimbursable Charges.
- expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure.
- charges made by any covered provider who is a member of your family or your Dependent’s family.
- any expenses incurred Out-of-Network, to the extent of the exclusions imposed by the Certification Requirements shown in this booklet.

GM6000 05BPT14 V143 M
GM6000 05BPT105 M
GM6000 06BNR2V2 (7) M

Coordination of Benefits

This section applies if you or any of your Dependents are covered under more than one Plan, and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for medical care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured, which can neither be purchased by the general

public, nor individually underwritten, including closed panel coverage.

- Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan, or part of a Plan, which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides medical benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes coverage for services rendered by providers outside of the panel, except in the case of emergency (or if referred by a provider within the panel).

Primary Plan

The Plan that provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines its benefits after the benefits provided or paid by the Primary Plan (and that may reduce its benefits accordingly). A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided.

GM6000 COB11 M

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance, or copayments, that is covered, in full or in part, by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to, the following:

- An expense or service, or a portion of an expense or service, that is not covered by any of the Plans is not an Allowable Expense.
- If an insured is confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- If an insured is covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If an insured is covered by one Plan that provides services or supplies on the basis of reasonable and customary fees, and another Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If an insured's benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because he did not comply with Plan provisions; or because he did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include pre-certification of admissions or services.

Claim Determination Period

The term Claim Determination Period means a calendar year, but does not include any part of such a year during which a person is not covered under this plan; or any date before this section or any similar provision takes effect.

GM6000 COB12 M

Reasonable Cash Value

An amount which a duly-licensed provider of health care services usually charges patients, and which is within the range of fees usually charged for the same service rendered under similar or comparable circumstances by other health care providers located within the immediate geographic area.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If a Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation will be utilized:

- The Plan that covers a person as an enrollee or an employee shall be the Primary Plan, and the Plan that covers that person as a Dependent shall be the Secondary Plan;
- For a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent as an enrollee or employee whose birthday falls first in the calendar year;
- For the Dependent child of divorced or separated parents, benefits for that child shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's health care expenses or health coverage, and the Plan for that parent has actual knowledge of the terms of the order (but only from the time of actual knowledge);
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child, and
  - finally, the Plan of the spouse of the parent not having custody of the child.

GM6000 COB13 M

- The Plan that covers a person as an active employee (or as a Dependent thereof) shall be the Primary Plan, and the Plan that covers that person as laid-off or retired employee (or as a Dependent thereof) shall be the Secondary Plan. If the other Plan does not have a similar provision and, as a result, the

Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

- The Plan that covers a person under a right of continuation which is provided by federal or state law shall be the Secondary Plan, and the Plan that covers that person as an active employee or retiree (or as a Dependent therof) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers an insured is governed by the laws of the state whose laws govern this Plan; and that Plan determines the order of benefits based upon the gender of a parent; and, as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered an insured for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965 (as amended). However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above will be used to determine how benefits will be coordinated.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for the insured. CG will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

GM6000 COB14 M

As each claim is submitted, CG will determine the following:

- the extent of the Plan's obligation to provide coverage for services and supplies;
- whether a benefit reserve has been recorded for the insured; and
- whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, the Plan will use the benefit reserve recorded for the insured to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, the benefit reserve will return to zero and a new benefit reserve shall be calculated for each new Claim Determination Period.

Recovery of Excess Benefits

If CG pays benefits for charges that should have been paid by the Primary Plan; or if CG pays benefits in excess of those for which it is obligated to provide under the Plan; CG will have the right to recover the actual payment made (or the Reasonable Cash Value of any services).

CG will have sole discretion to seek such recovery from any person to or for whom, or with respect to whom, benefits for such services were provided, or such payments made, by any insurance company, health care plan, or other organization. If requested, the insured must execute and deliver to CG such instruments and documents as it determines are necessary to secure the right of recovery.

Right to Receive and Release Information

CG, without consent or notice, may obtain information from, and release information to, any other Plan in order to coordinate benefits pursuant to this section. The insured must provide CG with any information it requests in order to coordinate benefits pursuant to this section. This request may occur in conjunction with a submitted claim; if so, the insured will be advised that "other coverage" information (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed at that time.

GM6000 COB15 M

Medicare Eligibles

CG will pay as the Secondary Plan, as permitted by the Social Security Act of 1965 (as amended), for the following:

(a) a former Employee who is eligible for Medicare, and whose insurance is continued for any reason as provided in this plan;

(b) a former Employee's Dependent, or a former Dependent spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

(c) an Employee whose Employer (and each other Employer participating in the Employer's plan) has fewer than 100 Employees, and that Employee is eligible for Medicare due to disability;

(d) the Dependent of an Employee whose Employer (and each other Employer participating in the Employer's plan) has

fewer than 100 Employees, and that Dependent is eligible for Medicare due to disability;

(e) an Employee (or a Dependent thereof) of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;

(f) an Employee or retired Employee (or a Dependent thereof) who is eligible for Medicare due to End Stage Renal Disease, after that person has been eligible for Medicare for 30 months.

GM6000 MEL23 V4 M

CG will assume the amount payable under:

- Part A of Medicare, for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.
- Part B of Medicare, for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.
- Part B of Medicare, for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.

This reduction will not apply to any Employee, former Employee, or Dependent unless he is listed under (a) through (f) above.

Domestic Partners

Under federal law, the Medicare Secondary Payer Rules do not apply to Domestic Partners covered under a group health plan. Therefore, Medicare is always the Primary Plan for a person covered as a Domestic Partner, and CIGNA is the Secondary Plan.

GM6000 MEL45V2 M

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

1. Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
2. Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

Subrogation/Right of Reimbursement

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:

1. Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.
2. Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

Lien of the Plan

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;

- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

GM6000 CCP7 CCL1V24

Payment of Benefits

To Whom Payable

All medical benefits are payable to you. However, at the option of CG, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

Medical benefits are not assignable unless agreed to by CG. CG may, at its option, make payment to you for the cost of any Covered Expenses incurred by you or your Dependent from a non-Participating Provider, even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependent is responsible for reimbursing the provider. If any person to whom benefits are payable is a minor or, in the opinion of CG, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, CG may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain upaid, CG may choose to make direct payment to any of your following living relatives: spouse; mother or father; child or children; brothers or sisters; to a beneficiary (if one is designated); or to the executors or administrators of your estate.

Payment as described above will release CG from all liability to the extent of any payment made.

Time of Payment

Benefits will be paid by CG not more than 60 days after it receives due proof of loss.

Recovery of Overpayment

When an overpayment has been made by CG, CG will have the right, at any time, to: (a) recover that overpayment from the person to whom, or on whose behalf, it was made; or (b) offset the amount of that overpayment from a future claim payment.

Calculation of Covered Expenses

CG, at its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural Terminology.
- the methodologies as reported by generally-recognized professionals or publications.

GM6000 TRM366 M

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or otherwise cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.

- the date the policy is canceled.
- the last day of the calendar month in which your Active Service ends, except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer cancels your insurance.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, the insurance will not continue past the date your Employer cancels the insurance.

Retirement

If your Active Service ends because you retire, your insurance will be continued until the earlier of: (a) the date on which your Employer stops paying premium for you or otherwise cancels the insurance; or (b) the date you attain age 65.

GM6000 TRM15V44 M

Dependents

Insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

GM6000 TRM62 M

Federal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this certificate, the provision which provides the better benefit will apply.

FDRL1 M

Notice of Provider Directory/Networks

If your Plan utilizes a network of providers/pharmacies, a separate listing of Participating Providers/Pharmacies can be obtained by contacting member services at the telephone number shown on the back of your benefit identification card, or by accessing www.cigna.com or www.mycigna.com. See your Plan Administrator if you have any questions.

The Participating Provider networks consist of a group of local medical practitioners, Hospitals, providers, and facilities of varied specialties, as well as general practice, who are employed by, or contracted with, CIGNA HealthCare.

Participating Pharmacy networks consist of groups of local pharmacies employed by, or contracted with, CIGNA HealthCare.

FDRL32 M

Qualified Medical Child Support Order (QMCSO)

A. Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child and yourself, if you are not already enrolled, within 31 days of the QMCSO being issued.

B. Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

1. the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
2. the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
3. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
4. the order states the period to which it applies; and
5. if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

C. Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial

parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

FDRL2 V1

Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)

If you or your eligible Dependent(s) experience a special enrollment event as described below, you or your eligible Dependent(s) may be entitled to enroll in the Plan outside of a designated enrollment period upon the occurrence of one of the special enrollment events listed below. If you are already enrolled in the Plan, you may request enrollment for you and your eligible Dependent(s) under a different option offered by the Employer for which you are currently eligible. If you are not already enrolled in the Plan, you must request special enrollment for yourself in addition to your eligible Dependent(s). You and all of your eligible Dependent(s) must be covered under the same option. The special enrollment events include:

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; spouse only; Employee and spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, spouse and Dependent child(ren). Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage. Dependent children who were already Dependents of the Employee but not currently enrolled in the Plan are not entitled to special enrollment.
- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
  - divorce or legal separation;
  - cessation of Dependent status (such as reaching the limiting age);
  - death of the Employee;
  - termination of employment;
  - reduction in work hours to below the minimum required for eligibility;
  - you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
  - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
  - the other plan no longer offers any benefits to a class of similarly situated individuals.
- **Termination of employer contributions (excluding continuation coverage).** If a current or former employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).
- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: (a) due to failure of the employer or other responsible entity to remit premiums on a timely basis; (b) when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or (c) when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.

FDRL3 V3

Special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective on the first day of the calendar month following receipt of the request for special enrollment.

Individuals who enroll in the Plan due to a special enrollment event will not be considered Late Entrants. Any Pre-existing Condition limitation will be applied upon enrollment, reduced by prior Creditable Coverage, but will not be extended as for a Late Entrant.

Domestic Partners and their children (if not legal children of the Employee) are not eligible for special enrollment.

FDRL4 V2

Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. In accordance with this regulation, you may agree to a pretax salary reduction to be applied toward the cost of your benefits.
Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage Elections

Per Section 125 regulations, you are generally allowed to enroll for (or change) coverage only during a specified Open Enrollment Period that precedes each annual benefit period. However, exceptions are allowed if your Employer agrees and you enroll for (or change) coverage no later than 30 days after the date you meet the criteria shown in the following Sections B through F.

B. Change of Status

A change in status is defined as:

(a) a change in legal marital status due to marriage, death of a spouse, divorce, annulment, or legal separation;

(b) a change in the number of your Dependents due to birth, adoption, placement for adoption, or death of a Dependent;

(c) a change in your employment status, or that of your spouse or Dependent child due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence [including leaves that qualify under the Family and Medical Leave Act (FMLA)], or change in worksite;

(d) changes in your employment status, or that of your spouse or Dependent child, resulting in eligibility or ineligibility for coverage;

(e) a change in residence on the part of you or your Dependent(s) to a location outside of the Plan's network service area; and

(f) changes which cause a Dependent to become eligible or ineligible for coverage.

C. Court Order

A change in coverage due to, and consistent with, a court order that requires you to cover a Dependent.

D. Medicare or Medicaid Eligibility/Entitlement

You or one of your Dependents cancels or reduces coverage due to entitlement to Medicare or Medicaid, or enrolls or increases coverage due to loss of Medicare or Medicaid eligibility.

E. Change in Cost of Coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.
When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

F. Changes in Coverage of Dependent Under Another Employer's Plan

You may make a coverage election change if another plan that covers your Dependents: (a) incurs a change, such as adding or deleting a benefit option; (b) allows election changes due to Special Enrollment, Change in Status, Court Order, or Medicare or Medicaid Eligibility/Entitlement; or (c) the other plan has different periods of coverage or open enrollment than this Plan.

FDRL5 M

Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

FDRL6 M

Federal Tax Implications for Dependent Coverage

Premium payments for Dependent health insurance are usually exempt from federal income tax consideration. Generally, if you can claim an individual as a Dependent for the purposes of federal income tax, then the premium for that Dependent's health insurance coverage will not be taxable to you as income. However, in the rare instance that you cover an individual under your health insurance who does not meet the federal definition of a Dependent, the premium may be taxable to you as income. If you have questions concerning your specific situation, you should seek the counsel of your own tax consultant or attorney.

FDRL7 M

Coverage for Maternity Hospital Stay

Group health plans and health insurance carriers offering group health insurance coverage generally may not, under a federal law known as the "Newborns' and Mothers' Health Protection Act," restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section; or require that a provider obtain authorization from the plan or insurance carrier for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

FDRL8 M

Women's Health and Cancer Rights Act (WHCRA)

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including: all stages of reconstruction and surgery to achieve symmetry between the breasts; prostheses; and complications resulting from a mastectomy, including lymphedema. Call Member Services at the toll-free telephone number shown on your benefit identification card for more information.

FDRL51 M

Group Plan Coverage Instead of Medicaid

If your income does not exceed 100% of the official poverty line and your liquid resources are at or below twice the Social Security income level, the state may decide to pay premiums for this coverage instead of Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

FDRL10 M

Obtaining a Certificate of Creditable Coverage Under This Plan

Upon loss of coverage under this Plan, a Certificate of Creditable Coverage will be mailed to each terminating individual at the last address on file. You or your dependent may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Plan and for 24 months following termination of coverage. You may need this document as evidence of your prior coverage to reduce any pre-existing condition limitation period under another plan, to help you get special enrollment in another plan, or to obtain certain types of individual health coverage even if you have health problems. To obtain a Certificate of Creditable Coverage, contact the Plan Administrator or call the toll-free customer service number on the back of your ID card.

FDRL50

Requirements of Family and Medical Leave Act of 1993 (FMLA)

Any provisions of the plan that provide for: (a) continuation of insurance during a leave of absence; and (b) reinstatement of insurance following a return to Active Service, are modified by the following provisions of the federal Family and Medical Leave Act of 1993 (where applicable):

A. Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by the Employer; in part by you and the Employer; or entirely by you.

B. Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, any canceled insurance will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period to the extent that it had been satisfied prior to the start of such leave of absence.

The Plan Administrator will give you detailed information about the Family and Medical Leave Act of 1993.

FDRL13 M

Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment with respect to an Employee's military leaves of absence. These requirements apply to medical and dental coverage for you and your Dependents.

A. Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the section of the **Termination** provisions regarding "Leave of Absence."

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows.

You may continue benefits by paying the required cost to your Employer, until the earliest of the following:

- 24 months from the last day of employment with the Employer;
- the day after you fail to return to work; and
- the date the policy cancels.

Your Employer may charge you and your Dependents up to 102% of the total cost.

B. Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA and you are re-employed by your current Employer, coverage for you and your Dependents may be reinstated, if: (a) you gave your Employer advance written or verbal notice of your military service leave; and (b) the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of any Pre-Existing Condition Limitation (PCL) or eligibility waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

Any 63-day break in coverage rule regarding credit for time accrued toward a PCL waiting period will be waived.

If your coverage under this plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

FDRL58 M

Claim Determination Procedures Under ERISA

The following complies with federal law effective July 1, 2002. Provisions of the laws of your state may supersede.

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical Necessity determinations are made on either a preservice, concurrent, or postservice basis, as described below:

Certain services require prior authorization in order to be covered. This prior authorization is called a "preservice medical necessity determination." The Certificate describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care provider) must request Medical Necessity determinations according to the procedures described below, in the Certificate, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not Medically Necessary, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Certificate, in your provider's network participation documents, and in the determination notices.

Preservice Medical Necessity Determinations

When you or your representative request a required Medical Necessity determination prior to care, CG will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond CG's control, CG will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to CG within 45 days after receiving the notice. The determination period will be suspended on the date CG sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

If the determination periods above would (a) seriously jeopardize your life or health, your ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, CG will make the preservice determination on an expedited basis. CG's Physician reviewer, in consultation with the treating Physician, will decide if an expedited determination is necessary. CG will notify you or your representative of an expedited determination within 72 hours after receiving the request.

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However, if necessary information is missing from the request, CG will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to CG within 48 hours after receiving the notice. CG will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If you or your representative fails to follow CG's procedures for requesting a required pre-service Medical Necessity determination, CG will notify you or your representative of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless you or your representative requests written notification.

Concurrent Medical Necessity Determinations

When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a concurrent Medical Necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, CG will notify you or your representative of the determination within 24 hours after receiving the request.

Post-Service Medical Necessity Determinations

When you or your representative requests a Medical Necessity determination after services have been rendered, CG will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond CG's control, CG will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to CG within 45 days after receiving the notice. The determination period will be suspended on the date CG sends such a notice of missing information, and resume on the date you or your representative responds to the notice.

FDRL42 M

Post-Service Claim Determinations

When you or your representative requests payment for services which have been rendered, CG will notify you of the claim payment determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond CG's control, CG will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information within 45 days after receiving the notice. The determination period will be suspended on the date CG sends such a notice of missing information, and resume on the date you or your representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on appeal; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination regarding your claim; (6) an explanation of the scientific or clinical judgment for a determination that is based on Medical Necessity, experimental treatment, or other similar exclusion or limit; and (7) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

FDRL36 M

When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "you," "your," or "member" also refers to a duly-authorized representative or provider designated by you to act on your behalf, unless otherwise noted.

“Physician Reviewers” are licensed Physicians specializing in the care, service, or treatment under review.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start With Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you may call the toll-free telephone number on your benefit identification card, explanation of benefits, or claim form and explain your concern to one of our Member Services representatives. You may also express that concern in writing.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

Appeals Procedure

CG has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing to CG within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable (or choose not) to write, you may ask CG to register your appeal by telephone. Call or write to us at the toll-free telephone number on your benefit identification card, explanation of benefits, or claim form.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required pre-service or concurrent care coverage determination, and within 30 calendar days after we receive an appeal for a post-service coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days, and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited, if: (a) the time frames under this process would seriously jeopardize your life, health, ability to regain maximum functionality, or, in the opinion of your Physician, would cause you severe pain which would not be manageable without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. CG's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CG will respond orally with a decision within 72 hours, followed up in writing.

FDRL37 M

Level-Two Appeal

If you are dissatisfied with our level-one appeal decision, you may request a second review. To initiate a level-two appeal, follow the same process required for a level-one appeal.

Most requests for a second review will be conducted by the Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness the Committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by CG's Physician reviewer. You may present your situation to the Committee in person or by conference call.

For level-two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For required preservice and concurrent care coverage determinations the Committee review will be completed within 15 calendar days and for post service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within 5 business days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician, would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. CG's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CG will respond orally with a decision within 72 hours, followed up in writing.

Independent Review Procedure

If you are not fully satisfied with the decision of CG's level-two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by CIGNA HealthCare, or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this Independent Review Process. CG will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, the reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by CG. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

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To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of the level-two appeal review denial. CG will then forward the file to the Independent Review organization. The Independent Review Organization will render an opinion within 30 days. When requested, and when a delay would be detrimental to your medical condition (as determined by CG's Physician reviewer), the review shall be completed within 3 days. The Independent Review Program is a voluntary program.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other Relevant Information, as defined; (4) a statement describing any voluntary appeal procedures offered by the plan; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination regarding your appeal; and (6) an explanation of the scientific or clinical judgment for a determination that is based on Medical Necessity, experimental treatment, or other similar exclusion or limit.

You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to determine what options may be available to you is to contact your local U.S. Department of Labor office, or your state insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

"Relevant Information" refers to any document, record, or other information which: (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

In most instances, you may not initiate a legal action against CG until you have completed the Level One and Level Two appeal processes. If your appeal is expedited, there is no need to

complete the Level Two process prior to bringing legal action.

FDRL40 M

Arbitration

To the extent permitted by law, any controversy between CG and the Group, or an insured (including any legal representative acting on behalf of an insured), arising out of, or in connection with, this document may be submitted to arbitration upon written notice by one party to another. Such arbitration shall be governed by the provisions of the Commercial Arbitration Rules of the American Arbitration Association, to the extent that such provisions are not inconsistent with the provisions of this section.

If the parties cannot agree upon a single arbitrator within 30 days of the effective date of written notice of arbitration, each party shall choose one arbitrator within 15 working days after the expiration of such 30-day period and the two arbitrators so chosen shall choose a third arbitrator, who shall be an attorney duly licensed to practice law in the applicable state. If either party refuses, or otherwise fails, to choose an arbitrator within such 15-working-day period, the arbitrator chosen shall choose a third arbitrator in accordance with these requirements.

The arbitration hearing shall be held within 30 days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses, or otherwise fails, to participate in such arbitration hearing, the hearing shall proceed and shall be fully effective in accordance with this section, notwithstanding the absence of such party.

The arbitrator(s) shall render his (their) decision within 30 days after the termination of the arbitration hearing. To the extent permitted by law, the decision of the arbitrator (or the decision of any two, if there are three arbitrators) shall be binding upon both parties, conclusive of the controversy in question, and enforceable in any court of competent jurisdiction.

No party to this document shall have a right to cease performance of services or otherwise refuse to carry out its obligations under the plan, pending the outcome of arbitration in accordance with this section, except as otherwise specifically provided in this document.

FDRL41 M

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan's coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct, or
- your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your death;
- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, same sex spouses, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates.

FDRL20 V1

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events

are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under Title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, both of the following requirements must be satisfied:

(a) The SSA must determine that the disability occurred prior to, or within, 60 days after the disabled individual elected COBRA continuation coverage; and

(b) A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made, *and* before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B, or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

FDRL21 M

Termination of COBRA Continuation

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with CIGNA;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: (a) the end of the applicable maximum period; (b) the date the pre-existing condition provision is no longer applicable; or (c) the occurrence of an event described in one of the first three bullets above; or
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

Moving Out of Employer's Service Area or Elimination of a Service Area (for Employees enrolled in an In and Out-of-Network Plan)

If you and/or your Dependents move out of the Employer's service area or the Employer eliminates a service area in your location, your COBRA continuation coverage under the plan will be limited to out-of-network coverage only. In-network coverage is not available outside of the Employer's service area. If the Employer offers another benefit option through CIGNA or another carrier which can provide coverage in your location, you may elect COBRA continuation coverage under that option.

FDRL22 V1

Notification Requirements

The Employer is required to provide you and/or your Dependents with the following notices:

An initial notification of COBRA continuation rights must be provided within 90 days after coverage for you or your Dependent spouse under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.

A COBRA continuation election notice must be provided to you and/or your Dependents within the following time frames:

(a) if the Plan provides that COBRA continuation coverage and the period within which the Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;

(b) if the Plan provides that COBRA continuation coverage and the period within which the Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or

(c) in the case of a multi-employer plan, no later than 14 days after the end of the period in which the Employer must provide notice of a qualifying event to the Plan

Administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable cost. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your Dependent spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA continuation.

FDRL23 M

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated active Employee or family member. For example:

If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

FDRL24 V2

You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation;
- Your child ceases to qualify as a Dependent under the Plan; or
- The occurrence of a secondary qualifying event as discussed under “Secondary Qualifying Events” above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled “Disability Extension” for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer's Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under "Termination of COBRA Continuation" above.

FDRL25 V1

Trade Act of 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC-eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center, toll-free, at 1-866-628-4282. TDD/TYY callers may call, toll-free, at 1-866-626-4282. More information about the Trade Act is also available at:

www.doleta.gov/tradeact/2002act_index.asp

In addition, if you initially declined COBRA continuation coverage and, within 60 days after your loss of coverage under the Plan, you are deemed eligible by the U.S. Department of Labor or a state labor agency for Trade Adjustment Assistance (TAA) benefits and the tax credit, you may be eligible for a special 60-day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless you experience one of the events specified under the "Termination of COBRA Continuation" provisions above. Coverage will not be retroactive to the initial loss of coverage. If you receive a determination that you are TAA-eligible, you must notify the Plan Administrator immediately.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

FDRL26 M

ERISA Required Information

The name of the Plan is:

Wesleyan University Group Insurance Program

The name, address, ZIP code, and business telephone number of the sponsor of the Plan is:

Wesleyan University
212 College Street
Middletown, CT 06459-0418
(860) 685-4889

Employer Identification Number (EIN)	Plan Number
06-0646959	511

The name, address, ZIP code, and business telephone number of the Plan Administrator is:

Employer named above

The name, address and ZIP code of the person designated as agent for the service of legal process is:

Employer named above (may be Plan trustee, if any; or Plan Administrator.)

The office designated to consider the appeal of denied claims is:

The CG claim office responsible for this Plan

The cost of the Plan is shared by Employee and Employer.

The Plan's fiscal year ends on December 31st.

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

Plan Trustees

A list of the Trustees of the Plan (if any), which includes name, title and address, is available upon request from the Plan Administrator.

Plan Type

The Plan is a health care benefit plan.

Collective Bargaining Agreements

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective

bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.

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Discretionary Authority

The Plan Administrator delegates to CG the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, determination of the eligibility of persons desiring to enroll in, or claim benefits under, the plan; determination of whether a person is entitled to benefits under the plan; and the computation of any and all benefit payments. The Plan Administrator also delegates to CG the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant (or his duly-authorized representative).

Plan Modification, Amendment and Termination

The Employer, as Plan Sponsor, reserves the right, at any time, to change or terminate benefits under the Plan; to change or terminate the eligibility of classes of Employees to be covered by the Plan; to amend or eliminate any plan term or condition; and to terminate the whole plan, or any part of it. The procedure by which benefits may be changed or terminated; by the which the eligibility of classes of Employees may be changed or terminated; or by which part of all of the Plan may be terminated; is contained in the Employer's Plan Document, which is available for inspection and copying from the Plan Administrator designated by the Employer. No consent of any participant is required to terminate, modify, amend, or change the Plan.

Termination of the Plan, together with termination of the insurance policy(s) which funds the Plan benefits, will have no adverse effect on any benefits to be paid under the policy(s) for any covered medical expenses incurred prior to the date that policy(s) terminates. Likewise, any extension of benefits under the policy(s) resulting from the total disability of you or your Dependent which began prior to, and which has continued beyond, the date the policy(s) terminates, will not be affected by the Plan termination. Rights to purchase limited amounts of medical insurance to replace part of the benefits lost because the policy(s) terminated may arise under the terms of the policy(s). A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the last day of the calendar month in which your Active Service ends;
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents under this policy(s). No extension of benefits or rights will be available solely because the Plan terminates.

Statement of Rights

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

FDRL28 M

Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrator's office (and at other specified locations, such as worksites and union halls), all documents governing the plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor [and also available at the Public Disclosure room of the Employee Benefits Security Administration].
- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

Continue Group Health Plan Coverage

- continue health care coverage for yourself or your Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your federal continuation coverage rights.
- reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance carrier when you lose coverage under the plan; when you become entitled to elect federal continuation coverage; when your federal continuation coverage ceases (if you request it before losing coverage); or if you request it, up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the

Employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

FDRL29 M

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

FDRL59

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on that day, either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days, if you were in Active Service on the preceding scheduled work day.

DFS1

Bed and Board

The term Bed and Board includes all charges made by a Hospital, on its own behalf, for room and meals and for all general services and activities needed for the care of registered bed patients.

DFS14

Charges

The term "charges" means the actual billed charges; except when the provider has contracted, directly or indirectly, with CG for a different amount.

DFS940

Custodial Services

Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age, or mental or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include, but are not limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking; (b) grooming; (c) bathing; (d) dressing; (e) getting in or out of bed; (f) toileting; (g) eating; (h) preparing foods; or (i) taking medications that can be self-administered; and
- Services that are not required to be performed by trained or skilled medical or paramedical personnel.

DFS1812

Dependent

Dependents are:

- your lawful spouse or Domestic Partner; and
- any unmarried child of yours who is
  - less than 19 years old;
  - 19 years old or older, but less than 25 years old, enrolled in school as a full-time student and primarily supported by you;
  - 19 years old or older, primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition

and dependence must be submitted to CG within 31 days after the date the child ceases to qualify above. During the next two years, CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

A child includes a legally adopted child. It also includes a stepchild who lives with you, and any child for whom you are the legal guardian. If your Domestic Partner has a child who lives with you, that child will also be included as a Dependent.

Benefits for a Dependent child or student will continue until the last day of the calendar year in which the limiting age is reached.

Anyone who is covered as an Employee will not be covered as a Dependent.

No one may be covered as a Dependent of more than one Employee.

DFS57

Domestic Partner

A Domestic Partner is defined as a person of the same or opposite sex who:

- shares your permanent residence;
- has resided with you for no less than 6 months;
- is no younger than 18 years of age;
- is financially interdependent with you, and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is considered by CG to be sufficient to establish financial interdependency under the circumstances of your particular case;
- is not a blood relative any closer than would prohibit legal marriage; and
- has signed, jointly with you, a notarized affidavit which can be made available to CG upon request.

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:

- has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
- is currently legally married to another person; or
- has any other Domestic Partner, spouse, or spouse equivalent of the same or opposite sex.

You and your Domestic Partner must have registered as Domestic Partners, if you reside in a state that provides for such registration.

The "Continuation Rights Under Federal Law (COBRA)" will not apply to your Domestic Partner and his or her Dependents.

DFS1222

Emergency Services

Emergency Services are medical, psychiatric, surgical, Hospital, and related health care services and testing, including ambulance service, required to treat a sudden bodily Injury or the unexpected onset of a serious Sickness, which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life, or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures, loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis, slurred speech, burns, cuts, and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the Hospital on the UB92 claim form (or its successor), or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.

DFS1533

Employee

The term Employee means a person who is: (a) working for the Employer on a regularly-scheduled basis and currently in Active Service; or (b) an eligible retiree. The term does not include persons who are working on a temporary basis for the Employer.

DFS1427

Employer

The term Employer means the plan sponsor self-insuring the benefits described in this booklet, on whose behalf CG is providing claim administration services.

DFS1595

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

DFS60

Free-Standing Surgical Facility

The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses, and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;

- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement; and
- it is licensed in accordance with the laws of the appropriate, legally-authorized agency.

DFS682

Hospice Care Program

The term Hospice Care Program means:

- a coordinated, interdisciplinary program designed to meet the physical, psychological, spiritual, and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing, and other health services through home or inpatient care during the Sickness;
- a program for persons who have a Terminal Illness and for the families of those persons.

DFS70

Hospice Care Services

The term Hospice Care Services means any services provided by: (a) a Hospital; (b) a Skilled Nursing Facility or a similar institution; (c) a Home Health Care Agency; (d) a Hospice Facility; or (e) any other licensed facility or agency under a Hospice Care Program.

DFS599

Hospice Facility

The term Hospice Facility means an institution, or part of it, which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by CG; and
- fulfills any licensing requirements of the state or locality in which it operates.

DFS72

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital, or a tuberculosis hospital, and as a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: (a) specializes in treatment of Mental Health conditions and Substance Abuse or other related Sickness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate, legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

DFS1693

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment Mental Health and Substance Abuse Services in a Partial Hospitalization program;
- receiving treatment for Substance Abuse Services in a Substance Abuse Residential Treatment Center.

DFS1815

Injury

The term Injury means an accidental bodily injury.

DFS147

Maximum Reimbursable Charge - Medical

The Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or
- a policyholder-selected percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by CG.

The percentile used to determine the Maximum Reimbursable Charge is listed in The Schedule.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by CG. Additional information about how CG determines the Maximum Reimbursable Charge is available upon request.

GM6000 DFS1997 V5

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 (as amended).

DFS192

Medically Necessary/Medical Necessity

Medically Necessary services and supplies are those determined by CG to be:

- required to diagnose or treat a Sickness, Injury, disease, or its symptoms;
- in accordance with generally accepted standards of medical practice;

- clinically appropriate in terms of type, frequency, extent, site, and duration;
- not primarily for the convenience of the patient, Physician, or Other Health Care Professional; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, CG may compare the cost-effectiveness of alternative services, settings, or supplies when determining the least intensive setting.

DFS1813

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 (as amended).

DFS149

Necessary Services and Supplies

The term Necessary Services and Supplies includes any charges (except for Bed and Board) made by a Hospital, on its own behalf, for medical services and supplies actually used during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees, or medical fees.

DFS285

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse, or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or L.V.N."

DFS155

Ophthalmologist

The term Ophthalmologist means a person practicing ophthalmology within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the vision care services described in the plan.

DFS156

Optometrist

The term Optometrist means a person practicing optometry within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the vision care services described in the plan.

DFS157

Other Health Care Facility

The term Other Health Care Facility means a facility other than a Hospital or Hospice Facility. Examples of Other Health Care Facilities include, but are not limited to, licensed Skilled Nursing Facilities, rehabilitation Hospitals, and subacute facilities.

DFS1686

Other Health Care Professional

The term Other Health Care Professional means an individual (other than a Physician) who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Care Professionals include, but are not limited to, physical therapists, registered nurses, and licensed practical nurses.

DFS1685

Participating Provider

The term Participating Provider means a Hospital, a Physician, or any other health care practitioner or entity that has a direct or indirect contractual arrangement with CG to provide services with regard to a particular plan under which the participant is covered.

DFS1910

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law, if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

DFS164

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law, if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Psychologist.

DFS170

Review Organization

The term Review Organization refers to an affiliate of CG, or to another entity to which CG has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.

DFS1688

Sickness

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

DFS531

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

DFS193

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed and certified by a Physician.

DFS197

Urgent Care

Urgent Care refers to medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by CG, in accordance with generally-accepted medical standards, to be necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services, including, but not limited to, dialysis, scheduled medical treatments or therapy; or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

DFS1534