



Cigna HealthCare
Point of Service

Important Information

THIS IS A SAMPLE DOCUMENT.

NO BENEFITS ARE GUARANTEED. NO COVERAGE REPRESENTATION IS CONSIDERED TO BE ACTUAL MEDICAL BENEFITS PROVIDED TO YOU BY CIGNA.



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SAMPLE DOCUMENT

Group Service Agreement

SAMPLE DOCUMENT

NOTICE

Continuity of Care

In certain circumstances, if you are receiving continued care from a network provider and that provider's network status changes to out-of-network, you may be eligible to continue to receive care from the provider at the Participating Provider cost-sharing amount for up to 90 days from the date you are notified of your provider's termination. A continuing care patient is an individual who is: undergoing treatment for a serious and complex condition; pregnant and undergoing treatment for the pregnancy; receiving inpatient care; scheduled to undergo urgent or emergent surgery, including postoperative; or terminally ill (having a life expectancy of 6 months or less) and receiving treatment from the provider for the illness. If applicable, you will be notified of your continuity of care options.

Provider Directories and Provider Networks

A list of network providers is available to you, without charge, by visiting the website or calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as generic practice, affiliated or contracted with Cigna Healthcare or an organization contracting on its behalf.

Provider directory content is verified and updated, and processes are established for responding to provider network status inquiries, in accordance with applicable requirements of the federal No Surprises Act.

A list of network pharmacies is available to you, without charge, by visiting the website or calling the phone number on your ID card. The network consists of pharmacies affiliated or contracted with Cigna Healthplan or an organization contracting on its behalf.

If you rely on a provider's network status in the provider directory or by contacting Cigna Healthcare at the website or phone number on your ID card to receive covered services from that provider, and that network status is incorrect, then an in-network cost-share must be applied to the covered service as if the service were provided by a Participating Provider.

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, access the website or call the phone number on your ID.

Selection of a Primary Care Provider

Your plan may require or allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. If your plan requires designation of a primary care provider, Cigna may designate one for you until you make this designation. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, access the website or call the phone number on your ID card.



Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at a network hospital or ambulatory surgical center, you are protected from balance billing. In these situations, you should not be charged more than your plan's copayments, coinsurance, and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or deductible. You may have added costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

"Out-of-network" means providers and facilities that have not signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**". This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

1. "Surprise billing" is an unexpected balance bill. This can happen when you cannot control who is involved in your care – such as when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.
2. *You are protected from balance billing for:*
 - **Emergency services** – If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as a copayments, coinsurance, and deductibles). You cannot be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.
 - **Certain non-emergency services at an in-network hospital or ambulatory surgical center** – When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **cannot** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you have these protections:

- You are only responsible for paying your share of the cost (such as copayments, coinsurance, and deductibles that you would pay if the provider were in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - Cover emergency services without requiring you to get approval in advance for services (also known as prior authorization).
 - Cover emergency services provided by out-of-network providers.
 - Base what you owe the provider or facility (cost sharing) on what it would pay an in-network provider or facility and show that amount in your Explanation of Benefits (EOB).



- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you have been wrongly billed, contact Cigna Healthcare at the phone number on your ID card. You can also contact No Surprises Help Desk at 1-800-985-3059 or www.cms.gov/nosurprises for more information about your rights under federal law.

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NOTICE

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

The group agreement is amended as stated below.

In the event of a conflict between the provisions of your plan documents and the provisions of this notice, the provisions that provide the better benefit shall apply.

Covered Services and Supplies:

Mental Health Residential Treatment Services

Benefits are payable for Mental Health Residential Treatment Services.

Inpatient Mental Health Services

Services that are provided by a Participating Hospital while you or your Dependent is confined in a Participating Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Mental Health Residential Treatment Services.

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

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

A Member 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 Participating Provider.

Outpatient Mental Health Services

Partial Hospitalization sessions are services that are provided for not less than four (4) hours and not more than twelve (12) hours in a twenty-four (24) hour period by a certified/licensed Mental Health program in accordance with the laws of the appropriate legally-authorized agency.

Inpatient Substance Use Disorder Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent is confined in a Participating Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Use Disorder Services include Residential Treatment services.

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

Substance Use Disorder Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Use Disorder; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Participating Providers; provides twenty-four (24) hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

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

Outpatient Substance Use Disorder Services

Partial Hospitalization sessions are services that are provided for not less than four (4) hours and not more than twelve (12) hours in a twenty-four (24) hour period by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally-authorized agency.

Mental Health and Substance Use Disorder Exclusions:

The following exclusions are hereby deleted and no longer apply:

- 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 Agreement;
- Mental Health residential treatment.

Terms within the agreement:

The term "*mental retardation*" within your Group Service Agreement is hereby changed to "*intellectual disabilities*".

Visit Limits:

Any health care service billed with a Mental Health or Substance Use Disorder diagnosis, will not incur a visit limit, including but not limited to genetic counseling and nutritional evaluation.

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NOTICE

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)

The group agreement is amended as stated below.

In the event of a conflict between the provisions of your plan documents and the provisions of this endorsement, the provisions that provide the better benefit shall apply.

Clinical Trials

Benefits are payable for Routine Patient Services associated with an approved clinical trial (Phases I-IV) for treatment of cancer or other life-threatening diseases or conditions for a covered person who meets the following requirements:

1. Is eligible to participate in an approved clinical trial according to the trial protocol with respect to the prevention, detection or treatment of cancer or other life-threatening disease or condition; and
2. Either
 - the referring health care professional is a participating health care provider and has concluded that the individual's participation in such a trial would be appropriate based upon the individual meeting the conditions described in Paragraph (1); or
 - the covered person provides medical and scientific information establishing that participation in such a trial would be appropriate based on the individual meeting the conditions described in Paragraph (1).

For purposes of clinical trials, the term "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

An approved clinical trial must meet one of the following requirements:

- be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
- be conducted under an investigational new drug application reviewed by the Food and Drug administration; or
- involve a drug trial that is exempt from having such an investigational new drug application.

Routine Patient Services are costs associated with the provision of health care items and services including drugs, items, devices and services typically covered by Cigna for a covered patient who is not enrolled in a clinical trial, including the following:

- services typically provided absent a clinical trial;
- services required for the clinically appropriate monitoring of the investigational drug, device, item or service;
- services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service; and
- reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.

Routine Patient Services do not include:

- the investigational item, device, or service itself; or
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

Clinical trials conducted by non-participating providers will be covered at the in-network benefit level if:

-
- there are not in-network providers participating in the clinical trial that are willing to accept the individual as a patient; or
 - the clinical trial is conducted outside the individual's state of residence.

Exclusions and Limitations

Any services and supplies for or in connection with experimental, investigational or unproven services.

Experimental, investigational or unproven services do not include routine patient care costs related to qualified clinical trials as described in your plan document.

Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be:

- not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or
- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or
- the subject of review or approval by an Institutional Review Board for the proposed use.

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NOTICE

Discrimination is Against the Law

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Cigna:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Customer Service at the toll-free phone number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by sending an email to ACAGrievance@cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Disorder
P.O. Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card or send an email to ACAGrievance@cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Proficiency of Language Assistance Services

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224（聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên của quý vị. Các trường hợp khác, xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자분들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주시고. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주시고.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون على ظهر بطاقتكم الشخصية. او اتصل ب 1.800.244.6224 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki deyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

French – ATTENTION : Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese – 注意事項: 日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224 (TTY: 711)まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).

Thank you for choosing Cigna.

We are pleased to provide important information about your Point of Service plan.

Your plan:

Does more than provide coverage when you're sick or injured. We focus on helping you take care of yourself so you can stay your healthiest.

- **Includes preventive care services.** We cover physicals, child immunizations, and women's health services such as no-referral OB/GYN checkups, mammograms and Pap tests. You'll also receive discounts on health and wellness programs and services.
- **Covers emergency and urgent care, 24 hours a day, worldwide.**
- **Gives you options for accessing quality health care.** Each time you access care, you have two options. You can choose to see your Primary Care Physician (PCP) first and use participating health care professionals, a choice that will keep your costs lower and eliminate paperwork. Your PCP will provide care and refer you to participating specialists or facilities when you need them. Your second option gives you the freedom to visit any doctor or use any facility -even those not contracted with Cigna -or to go to any doctor without a referral from your PCP. However, your costs will be higher and you will have to file claims.

It's easy to get the information you need.

myCigna.com offers a number of self-service features. You can review your benefits plan information; find participating doctors, specialists, pharmacies and hospitals closest to home or work; view the status of your claims; order a new Cigna ID card; or change your PCP.

- **Customer Service Representatives** are ready to answer your questions and help solve problems. Just call the toll-free number on your Cigna ID card.
- **Your Cigna ID** card lists the toll-free Customer Service phone number, your PCP's name and phone number, and payment information.
- **Our Commitment to Quality** guide gives you access to the latest information about our program activities and results, including how we met our goals, as well as details about key guidelines and procedures. Log on to www.myCigna.com to view this information. If you have questions about the quality program, would like to provide your feedback and/or cannot access the information online and would like a paper copy, please call the number on the back of your Cigna ID card.

We want you to be satisfied with your Cigna HealthCare plan. If you ever have a question about your plan or how to obtain services and supplies, just call. We're here to help.

Table of Contents

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I. Definitions of Terms Used in This Group Service Agreement

Section I. Definitions of Terms Used in This Group Service Agreement

The following definitions will help you in understanding the terms that are used in this Group Service Agreement. As you are reading this Group Service Agreement you can refer back to this section. We have identified defined terms throughout the Agreement by capitalizing the first letter of the term.

Agreement

This Agreement, the Face Sheet, the Schedule of Copayments, any optional Riders, any other attachments, your Enrollment Application, and any subsequent written amendment or written modification to any part of the Agreement.

Anniversary Date of Agreement

The date written on the Face Sheet as the Agreement anniversary date.

Contract Year

The 12-month period beginning at 12:01 a.m. on the first day of the initial term or any renewal term and ending at 12:01 a.m. on the next anniversary of that date.

Copayment

The amount shown in the Schedule of Copayments that you pay for certain Covered Services and Supplies. The Copayment may be a fixed dollar amount or a percentage of the Participating Providers' negotiated charge. The Copayment you are required to pay under the plan is in addition to any Plan Deductible. When the Participating Provider has contracted with the Healthplan to receive payment on a basis other than a fee-for-service amount, the charge may be calculated based on a Healthplan-determined percentage of actual billed charges.

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 not required to be performed by trained or skilled medical or paramedical personnel.

Days

Calendar days; not 24 hour periods unless otherwise expressly stated.

Deductible

See Plan Deductible.

Dependent

An individual in the Subscriber's family who is enrolled as a Member under this Agreement. You must meet the Dependent eligibility requirements in "Section II. Enrollment and Effective Date of Coverage" to be eligible to enroll as a Dependent.

Emergency Services

Emergency Services are defined in "Section IV. Covered Services and Supplies."

Enrollment Application

The enrollment process that must be completed by an eligible individual in order for coverage to become effective.

Essential Health Benefits

Means, to the extent covered under the plan, expenses incurred with respect to covered services, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive



I. Definitions of Terms Used in This Group Service Agreement

and wellness services and chronic disease management and pediatric services, including oral and vision care.

Face Sheet

The part of this Agreement that contains certain provisions affecting the relationship between the Healthplan and the Group. You can get a copy of the Face Sheet from the Group.

Group

The employer, labor union, trust, association, partnership, government entity, or other organization listed on the Face Sheet to this Agreement which enters into this Agreement and acts on behalf of Subscribers and Dependents who are enrolled as Members in the Healthplan.

Healthplan

The Cigna HealthCare health maintenance organization (HMO) which is organized under applicable law and is listed on the Face Sheet to this Agreement. Also referred to as "we", "us" or "our".

Healthplan Medical Director

A Physician charged by the Healthplan to assist in managing the quality of the medical care provided by Participating Providers in the Healthplan; or designee.

Medical Services

Professional services of Physicians or Other Participating Health Professionals (except as limited or excluded by this Agreement), including medical, psychiatric, surgical, diagnostic, therapeutic, and preventive services.

Medically Necessary/Medical Necessity

Medically Necessary Covered Services and Supplies are those determined by the Healthplan Medical Director to be:

- required to diagnose or treat an illness, injury, disease or its symptoms; and
- in accordance with generally accepted standards of medical practice; and
- clinically appropriate in terms of type, frequency, extent, site and duration; and
- not primarily for the convenience of the patient, Physician, or other health care provider; and

- not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your sickness, injury, condition, disease or its symptoms; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Healthplan Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining the least intensive setting.

In determining whether health care services, supplies, or medications are Medically Necessary, the HealthPlan Medical Director or Review Organization may rely on the clinical coverage policies maintained by the Healthplan or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

Member

An individual meeting the eligibility criteria as a Subscriber or a Dependent who is enrolled for Healthplan coverage and for whom all required Prepayment Fees have been received by the Healthplan. Also referred to as "you" or "your".

Membership Unit

The unit of Members made up of the Subscriber and his or her Dependent(s).

Open Enrollment Period

The period of time established by the Healthplan and the Group as the time when Subscribers and their Dependents may enroll for coverage. The Open Enrollment Period occurs at least once every Contract Year.

Other Participating Health Care Facility

Other Participating Health Care Facilities are any facilities other than a Participating Hospital or hospice facility that is operated by or has an agreement to render services to Members. Examples of Other



I. Definitions of Terms Used in This Group Service Agreement

Participating Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation hospitals and sub-acute facilities.

Other Participating Health Professional

An individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver Medical Services and who has an agreement with the Healthplan to provide Covered Services and Supplies to Members. Other Participating Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses.

Participating Hospital

An institution licensed as an acute care hospital under the applicable state law, which has an agreement to provide hospital services to Members.

Participating Physician

A Primary Care Physician (PCP) or other Physician who has an agreement to provide Medical Services to Members.

Participating Provider

Participating Providers are Participating Hospitals, Participating Physicians, Other Participating Health Professionals, and Other Participating Health Care Facilities.

Patient Protection and Affordable Care Act of 2010

Means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Physician

An individual who is qualified to practice medicine under the applicable state law (or a partnership or professional association of such people) and who is a licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.).

Plan Deductible

The Plan Deductible includes Covered Services and Supplies to be paid by you or your Dependent before benefits are payable under this plan. Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached, you

and your family need not satisfy any further medical deductible for the rest of that year.

The **Individual Deductible** is the amount you are responsible for paying out-of-pocket, each Contract Year, for covered Prescription Drugs Products (as identified in the Supplemental Prescription Drug Rider) and Covered Services and Supplies (as identified in the Group Service Agreement).

You must meet your Individual Deductible before the Healthplan begins to pay the cost associated with your coverage.

However, when the amount paid by individuals in your Membership Unit to meet their Individual Deductibles equals the **Family Deductible** amount, all Members in the Membership Unit will be considered to have met their Individual Deductible for that Contract Year.

Prepayment Fee

The sum of money paid to the Healthplan by the Group in order for you to receive the Services and Supplies covered by this Agreement.

Primary Care Physician (PCP)

A Physician who practices general medicine, family medicine, internal medicine or pediatrics who, through an agreement with the Healthplan, provides basic health care services to you if you have chosen him as your Primary Care Physician (PCP). Your Primary Care Physician (PCP) also arranges specialized services for you.

Primary Plan

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

Prior Authorization

The approval a Participating Provider must receive from the Healthplan Medical Director, prior to services being rendered, in order for certain Services and Supplies to be covered under this Agreement.

Qualified Medical Child Support Order

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

I. Definitions of Terms Used in This Group Service Agreement

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:

- the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
- 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;
- the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- the order states the period to which it applies; and
- 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 requirement above.

Referral

The approval you must receive from your PCP in order for the services of a Participating Provider, other than the PCP, or participating OB/GYN, chiropractic Physician to be covered.

Review Organization

The term Review Organization refers to an affiliate of the Healthplan or another entity to which the Healthplan 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 use disorder professionals, and other trained staff members who perform utilization review services.

Rider

An addendum to this Agreement between the Group and the Healthplan.

Schedule of Copayments

The section of this Agreement that identifies applicable Copayments and maximums.

Service Area

The geographic area, as described in the Provider Directory applicable to your plan, where the Healthplan is authorized to provide services.

Stabilize

Means, with respect to an emergency medical condition, to provide medical treatment as necessary to assure that no material deterioration of the condition is likely if the individual is transferred from a facility, or with respect to a pregnant woman who is having contractions, to deliver.

Subscriber

An employee, retiree or a participant in the Group who is enrolled as a Member under this Agreement. You must meet the requirements contained in "Section II. Enrollment and Effective Date of Coverage" to be eligible to enroll as a Subscriber.

Total Copayment Maximums

The total amount of Copayments that an individual Member or Membership Unit must pay within a Contract Year. When the individual Member or Membership Unit has paid applicable Copayments up to the Total Copayment Maximums, that Member or Membership Unit will not be required to pay Copayments for those Services and Supplies for the remainder of the Contract Year. It is the Subscriber's responsibility to maintain a record of Copayments which have been paid and to inform the Healthplan when the amount reaches the Total Copayment Maximums. The Total Copayment Maximums and the Copayments that apply toward these maximums are identified in the Schedule of Copayments.

Urgent Care

Urgent Care is defined in "Section IV. Covered Services and Supplies."

We/Us/Our

Cigna HealthCare Inc.

You/Your

The Subscriber and/or any of his or her Dependents.



II. Enrollment and Effective Date of Coverage

Section II. Enrollment and Effective Date of Coverage

Who Can Enroll as a Member

To be eligible for covered Services and Supplies you must be enrolled as a Member. To be eligible to enroll as a Member you must meet either the Subscriber or Dependent eligibility criteria listed below. You must also meet and continue to meet the Group-specific enrollment and eligibility rules on the Face Sheet.

A. To be eligible to enroll as a Subscriber, you must:

1. be an employee of the Group or a participant in the Group; and
2. reside or work in the Service Area; and
3. meet and continue to meet these criteria.

B. To be eligible to enroll as a Dependent, you must:

1. be the Subscriber's lawful spouse of same or opposite sex and you must reside in the Service Area; or
2. be the natural child, step-child, or adopted child of the Subscriber; or the child for whom the Subscriber is the legal guardian, or the child legally placed with the Subscriber for adoption, or supported pursuant to a court order imposed on the Subscriber (including a qualified medical child support order), provided that the child.
 - a. resides in the Service Area (unless the child is a full-time registered student outside the Service Area) and
 - i. has not yet reached age twenty-six (26); or
 - ii. the child is twenty-six (26) or older and continuously incapable of self-sustaining support because of intellectual disabilities or a physical handicap which existed prior to attaining twenty-six (26) years of age and became mentally or physically handicapped prior to the age at which Dependent coverage would otherwise terminate under this Agreement. If the child became mentally or physically handicapped while covered under this

Agreement you may be required to submit proof of the child's condition and dependence within thirty-one (31) days after the date the child ceases to qualify as a Dependent under subsection (i) and (ii) above or upon enrollment if the handicap existed prior to enrollment. You may be required, from time to time during the next two (2) years, to provide proof of the continuation of the child's condition and dependence. Thereafter, you may be required to provide such proof only once a year.

A Subscriber's grandchild is not eligible for coverage unless the grandchild meets the eligibility criteria for a Dependent.

A child born of a Member, when that Member is acting as a surrogate parent, is not eligible for coverage.

Anyone who is eligible as an employee will not be considered as a Dependent spouse. A child under age 26 may be covered as either an employee or as a Dependent child. You cannot be covered as an employee while also covered as a Dependent of a Subscriber.

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C. To be eligible to enroll as a domestic partner, you must be a person of the same or opposite sex who:

1. shares a permanent residence with the Subscriber;
2. has resided with the Subscriber for not less than one year;
3. is at least eighteen years of age;
4. is financially interdependent with the Subscriber and have proven such interdependence by providing documentation of at least two (2) of the following arrangements:
 - a. common ownership of real property or a common leasehold interest in such property;
 - b. common ownership of a motor vehicle;

II. Enrollment and Effective Date of Coverage

- c. a joint bank account or a joint credit account;
 - d. designation as a beneficiary for life insurance or retirement benefits or under the Subscriber's last will and testament;
 - e. assignments of a durable power of attorney or health care power of attorney; or
 - f. such other proof as is considered by the Healthplan to be sufficient to establish financial interdependency under the circumstances of a particular case.
5. is not a blood relative any closer than would prohibit legal marriage;
 6. has signed jointly with the Subscriber a notarized affidavit in form and content which is satisfactory to the Healthplan and make this affidavit available to the Healthplan; and
 7. has registered with the Subscriber as domestic partners if you reside in a state that provides for such registration.

You are not eligible to enroll as a domestic partner if either you or the Subscriber has signed a domestic partner affidavit or declaration with any other person within twelve months prior to designating each other as domestic partners under this Agreement; are currently legally married to another person; or have any other domestic partner, spouse or spouse equivalent of the same or opposite sex.

An eligible domestic partner's children who meet the Dependent eligibility requirements in "Section II. Enrollment and Effective Date of Coverage" are also eligible to enroll.

The "Continuation of Group Coverage under COBRA" section of this Agreement does not apply to the Subscriber's domestic partner and his or her Dependents.

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Enrollment and Effective Date of Coverage

A. Enrollment during an Open Enrollment Period

If you meet the Subscriber or Dependent eligibility criteria, you may enroll as a Member during

the Open Enrollment Period by submitting a completed Enrollment Application, together with any applicable fees, to the Group.

If enrolled during the Open Enrollment Period, your effective date of coverage is the first day of the Contract Year.

B. Enrollment after an Open Enrollment Period

1. If, after the Open Enrollment Period, you become eligible for coverage as a Subscriber or a Dependent, you may enroll as a Member within thirty-one (31) days of the day on which you met the eligibility criteria. To enroll, you must submit an Enrollment Application, together with any additional fees due, to the Group. If so enrolled, your effective date of coverage will be the day on which you meet the eligibility criteria.

If you do not enroll within the thirty-one (31) days, your next opportunity to enroll will be during the next Open Enrollment Period.

2. If you are a Subscriber who is enrolled as a Member, you may enroll a newborn child prior to the birth of the child or within thirty-one (31) days after the child's birth. To enroll a newborn child, you must submit an Enrollment Application, together with any additional fees due, to the Group. If so enrolled, the effective date of coverage for your newborn child will be the date of his or her birth.

If you do not enroll a newborn child within the thirty-one (31) days, your next opportunity to enroll the child will be during the next Open Enrollment Period.

3. If you are a Subscriber who is enrolled as a Member, you may enroll an adopted child or child for whom you have been granted legal guardianship within thirty-one (31) days of the date the child is legally placed with you for adoption or within thirty-one (31) days of the date you are granted legal guardianship. To enroll an adopted child or a child for whom you are the legal guardian, you must submit an Enrollment Application, together with any additional fees due, to the Group. If so enrolled,



II. Enrollment and Effective Date of Coverage

the effective date of coverage for your child will be the date of legal placement of the child for adoption or the date of court ordered legal guardianship.

If you do not enroll an adopted child or a child for whom you are legal guardian within the thirty-one (31) days, your next opportunity to enroll the child will be during the next Open Enrollment Period.

the reasons explained in the "Section VII. Termination of Your Coverage" and

2. not have any unpaid financial obligations to the Healthplan or any other Cigna HealthCare Healthplan.

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C. Full and Accurate Completion of Enrollment Application

Each Subscriber must fully and accurately complete the Enrollment Application. False, incomplete or misrepresented information provided in any Enrollment Application may, in the Healthplan's sole discretion, cause the coverage of the Subscriber and/or his or her Dependents to be null and void from its inception.

D. Hospitalization on the Effective Date of Coverage

If you are confined in a hospital on the effective date of your coverage, you must notify us of such a hospitalization within two (2) days, or as soon as reasonably possible thereafter. When you become a Member of the Healthplan, you agree to permit the Healthplan to assume direct coordination of your health care. We reserve the right to transfer you to the care of a Participating Provider and/or Participating Hospital if the Healthplan Medical Director, in consultation with your attending Physician, determines that it is medically safe to do so.

If you are hospitalized on the effective date of coverage and you fail to notify us of this hospitalization, refuse to permit us to coordinate your care, or refuse to be transferred to the care of a Participating Provider or Participating Hospital, we will not be obligated to pay for any medical or hospital expenses that are related to your hospitalization following the first two (2) days after your coverage begins.

E. To be eligible to enroll as a Member, you must:

1. never have been terminated as a Member of any Cigna HealthCare Healthplan for any of

Section III. Agreement Provisions

A. Healthplan's Representations and Disclosures

1. The Healthplan is a for-profit health maintenance organization (HMO) which arranges for the provision of covered Services and Supplies through a network of Participating Providers. The list of Participating Providers is provided to all Members at enrollment without charge. If you would like another list of Participating Providers, please contact Member Services at the toll-free number found on your Cigna HealthCare ID card or visit the Cigna HealthCare web site at myCigna.com.
2. With the exception of any employed Physicians who work in a facility operated by the Healthplan (so-called "staff model" providers), the Participating Providers are independent contractors. They are not the agents or employees of the Healthplan and they are not under the control of the Healthplan or any Cigna company. All Participating Providers are required to exercise their independent medical judgment when providing care.
3. The Healthplan maintains all medical information concerning a Member as confidential in accordance with applicable laws and professional codes of ethics. A copy of the Healthplan's confidentiality policy is available upon request.
4. We do not restrict communication between Participating Providers and Members regarding treatment options.
5. Under federal law (the Patient Self Determination Act), you may execute advance directives, such as living wills or a durable power of attorney for health care, which permit you to state your wishes regarding your health care should you become incapacitated.
6. Upon your admission to a participating inpatient facility, a Participating Physician other than your PCP may be asked to direct and oversee your care for as long as you are in the inpatient facility. This Participating Physician is often referred to as an "inpatient manager" or "hospitalist."

7. The terms of this Agreement may be changed in the future either as a result of an amendment agreed upon by the Healthplan and the Group or to comply with changes in law. The Group or the Healthplan may terminate this Agreement as specified in this Agreement. In addition, the Group reserves the right to discontinue offering any plan of coverage.

8. Choosing a Primary Care Physician

When you enroll as a Member, you must choose a Primary Care Physician (PCP). Each covered Member of your family must also choose a PCP. Your PCP is your personal doctor and serves as your health care manager. If you do not select a PCP, we will assign one for you. If your PCP leaves the Cigna HealthCare network, you will be able to choose a new PCP. You may voluntarily change your PCP for other reasons but not more than once in any calendar month. We reserve the right to determine the number of times during a Contract Year that you will be allowed to change your PCP.

If you select a new PCP before the fifteenth day of the month, the designation will be effective on the first day of the month following your selection. If you select a new PCP on or after the fifteenth day of the month, the designation will be effective on the first day of the month following the next full month. For example, if you notify us on June 10, the change will be effective on July 1. If you notify us on June 15, the change will be effective on August 1.

Your choice of a PCP may affect the specialists and facilities from which you may receive services. Your choice of a specialist may be limited to specialists in your PCP's medical group or network. Therefore, you may not have access to every specialist or Participating Provider in your Service Area. Before you select a PCP, you should check to see if that PCP is associated with the specialist or facility you prefer to use. If the Referral is not possible, you should ask the specialist or facility about which PCPs can make Referrals to them, and then verify the information with the PCP before making your selection.

9. Referrals to Specialists

You must obtain a Referral from your PCP before visiting any provider other than your PCP in order for the visit to be covered. The Referral authorizes the specific number of visits that you may make to a provider within a specified period of time. If you receive treatment from a provider other than your PCP without a Referral from your PCP, the treatment is not covered.

Exceptions to the Referral Process:

If you are a female Member, you may visit a qualified Participating Provider for covered obstetrical and gynecological services, as defined in "Section IV. Covered Services and Supplies," without a Referral from your PCP.

You do not need a Referral from your PCP for Emergency Services as defined in the "Section IV. Covered Services and Supplies." In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help. You do not need a Referral from your PCP for Emergency Services, but you do need to call your PCP as soon as possible for further assistance and advice on follow-up care. If you require specialty care or a hospital admission, your PCP will coordinate it and handle the necessary authorizations for care or hospitalization.

In an emergency, you should seek immediate medical attention and then as soon as possible thereafter you need to call your PCP for further assistance and advice on follow-up care. If you require specialty care or a hospital admission, your PCP will coordinate it and handle the necessary authorization for care or hospitalization.

In an Urgent Care situation a Referral is not required but you should, whenever possible, contact your PCP for direction prior to receiving services.

You may also visit a qualified Participating Provider for covered Chiropractic Care Services, as defined in "Section IV. Covered Services and Supplies", without a Referral from your PCP.

Direct Access for Mental Health and Substance Use Disorder Services

Members covered by this Agreement are allowed direct access to a licensed/certified Participating Provider for covered Mental Health and Substance Use Disorder Services. There is no requirement to obtain a referral from your Primary Care Physician for individual or group therapy visits to the Participating Provider of your choice for Mental Health and Substance Use Disorder Services.

10. Provider Compensation

We compensate our Participating Providers in ways that are intended to emphasize preventive care, promote quality of care, and assure the most appropriate use of Medical Services. You can discuss with your provider how he is compensated by us. The methods we use to compensate Participating Providers are:

Discounted fee for service - payment for service is based on an agreed upon discounted amount for the services provided.

Capitation - Physicians, provider groups and Physician/hospital organizations are paid a fixed amount at regular intervals for each Member assigned to the Physician, provider group or Physician/hospital organization, whether or not services are provided. This payment covers Physician and/or, where applicable, hospital or other services covered under the benefit plan. Medical groups and Physician/hospital organizations may in turn compensate providers using a variety of methods.

Capitation offers health care providers a predictable income, encourages Physicians to keep people well through preventive care, eliminates the financial incentive to provide services that will not benefit the patient, and reduces paperwork.

Providers paid on a "capitated" basis may participate with us in a risk sharing arrangement. They agree upon a target amount for the cost of certain health care services, and they share all or some of the amount by which actual costs are over target. Provider services are monitored for appropriate utilization, accessibility, quality and Member satisfaction.

We may also work with third parties who administer payments to Participating Providers. Under these arrangements, we pay the third party a fixed monthly amount for these services. Providers are compensated by the third party for services provided to Healthplan participants from the fixed amount. The compensation varies based on overall utilization.

Salary - Physicians and other providers who are employed to work in our medical facilities are paid a salary. The compensation is based on a dollar amount, decided in advance each year, that is guaranteed regardless of the services provided. Physicians are eligible for any annual bonus based on quality of care, quality of service and appropriate use of Medical Services.

Incentives to Participating Providers

Cigna continuously develops programs to help you access quality, cost-effective health care. Some programs include Participating Providers receiving financial incentives from Cigna Healthplan for providing care to you in a way that meets or exceeds certain quality and/or cost-efficiency standards, when, in the Participating Provider's professional judgment, it is appropriate to do so within the applicable standard of care. For example, some Participating Providers could receive financial incentives for prescribing lower-cost prescription drugs to manage certain conditions, utilizing or referring you to alternative sites of care as determined by the plan rather than in a more expensive setting, or achieving particular outcomes for certain health conditions. Participating Providers may also receive purchasing discounts when purchasing certain prescription drugs from Cigna Healthplan affiliates. Such programs can help make you healthier, decrease your health care costs, or both. These programs are not intended to affect your access to the health care that you need. We encourage you to talk to your Participating Provider if you have questions about whether they receive financial incentives from Cigna Healthplan and whether those incentives apply to your care.

Per Diem - A specific amount is paid to a hospital per day for all health care received. The payment may vary by type of service and length of stay.

Case Rate - A specific amount is paid for all the care received in the hospital for each standard service category as specified in our contract with the provider (e.g., for a normal maternity delivery).

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11. Care Management and Care Coordination Services

Your plan may enter into specific collaborative arrangements with health care professionals committed to improving quality care, patient satisfaction and affordability. Through these collaborative arrangements, health care professionals commit to proactively providing participants with certain care management and care coordination services to facilitate achievement of these goals. Reimbursement is provided at 100% for these services when rendered by designated health care professionals in these collaborative arrangements.

Services may include, but are not limited to: professional-to-professional consultations, outreach to patients, care coordination, and other services intended to achieve improved health outcomes.

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B. Member's Rights, Responsibilities and Representations

You have the right to:

1. Medical treatment that is available when you need it and is handled in a way that respects your privacy and dignity.
2. Get the information you need about your health care plan, including information about services that are covered, services that are not covered, and any costs that you will be responsible for paying.
3. Have access to a current list of providers in our network and have access to information about a particular provider's education, training and practice.
4. Select a Primary Care Physician (PCP) for yourself and each covered Member of your family, and to change your PCP for any reason.

3. Have your medical information kept confidential by our employees and your health care provider. Confidentiality laws and professional rules of behavior allow us to release medical information only when it's required for your care, required by law, necessary for the administration of your plan or to support our programs or operations that evaluate quality and service. We may also summarize information in reports that do not identify you or any other participants specifically.
6. Have your health care provider give you information about your medical condition and your treatment options, regardless of benefit coverage or cost. You have the right to receive this information in terms you understand.
7. Learn about any care you receive. You should be asked for your consent to all care unless there is an emergency and your life and health are in serious danger.
8. Refuse medical care. If you refuse medical care, your health care provider should tell you what might happen. We urge you to discuss your concerns about care with your PCP or another Participating Physician. Your doctor will give you advice, but you will always have the final decision.
9. Be heard. Our complaint-handling process is designed to hear and act on your complaint or concern about us and/or the quality of care you receive, provide a courteous, prompt response, and to guide you through our appeals process if you do not agree with our decision.
10. Make recommendations regarding our policies on Member rights and responsibilities. If you have recommendations, please contact Member Services at the toll-free number on your Cigna HealthCare ID card.
3. Show your Cigna HealthCare ID card before you receive care.
4. Schedule a new patient appointment with any new Cigna HealthCare PCP; build a comfortable relationship with your doctor; ask questions about things you don't understand; and follow your doctor's advice. You should also understand that your condition may not improve and may even get worse if you don't follow your doctor's advice.
5. Understand your health condition and work with your doctor to develop treatment goals that you both agree upon, to the extent that this is possible.
6. Provide honest, complete information to the providers caring for you.
7. Know what medicine you take, why, and how to take it.
8. Pay all Copayments for which you are responsible at the time the service is received.
9. Keep scheduled appointments and notify the doctor's office ahead of time if you are going to be late or miss an appointment.
10. Pay all charges for missed appointments and for services that are not covered by your plan.
11. Voice your opinions, concerns or complaints to Cigna HealthCare Member Services and/or your provider.
12. Notify your employer as soon as possible about any changes in family size, address, phone number or membership status.

You represent that:

1. The information provided to us and the Group in the Enrollment Application is complete and accurate.
 2. By enrolling in the Healthplan, you accept and agree to all terms and conditions of this Agreement.
 3. By presenting your Cigna HealthCare ID card and receiving treatment and services from our Participating Providers, you authorize the following to the extent allowed by law:
 - a. any provider to provide us with information and copies of any records related to your condition and treatment;
- You have the responsibility to:**
1. Review and understand the information you receive about your health care plan. Please call Cigna HealthCare Member Services when you have questions or concerns.
 2. Understand how to obtain covered Services and Supplies that are provided under your plan.

- b. any person or entity having confidential information to provide any such confidential information upon request to us, any Participating Provider, and any other provider or entity performing a service, for the purpose of administration of the plan, the performance of any Healthplan program or operations, or assessing or facilitating quality and accessibility of health care Services and Supplies;
- c. us to disclose confidential information to any persons, company or entity to the extent we determine that such disclosure is necessary or appropriate for the administration of the plan, the performance of the Healthplan programs or operations, assessing or facilitating quality and accessibility of health care Services and Supplies, or reporting to third parties involved in plan administration; and
- d. that payment be made under Part B of Medicare to us for medical and other services furnished to you for which we pay or have paid, if applicable.

This authorization will remain in effect until you send us a written notice revoking it or for such shorter period as required by law. Until revoked, we and other parties may rely upon this authorization.

With respect to Members, confidential information includes any medical, dental, mental health, substance use disorder, communicable disease, AIDS and HIV related information and disability or employment related information.

- 4. You will not seek treatment as a Cigna HealthCare Member once your eligibility for coverage under this Agreement has ceased.

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C. 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 representative or provider designated by you to act on your behalf, unless otherwise noted.)

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

Start with Customer Service

We're here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, or a rescission of coverage, you can call us at our toll-free number and explain your concern to one of our Customer Services representatives. You can also express that concern in writing. Please call or write to us at the following:

Healthplan Name
Healthplan Address
Customer Services Toll-Free Number
that appears on your Cigna
HealthCare ID card or Benefit
Identification card.

We'll do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we'll get back to you as soon as possible, but in any case within thirty (30) days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

Any external review process available under the plan will apply to any adverse determination regarding claims subject to the federal No Surprises Act.

The Healthplan has a two step appeals procedure for coverage decisions. To initiate an appeal for most claims, you must submit a request for an appeal at the address shown above within 365 days of receipt of a denial notice. If you appeal a reduction or termination in coverage for an ongoing course of treatment that the Healthplan has previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. 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 to register your appeal by calling the toll-free number on your Cigna HealthCare ID card or Benefit Identification card.

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 fifteen (15) calendar days after we receive the appeal for a pre-service or concurrent coverage determination, and within thirty (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 fifteen calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if 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.

If you request that your appeal be expedited, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level-one appeal would be detrimental to your medical condition.

The Healthplan Medical Director, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within seventy-two (72) hours, followed up in writing.

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.

If the appeal involves a coverage decision based on issues of Medical Necessity, clinical appropriateness or experimental treatment, a medical review will be conducted by a Physician reviewer in the same or similar specialty as the care under consideration, as determined by the Healthplan Medical Director. For all other coverage plan-related appeals, a second-level review will be conducted by someone who was a) not involved in any previous decision related to your appeal, and b) not a subordinate of previous decision makers. Provide all relevant documentation with your second-level appeal request.

For required pre-service and concurrent care coverage determinations the Healthplan's review will be completed within fifteen (15) calendar days and for post-service claims, the Healthplan's review will be completed within thirty (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 fifteen (15) calendar days and to specify any additional information needed, to complete the review.

In the event any new or additional information (evidence) is considered, relied upon or generated by the Healthplan in connection with the level-two appeal, the Healthplan will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by the Healthplan, the Healthplan will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

You will be notified in writing of the decision within five (5) business days after the decision is made, and within the review time frames above if the Healthplan 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 non-authorization of an admission of continuing inpatient hospital stay. The Healthplan Medical Director, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within seventy-two (72) hours, followed up in writing.

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Independent Review Procedure

If you are not fully satisfied with the decision of the Healthplan'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 request an appeal to an

Independent Review Organization 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. The Healthplan will abide by the decision of the Independent Review Organization.

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

To request a review, you must notify the Appeals Coordinator within 180 (one hundred eighty) days of your receipt of the Healthplan level two appeal review denial. The Healthplan will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 45 days. When requested and if (a) a delay would be detrimental to your medical condition, as determined by The Healthplan Medical Director, or if (b) your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility, the review shall be completed within 72 hours.

Assistance from the State of State Name

You have the right to contact the Department of Insurance/Health Name for assistance at any time. The Regulator Name may be contacted at the following address and telephone number:

Department of Insurance/Health Name Department of
Insurance/Health Address Department of
Insurance/Health Toll Free Number

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and will include: (1) information sufficient to identify the claim; (2) the specific reason or reasons for the adverse determination; (3) reference to the specific plan provisions on which the determination is based; (4) 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; (5) a statement describing any voluntary appeal procedures offered by the plan and the

claimant's right to bring an action under ERISA section 502(a); (6) 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 an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; and (7) information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of an adverse determination will include a discussion of the decision.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is 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

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against the Healthplan 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.

Appointment of Authorized Representative

You may appoint an authorized representative to assist you in submitting a claim or appealing a claim denial. However, the Healthplan may require you to designate your authorized representative in writing using a form approved by the Healthplan. At all times, the appointment of an authorized representative is revocable by you. To ensure that a prior appointment remains valid, the Healthplan may require you to re-appoint your authorized representative, from time to time.

The Healthplan reserves the right to refuse to honor the appointment of a representative if the Healthplan reasonably determines that:

- the signature on an authorized representative form may not be yours, or

- the authorized representative may not have disclosed to you all of the relevant facts and circumstances relating to the overpayment or underpayment of any claim, including, for example, that the billing practices of the provider of medical services may have jeopardized your coverage through the waiver of the cost-sharing amounts that you are required to pay under your plan.

If your designation of an authorized representative is revoked, or the Healthplan does not honor your designation, you may appoint a new authorized representative at any time, in writing, using a form approved by the Healthplan.

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Arbitration

To the extent permitted by law, any controversy between the Healthplan and the Group, or an insured (including any legal representative acting on your behalf), arising out of or in connection with this Agreement 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 thirty (30) days of the effective date of the written notice of arbitration, each party shall choose one arbitrator within fifteen (15) working days after the expiration of such thirty (30) day period and the two (2) 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 fifteen (15) working day period, the arbitrator chosen shall choose a third (3rd) arbitrator in accordance with these requirements.

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

The arbitrator(s) shall render a decision within thirty (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 (2) arbitrators if there are three (3) 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 Agreement shall have a right to cease performance of services or otherwise refuse to carry out its obligations under this Agreement pending the outcome of arbitration in accordance with this section, except as otherwise specifically provided under this Agreement.

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IV. Covered Services and Supplies

Section IV. Covered Services and Supplies

The covered Services and Supplies available to Members under this plan are described below. Any applicable Copayments or limits are identified in the Schedule of Copayments. Unless otherwise authorized in writing by the Healthplan Medical Director, covered Services and Supplies are available to Members only if:

They are Medically Necessary and not specifically excluded in this Section or in Section V.

- **Provided by Your Primary Care Physician (PCP) or if Your PCP has given You a Referral, by another Participating Provider. However, "Emergency Services" do not require a Referral from Your PCP and do not have to be provided by Participating Providers. Also, You do not need a Referral from Your PCP for "Obstetrical and Gynecological Services," "Chiropractic Care Services," and "Urgent Care."**
- **Prior Authorization is obtained from the Healthplan Medical Director by the Participating Provider, for those services that require Prior Authorization. Services that require Prior Authorization include, but are not limited to, inpatient hospital services, inpatient services at any Other Participating Health Care Facility, residential treatment, Outpatient Facility Services, partial hospitalization, intensive outpatient programs, advanced radiological imaging, Home Health Care Services, Radiation Therapy, non-emergency ambulance, and Transplant Services.**

As determined by the Healthplan, Covered Services and Supplies may also include all charges made by an entity that has directly or indirectly contracted with the Healthplan to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies listed below.

Physician Services

All diagnostic and treatment services provided by Participating Physicians and Other Participating Health Professionals, including office visits, periodic health assessments, well-child care and routine immunizations provided in accordance with

accepted medical practices, hospital care, consultation, and surgical procedures.

Inpatient Hospital Services

Inpatient hospital services for evaluation or treatment of conditions that cannot be adequately treated on an ambulatory basis or in an Other Participating Health Care Facility. Inpatient hospital services include semi-private room and board; care and services in an intensive care unit; drugs, medications, biologicals, fluids, blood and blood products, and chemotherapy; special diets; dressings and casts; general nursing care; use of operating room and related facilities; laboratory and radiology services and other diagnostic and therapeutic services; anesthesia and associated supplies and administration services; inhalation therapy; radiation therapy; and other services which are customarily provided in acute care hospitals.

Inpatient hospital services rendered by a non-Participating Provider: Charges for services furnished by a non-Participating Provider in a Participating facility while you are receiving Participating Provider services at that Participating facility are payable at the cost-sharing level applicable to Participating Providers. The allowable amount used to determine the plan's benefit payment for the non-Participating Provider services is the amount agreed to by the non-Participating Provider and the Healthplan, or as required by applicable state or Federal law. You are responsible for applicable cost-sharing amounts (any Deductible, Copayment or Coinsurance). You are not responsible for any charges that may be made in excess of the allowable amount. If the non-Participating Provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Member Services at the phone number on your ID card.

Outpatient Facility Services

Services provided on an outpatient basis, including: diagnostic and/or treatment services; administered drugs, medications, fluids, biologicals, blood and blood products; inhalation therapy; and procedures which can be appropriately provided on an outpatient basis, including certain surgical procedures, anesthesia, and associated supplies and administration, and recovery room services.

IV. Covered Services and Supplies

Outpatient facility services rendered by a non-Participating Provider: Charges for services furnished by a non-Participating Provider in a Participating facility while you are receiving Participating Provider services at that Participating facility are payable at the cost-sharing level applicable to Participating Providers. The allowable amount used to determine the plan's benefit payment for the non-Participating Provider services is the amount agreed to by the non-Participating Provider and the Healthplan, or as required by applicable state or Federal law. You are responsible for applicable cost-sharing amounts (any Deductible, Copayment [or Coinsurance]). You are not responsible for any charges that may be made in excess of the allowable amount. If the non-Participating Provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Member Services at the phone number on your ID card.

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Emergency Services and Urgent Care

Emergency Services Both In and Out of the Service Area. In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help. You do not need a Referral for Emergency Services, but you do need to call your PCP or the Cigna HealthCare 24-Hour Health Information LineSM as soon as possible for further assistance and advice on follow-up care. If you require specialty care or a hospital admission, your PCP or the Cigna HealthCare 24-Hour Health Information LineSM will coordinate it and handle the necessary authorizations for care or hospitalization. Participating Providers are on call twenty-four (24) hours a day, seven (7) days a week, to assist you when you need Emergency Services.

If you receive Emergency Services outside the Service Area, you must notify us as soon as reasonably possible. We may arrange to have you transferred to a Participating Provider for continuing or follow-up care if it is determined to be medically safe to do so.

Emergency medical condition means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergency services means, with respect to an emergency medical condition: a medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency facility, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, or emergency department, as are required to stabilize the patient.

Urgent Care Inside the Service Area. For Urgent Care inside the Service Area, you must take all reasonable steps to contact the Cigna HealthCare 24-Hour Health Information LineSM or your PCP for direction and you must receive care from a Participating Provider, unless otherwise authorized by your PCP or the Healthplan.

Urgent Care Outside the Service Area. In the event you need Urgent Care while outside the Service Area, you should, whenever possible, contact the Cigna HealthCare 24 Hour Health Information LineSM or your PCP for direction and authorization prior to receiving services.

IV. Covered Services and Supplies

Urgent Care is defined as medical, surgical, hospital and related health care services and testing which are not Emergency Services, but which are determined by the Healthplan Medical Director in accordance with generally accepted medical standards to have been 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 are scheduled to receive services. Such care includes but is not limited to: dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that you should not travel due to any medical condition.

Continuing or Follow-up Treatment. Continuing or follow-up treatment, whether in or out of the Service Area, is not covered unless it is provided or arranged for by your PCP, a Participating Physician or upon Prior Authorization of the Healthplan Medical Director.

Notification, Proof of a Claim, and Payment. Inpatient hospitalization for any Emergency Services or Urgent Care requires notification to and authorization by the Healthplan Medical Director. Notification of inpatient hospitalization is required as soon as reasonably possible, but no later than within forty- eight (48) hours of admission. This requirement shall not cause denial of an otherwise valid claim if you could not reasonably comply, provided that notification is given to us as soon as reasonably possible. If you receive Emergency Services or Urgent Care from non-Participating Providers, you must submit a claim to us no later than sixty (60) days after the first service is provided. The claim shall contain an itemized statement of treatment, expenses, and diagnosis. This requirement shall not cause denial of an otherwise valid claim if you could not reasonably comply, provided you submit the claim and the itemized statement to us as soon as reasonably possible. Coverage for Emergency Services and Urgent Care received through non-Participating Providers shall be limited to covered services to which you would have been entitled under this Agreement. Emergency Services received through non-Participating Providers shall be reimbursed as indicated below. Urgent Care received through non- Participating Providers shall be reimbursed at the prevailing rate for self-pay patients in the area where the services were provided.

Emergency Services rendered by a non-Participating Provider. Emergency Services are covered at the cost-sharing level applicable to Participating Providers.

The allowable amount used to determine the plan's benefit payment for covered Emergency Services rendered in a non-Participating Hospital, or by a non-Participating Provider in a Participating Hospital, is the amount agreed to by the non-Participating provider and the Healthplan, or as required by applicable state or Federal law.

The allowable amount used to determine the plan's benefit payment when Emergency Services result in a non-Participating Hospital admission is the median amount negotiated with Participating facilities.

You are responsible for applicable cost-sharing amounts (any Deductible, Copayment or Coinsurance). You are not responsible for any charges that may be made in excess of the allowable amount. If the non-Participating Provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Member Services at the phone number on your ID card.

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Ambulance Service

Licensed ambulance services to the nearest appropriate provider or facility where the needed medical care and treatment can be provided.

Air ambulance services rendered by a non-Participating Provider: Covered air ambulance services are payable at the cost-sharing level applicable to Participating Providers. The allowable amount used to determine the plan's benefit payment for covered air ambulance services rendered by a non-Participating Provider is the amount agreed to by the non-Participating Provider and the Healthplan, or as required by applicable state or Federal law. You are responsible for applicable cost-sharing amounts (any Deductible, Copayment or Coinsurance). You are not responsible for any charges that may be made in excess of the allowable amount. If the non-Participating Provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Member Services at the phone number on your ID card.

IV. Covered Services and Supplies

Breast Reconstruction and Breast Prostheses

Following a mastectomy, the following Services and Supplies are covered:

- 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;
- post-operative breast prostheses; and
- mastectomy bras and prosthetics, limited to the lowest cost alternative available that meets prosthetic placement needs.

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

Clinical Trials

This benefit plan covers routine patient care costs and services related to an approved clinical trial for a qualified individual. The individual must be eligible to participate according to the trial protocol and EITHER of the following conditions are met:

- health care provider and has concluded
- that the individual's participation in such trial would be appropriate, or
- the individual provides medical and scientific information establishing that the individual's participation in the qualified trial would be appropriate.

In addition to qualifying as an individual, the clinical trial must also meet certain criteria in order for patient care costs and services to be covered: it is a phase I, phase II, phase III or phase IV clinical trial conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition that meets ANY of the following criteria:

it is a Federally funded trial: The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

- National Institutes of Health (NIH)
- Centers for Disease Control and Prevention (CDC)

Agency for Health Care Research and Quality (AHRQ)

Centers for Medicare and Medicaid Services (CMS)

• A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA)

• A qualified non-governmental research entity identified in NIH guidelines for center support grants.

Or ANY of the following:

Department of Energy

Department of Defense

Department of Veteran's Affairs

if BOTH of the following conditions are met:

study or investigation has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigations used by the National Institutes of Health assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

The benefit plan does not cover ANY of the following services associated with a clinical trial:

services that are not considered routine patient care costs/services, including the following:

- the investigational drug, device, item, or service that is provided solely to satisfy data collection and analysis needs.

IV. Covered Services and Supplies

an item or service that is not used in the direct clinical management of the individual

- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis
- an item or service provided by the research sponsors free of charge for any person enrolled in the trial
- travel and transportation expenses unless otherwise covered under the plan, including, but not limited to the following:
 - fees for personal vehicle, rental car, taxi, medical van, ambulance, commercial airline, train
 - mileage reimbursement for driving a personal vehicle
 - lodging
 - meals

Examples of Routine Patient Care Costs and Services include:

- Radiological services
- Laboratory services
- Intravenous therapy
- Anesthesia services
- Hospital services
- Physician services
- Office visits
- Hospital room and board, and medical supplies that typically would be covered under the plan for an individual who is not enrolled in a clinical trial.

Clinical trials conducted only by out-of-network providers will be covered at Out-of-Network benefit levels as described in the schedule only when the following conditions are met:

In-Network providers are not participating in the clinical trial

the clinical trial is conducted outside the individual's state of residence.

The Qualified Individual's plan provides coverage for out of network services.

Durable Medical Equipment

Purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Participating Physician and provided by a vendor approved by the Healthplan for use outside a Participating Hospital or Other Participating Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a member's misuse are the member's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the Healthplan Medical Director.

Durable Medical Equipment is defined as items which hroutine patient costs obtained out-of-network when are designed for and able to withstand repeated usnon-network benefits do not exist under the plan by more than one person; customarily serve a medical purpose; generally are not useful in the absence of illness or injury; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs and dialysis machines.

Durable Medical Equipment items that are not covered, include but are not limited to those that are listed below.

Bed related items: bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including non-power mattresses, custom mattresses and posturepedic mattresses.

Bath related items: bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats and spas.

Chairs, Lifts and Standing Devices: computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized - manual hydraulic lifts are covered if patient is two of metabolism (e.g. disorders of amino acid or organic acid metabolism).

- **Fixtures to real property:** ceiling lifts and wheelchair ramps.
- **Car/van modifications**

IV. Covered Services and Supplies

- **Air quality items:** room humidifiers, vaporizers, air purifiers, and electrostatic machines.
- **Blood/injection related items:** blood pressure cuffs, centrifuges, nova pens and needle-less injectors.
- **Other equipment:** heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adapters, Enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

Enteral Nutrition

Medically Necessary medical foods that are specially formulated for enteral feedings or oral consumption. Coverage includes medically approved formulas prescribed by a Physician for treatment of inborn errors of metabolism (e.g. disorders of amino acid or organic acid metabolism).

External Prosthetic Appliances and Devices

The initial purchase and fitting of external prosthetic appliances and devices that are ordered by a Participating Physician, available only by prescription and are necessary for the alleviation or correction of illness, injury or congenital defect.

External prosthetic appliances and devices include prostheses/prosthetic appliances and devices, orthoses and orthotic devices, braces and splints.

Prostheses/Prosthetic Appliances and Devices

Prostheses/Prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

- limb prostheses;
- Terminal devices such as hands or hooks;
- Speech prostheses; and
- Facial Prostheses

Orthoses and orthotic devices

Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

Non-foot orthoses - only the following non-foot orthoses are covered:

- a. Rigid and semi-rigid custom fabricated orthoses;
- b. Semi-rigid pre-fabricated and flexible orthoses; and
- c. Rigid pre-fabricated orthoses including preparation, fitting and basic additions, such as bars and joints.

Custom foot orthotics - custom foot orthoses are only covered as follows:

- a. For Members with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy
- b. and peripheral vascular disease);
- b. When the foot orthosis is an integral part of a leg brace, and it is necessary for the proper functioning of the brace;
- c. When the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputation) and is necessary for the alleviation or correction of illness, injury, or congenital defect; and
- d. For Members with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot, and there is reasonable expectation of improvement.

IV. Covered Services and Supplies

The following are specifically excluded orthosis and orthotic devices:

Prefabricated foot orthoses;

Cranial banding/cranial orthoses/other similar devices are excluded, except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;

- Orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- Non-foot Orthoses primarily used for cosmetic rather than functional reasons; and
- Non-foot Orthoses primarily for improved athletic performance or sports participation.

Braces

A brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

The following braces are specifically excluded:

Copes scoliosis braces.

Splints

A splint is defined as an appliance for preventing movement of joints or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

Replacement due to regular wear. Replacement for damage due to abuse or misuse by the member will not be covered; and

Replacement required because anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.

Replacement due to a surgical alteration or revision of the impacted site.

Coverage for replacement is limited as follows:

No more than once every 24 months for Members 19 years of age and older;

- No more than once every 12 months for Members 18 years of age and under;

The following are specifically excluded external prosthetic appliances and devices:

External and internal power enhancements;

- Power controls for prosthetic limbs and terminal devices; and
- Myoelectric prosthesis peripheral nerve stimulators.

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Family Planning Services (Contraception and Voluntary Sterilization)

Family planning services including: medical history; physical examination; related laboratory tests; medical supervision in accordance with generally accepted medical practice; other Medical Services; information and counseling on contraception; implanted/injected contraceptives; and, after appropriate counseling, Medical Services connected with surgical therapies (vasectomy or tubal ligation).

Family Planning Services- Men's Family Planning

Charges for Men's family planning, counseling, testing and sterilization (e.g. vasectomies), excluding reversals.

Foot Disorders – Medically Necessary

Medically Necessary foot care for diabetes, peripheral neuropathies and peripheral vascular disease.

IV. Covered Services and Supplies

Gene Therapy

Charges for gene therapy products and services directly related to their administration are covered when Medically Necessary. Gene therapy is a category of pharmaceutical products approved by the U.S. Food and Drug Administration (FDA) to treat or cure a disease by:

- replacing a disease-causing gene with a healthy copy of the gene.
- inactivating a disease-causing gene that may not be functioning properly.
- introducing a new or modified gene into the body to help treat a disease.

Each gene therapy product is specific to a particular disease and is administered in a specialized manner. The Healthplan determines which products are in the category of gene therapy, based in part on the nature of the treatment and how it is distributed and administered.

Coverage includes the cost of the gene therapy product; medical, surgical, and facility services directly related to administration of the gene therapy product; and professional services.

Gene therapy products and their administration are covered when approved by the Healthplan Medical Director and received at a facility that is designated by the Healthplan to provide the specific gene therapy service. Gene therapy products and their administration at other participating facilities are not covered.

Gene Therapy – Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized gene therapy procedure are covered subject to the following conditions and limitations.

Benefits for transportation and lodging are available to you only when you are the recipient of a prior authorized gene therapy, and when the gene therapy products and services directly related to their administration are received at a facility designated by the Healthplan for the specific gene therapy service. The term recipient is defined to include a person receiving prior authorized gene therapy related services during any of the following: evaluation, candidacy, event, or post care.

Travel expenses for the person receiving the gene therapy include charges for: transportation to and from the gene therapy site (including charges for a rental car used during a period of care at the facility); and lodging while at, or traveling to and from, the site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.

The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income; travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

Home Health Care Services

Home health care services are provided only if the Healthplan Medical Director has determined in advance that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for non-skilled care and/or Custodial Services (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 and/or Custodial Services needs.

Home health care services are services that can be provided during visits by Other Participating Health Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Participating Health Professionals. A visit is defined as a peri2 hours or less. Home health care services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Participating Health Professionals in providing home health care services are covered.

IV. Covered Services and Supplies

Home health care services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Participating Health Professional. Skilled nursing services or private duty nursing services are not covered outside the home and are subject to the rules that apply to home health care services. Physical, occupational, and other Outpatient Therapy services provided in the home are not subject to the Home Health Services benefit limitations in the Schedule of Copayments, but are subject to the benefit limitations described under Outpatient Therapy in the Schedule of Copayments.

Hospice Services

Hospice care services which are provided under an approved hospice care program when provided to a Member who has been diagnosed by a Participating Physician as having a terminal illness with a prognosis of six months or less to live. Hospice care services include inpatient care; outpatient services; professional services of a Physician; services of a psychologist, social worker or family counselor for individual and family counseling; and home health care services.

Hospice care services do not include the following:

- services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- services and supplies for curative or life-prolonging procedures;
- services and supplies for which any other benefits are payable under the Agreement;
- services and supplies that are primarily to aid you or your Dependent in daily living;
- services and supplies for respite (custodial) care; and
nutritional supplements, non-prescription drugs or substances, medical supplies, vitamins or minerals.

Hospice care services are services provided by a Participating Hospital; a participating skilled nursing facility or a similar institution; a participating home health care services agency; a participating hospice facility, or any other licensed facility or agency under a Medicare approved hospice care program.

A hospice care program is a coordinated, interdisciplinary program 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 illness; and a program for persons who have a terminal illness and for the families of those persons.

A hospice facility is a participating institution or portion of a facility which primarily provides care for terminally ill patients; is a Medicare approved hospice care facility; meets standards established by the Healthplan; and fulfills all licensing requirements of the state or locality in which it operates.

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Inpatient Services at Other Participating Health Care Facilities

Inpatient services at Other Participating Health Care Facilities including semi-private room and board; skilled and general nursing services; Physician visits; physiotherapy; speech therapy; occupational therapy; x-rays; and administration of drugs, medications, biologicals and fluids.

Internal Prosthetic/Medical Appliances

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

Laboratory and Radiology Services

Laboratory services and radiation therapy and other diagnostic and therapeutic radiological procedures including:

diagnostic x-ray

advanced radiological imaging, including for example CT Scans, MRI, MRA and PET scans and laboratory examinations, x-ray, radiation therapy and radium and radioactive isotope treatment and other therapeutic radiological procedures
chemotherapy.

Maternity Care Services

Medical, surgical and hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy.

Coverage for a mother and her newly born child shall be available for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician in consultation with the mother.

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Mental Health and Substance Use Disorder Services

Mental Health Services are services that are required to treat a disorder that impairs the 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 Use Disorder 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 Use Disorder.

Inpatient Mental Health Services

Inpatient services that are provided by a Participating Hospital for the treatment and evaluation of mental health. Inpatient Mental Health Services include Mental Health Residential Treatment Services.

Mental Health Residential Treatment Services

Services provided by a Participating Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of sub-acute Mental Health conditions.

Mental Health Residential Treatment Center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; (b) provides a sub-acute, structured, psychotherapeutic treatment program, under the supervision of Participating Providers; (c) provides twenty-four (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 Member 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 Participating Provider.

Outpatient Mental Health Services

Services of Participating Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis in an individual, group or Mental Health Partial Hospitalization or Mental Health Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interferes 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

IV. Covered Services and Supplies

and relapse prevention) and outpatient testing and assessment.

Mental Health Partial Hospitalization Services are rendered not less than four (4) hours and not more than twelve (12) hours in any twenty-four (24)-hour period by a certified/licensed Mental Health program in accordance with the laws of the appropriate legally-authorized agency.

Mental Health Intensive Outpatient Therapy Program

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed mental health program in accordance with the laws of the appropriate legally-authorized agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine (9) or more hours in a week.

Inpatient Substance Use Disorder Rehabilitation Services

Services provided by a facility designated by the Healthplan for rehabilitation when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Use Disorder Services include Residential Treatment Services.

Inpatient substance abuse benefits are exchangeable with partial hospitalization sessions when benefits are provided for not less than four (4) hours and not more than twelve (12) hours in any twenty four (24) hour period. The benefit exchange will be two (2) partial hospitalization sessions are equal to one (1) day of inpatient care.

Substance Use Disorder Residential Treatment Services

Services provided by a Participating Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of sub-acute Substance Use Disorder conditions.

Substance Use Disorder Residential Treatment Center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of Substance Use Disorder; (b) provides a sub-acute, structured, psychotherapeutic treatment program, under the supervision of Participating Providers; (c) provides twenty-four (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 Member is considered confined in a Substance Use Disorder Residential Treatment Center when she/he is a registered bed patient in a Substance Use Disorder Residential Treatment Center upon the recommendation of a Participating Provider.

Outpatient Substance Use Disorder Rehabilitation Services

Services for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs including outpatient rehabilitation in an individual or a Substance Use Disorder Partial Hospitalization or Intensive Outpatient Therapy Program.

Substance Use Disorder Partial Hospitalization services are rendered not less than four (4) hours and not more than twelve (12) hours in any twenty-four (24)-hour period by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally-authorized agency.

Substance Use Disorder Intensive Outpatient Therapy Program

A Substance Use Disorder Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Use Disorder Program in accordance with the laws of the appropriate legally-authorized agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine (9) or more hours in a week.

Substance Use Disorder Detoxification Services

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

Excluded Mental Health and Substance Use Disorder Services

The following are specifically excluded from Mental Health and Substance Use Disorder Services:

- 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; and
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

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Nutritional Counseling

Nutritional counseling from a Participating Provider when diet is a part of the medical management of a medical or behavioral condition.

Obstetrical and Gynecological Services

Obstetrical and gynecological services that are provided by qualified Participating Providers for pregnancy, well-women gynecological exams, primary and preventive gynecological care and acute gynecological conditions. For these services and supplies you have direct access to qualified Participating Providers; you do not need a Referral from your PCP.

Transplant Services and Related Specialty Care

Human organ and tissue transplant services at designated facilities throughout the United States. Transplant services include solid organ and bone marrow/stem cell procedures. 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, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestinal, which includes small bowel, small bowel/liver or multivisceral.

All transplant services other than cornea, must be received at a qualified or provisional Cigna LifeSOURCE Transplant Network® facility.

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 (refer to Transplant Travel Services), hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

IV. Covered Services and Supplies

Transplant Travel Services

Non-taxable travel expenses incurred by you 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 cornea transplants. Benefits for transportation and lodging are available to you only if you are 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 Member receiving authorized transplant related services during any of the following: evaluation, candidacy, transplant event, or post-transplant care. Travel expenses for the Member 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); and
- lodging while at, or traveling to and from the transplant site.

In addition to you being covered for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least eighteen (18) years of age.

The following are specifically excluded travel expenses:

- any expenses that if reimbursed would be taxable income;
- travel costs incurred due to travel within sixty (60) miles of your home;
- food and meals;
- laundry bills;
- telephone bills;
- alcohol or tobacco products; and
- charges for transportation that exceed coach class rates.

These benefits are only available when the Member is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above. Charges for the expenses of a donor companion are not covered. No benefits are available where the Member is a donor.

Oxygen

Oxygen and the oxygen delivery system. However, coverage of oxygen that is routinely used on an outpatient basis is limited to coverage within the Service Area. Oxygen Services and Supplies are not covered outside of the Service Area, except on an emergency basis.

Reconstructive Surgery

Reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement, which is accompanied by functional deficit (other than abnormalities of the jaw or related to TMJ disorder) provided that:

- the surgery or therapy restores or improves function; or
- reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or
- the surgery or therapy is performed prior to age (19) and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part.

Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the Healthplan Medical Director.

Obesity Surgery and Treatment (Bariatric) Services

Charges made for medical and surgical services for the treatment or control of clinically severe obesity as defined below, when performed at approved centers, and if the services are demonstrated, through existing peer reviewed, evidence based, scientific literature and scientifically based guidelines, to be safe and effective for the treatment or control of the condition. Clinically severe obesity is defined by the National Heart, Lung and Blood Institute (NHLBI) as a Body Mass Index (BMI) of 40 or greater without comorbidities, or a BMI of 35-39 with comorbidities. The following items are specifically excluded:

Medical and surgical services to alter appearances or physical changes that are the result of any

- medical or surgical services performed for the treatment or control of obesity or clinically severe obesity; and

Weight loss programs or treatments, whether or not they are prescribed or recommended by a Physician or under medical supervision.

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Charges made for preventive care services as defined by recommendations from the following:

- The U.S. Preventive Services Task Force (A and B recommendations);
- The Advisory Committee on Immunization Practices (ACIP) for immunizations;
- The American Academy of Pediatrics' Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care;
- The Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and
- With respect to women, evidence-informed preventive care and screening guidelines supported by the Health Resources and Services Administration.

Detailed information is available at www.healthcare.gov. For additional information on immunizations, visit the immunization schedule section of www.cdc.gov.

Short-term Rehabilitative Therapy

Short-term rehabilitative therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following limitation applies to short-term rehabilitative therapy:

occupational therapy is provided only for purposes of enabling Members to perform the activities of daily living after an illness or an injury.

Short-term Rehabilitative Therapy services that are not covered include, but are not limited to:

- sensory integration therapy; group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily-acted conditions without evidence of an underlying medical condition or neurological disorder;
- treatment for functional articulation disorder, such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or injury; and
- maintenance or preventive treatment consisting of routine, long-term or non-Medically Necessary care provided to prevent reoccurrences or to maintain the patient's current status.

If multiple outpatient services are provided on the same day they constitute one visit, but a separate Copayment will apply to the services provided by each Participating Provider.

Services that are provided by a chiropractic Physician are not covered. These services include the management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

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Virtual Care - Medical

Includes charges for the delivery of medical and health-related consultations via secure telecommunications technologies, including telephones and internet, when delivered through a contracted medical provider.

Virtual Care - Behavioral

Behavioral consultations and services via secure telecommunications technologies that include video capability, including telephones and internet, when delivered through a behavioral provider.

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SAMPLE DOCUMENT

Section V. Exclusions and Limitations

Exclusions

Any Services and Supplies which are not described as covered in "Section IV. Covered Services and Supplies" or in an attached Rider or are specifically excluded in "Section IV. Covered Services and Supplies" or an attached Rider are not covered under this Agreement.

In addition, the following are specifically excluded Services and Supplies:

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public school system or school district.
3. Care for military service disabilities treatable through governmental services if the Member is legally entitled to such treatment and facilities are reasonably available.
4. Treatment of an illness or injury which is due to war, declared or undeclared.
5. Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement. For example, if the Healthplan determines that a Participating Provider is or has waived, reduced, or forgiven any portion of its charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for Covered Services and Supplies (as shown on the Schedule of Copayments) without the Healthplan's express consent, then the Healthplan in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Services and Supplies, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the Participating Provider represents that you remain responsible for any amounts that this Agreement does not cover. In the exercise of that discretion, the Healthplan shall have the right to require you to provide proof sufficient to the Healthplan that you have made your required cost share payment(s) prior to the payment of any benefits by the Healthplan. This exclusion includes, but is not limited to, charges of a Non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received. Provided further, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a prescription medication or other product, the Healthplan may, in its sole discretion, reduce the benefits provided under the plan in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the pharmacy or other third party, and/or exclude from accumulation toward any Plan Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Coinsurance you are required to pay.
6. 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.
7. Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services do not include routine patient care costs related to qualified clinical trials as described in your plan document. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be.
 - not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or
 - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or
 - the subject of review or approval by an Institutional Review Board for the proposed use, or
 - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to

qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.

In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by the Healthplan or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

8. Cosmetic Surgery or Therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
9. The following services are excluded from coverage regardless of clinical indications:
 - Macromastia or Gynecomastia Surgeries;
 - Surgical treatment of varicose veins;
 - Abdominoplasty;
 - Panniculectomy;
 - Rhinoplasty;
 - Blepharoplasty;
 - Redundant skin surgery;
 - Removal of skin tags;
 - Acupressure;
 - Craniosacral/cranial therapy;
 - Dance therapy, movement therapy;
 - Applied kinesiology;
 - Rolfing;
 - Prolotherapy; and
 - Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
10. Treatment of surgical and non-surgical TMJ disorder.
11. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to teeth are covered.
12. Unless otherwise covered as a basic benefit, 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.
13. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under "Section IV. Covered Services and Supplies."
14. Infertility services, infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
15. Reversal of male and female voluntary sterilization procedures.
16. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
17. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
18. Non-medical counseling and/or ancillary services including, but not limited to Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return-to-work services, work hardening programs, and driving safety courses.
19. 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.

20. 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 "Inpatient Hospital Services," "Outpatient Facility Services," "Home Health Care Services" or "Breast Reconstruction and Breast Prostheses" sections of "Section IV. Covered Services and Supplies."
21. Private hospital rooms and/or private duty nursing except as provided in the "Home Health Care Services" section of "Section IV. Covered Services and Supplies."
22. 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 illness or injury.
23. Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
24. Hearing aids, including, but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
25. Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
26. Corrective lenses and associated services (prescription exams and fittings), including eyeglass lenses and frames and contact lenses, except for the first pair of contact lenses, or first set of eyeglass lenses and

V. Exclusions and Limitations

- frames, and associated services following treatment of keratoconus or post-cataract surgery.
27. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
 28. Treatment by acupuncture.
 29. All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Section IV. Covered Services and Supplies."
 30. 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.
 31. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
 32. 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.
 33. Dental implants for any condition.
 34. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
 35. Blood administration for the purpose of general improvement in physical condition.
 36. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
 37. Cosmetics, dietary supplements and health and beauty aids.

38. All nutritional supplements and formulae are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
39. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
40. Massage Therapy.
41. Charges for the delivery of medical and health related services via telecommunications technologies, including telephone and internet, unless provided as specifically described in "Section IV. Covered Services and Supplies".

In addition to the provisions of this "Exclusions and Limitations" section, you will be responsible for payments on a fee-for-service basis for Services and Supplies under the conditions described in the "Reimbursement" provision of "Section VI. Other Sources of Payment for Services and Supplies."

Limitations

Circumstance Beyond the Healthplan's Control. To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within our control results in our facilities, personnel, or financial resources being unavailable to provide or arrange for the provisions of a basic or supplemental health service or supplies in accordance with this Agreement, we will make a good faith effort to provide or arrange for the provision of the services or supplies, taking into account the impact of the event.

Section VI. Other Sources of Payment for Services and Supplies

Subrogation

If you are injured or rendered ill under circumstances which create a liability for a third party to pay claims or damages to you, we are subrogated to all rights, claims, or interests which you may have against such third party and shall have automatically, without the need to file with such third party or with a tribunal or court of competent jurisdiction, a lien upon the proceeds of any recovery from such third party as follows:

- We have the right to recover from the third party the cost of the care which we have provided for you; and
- We have the right to recover from the third party to the extent of payments that we have paid for Services and Supplies and not rendered services. If permitted by applicable state or federal law, we may require you, your guardian, personal representative, estate, Dependents, or survivors, as appropriate, to assign your claim or cause of action against the third party to us and to execute and deliver such instruments to secure our right to that claim.

You must assist the Healthplan in pursuing any subrogation rights by providing requested information.

Reimbursement

If you receive any payment from any third party, including, but not limited to, any worker's compensation fund or carrier, Medicare, a tortfeasor, or any other insurance carrier, for Services and Supplies either rendered or paid by us, we have the right to receive reimbursement from you to the extent that you have received payment as follows:

- We have the right to receive reimbursement from you to the extent of the prevailing rates for your care and treatment which we have directly rendered or arranged to be rendered for you; and
- We have the right to receive reimbursement from you to the extent that we have paid for Services and Supplies and not rendered services.

If you are not reimbursed from any third party because you knowingly chose not to apply for, or to reject, or to waive coverage, then you will be responsible for payment of all expenses for services rendered on account of such injury or illness. In addition, you will be obligated to fully cooperate with us in any attempts to recover such expenses from your employer if your employer failed to take the steps required by law or regulation to obtain such coverage.

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Coordination of Benefits

This section applies if you are covered under another plan besides this health plan and determines how the benefits under the plans will be coordinated. If you are covered by more than one health benefit plan, you should file all claims with each plan.

A. Definitions

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

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 neither can be purchased by the general public nor is 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 type of coverage you have in these three (3) categories shall be treated as a separate Plan. Also, if a Plan has two parts and only one part has coordination of benefit rules, each of the parts shall be treated as a separate Plan.

Closed Panel Plan

A Plan that provides health benefits primarily in the form of services through a panel of employed or contracted providers and that limits or excludes

VI. Other Sources of Payment for Services and Supplies

benefits provided 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 determines and provides or pays its benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines and may reduce its benefits after taking into consideration the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover the Reasonable Cash Value of any services it provided to you from the Primary Plan.

Allowable Expense

The amount of charges considered for payment under the plan for a Covered Service prior to any reductions due to coinsurance, copayment or deductible amounts. If the Healthplan contracts with an entity to arrange for the provision of Covered Services through that entity's contracted network of health care providers, the amount that the Healthplan has agreed to pay that entity is the allowable amount used to determine your coinsurance or deductible payments. If the 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 an Allowable Expense include, but are not limited to the following:

1. 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.
2. If you are confined to a private hospital room and no Plan provides coverage for more than the semi-private room, the difference in cost between the private and semi-private rooms is not an Allowable Expense.
3. If you are covered by two or more Plans that provide services or supplies on the basis of usual and customary fees, any amount in excess of the highest usual and customary fee is not an Allowable Expense.

4. If you are covered by one Plan that provides services or supplies on the basis of usual and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
5. If your 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 you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Examples of Plan provisions are second surgical opinions and pre-certification of admissions or services.

Claim Determination Period

A calendar year, but it does not include any part of a year during which you are not covered under this Agreement or any date before this section or any similar provision takes effect.

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 by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

B. 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 the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

1. The Plan that covers you as a Subscriber or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
2. If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent



VI. Other Sources of Payment for Services and Supplies

whose birthday falls first in the calendar year as a Subscriber or employee;

3. If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
 - a. 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;
 - b. then, the Plan of the parent with custody of the child;
 - c. then, the Plan of the spouse of the parent with custody of the child;
 - d. then, the Plan of the parent not having custody of the child, and
 - e. finally, the Plan of the spouse of the parent not having custody of the child.
4. The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as a laid-off or retired employee (or as that employee's Dependent) 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.
5. The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) 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.
6. If one of the Plans that covers you is issued out of the state whose laws govern this Agreement and 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 you 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.

C. Effect on the Benefits of this Agreement

If we are the Secondary Plan, we may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than one hundred (100%) percent of the total of all Allowable Expenses.

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

As to each claim that is submitted, we shall determine the following:

1. Our obligation to provide Services and Supplies under this Agreement;
2. Whether a benefit reserve has been recorded for you; and
3. Whether there are any unpaid Allowable Expenses during the Claim Determination Period.

If there is a benefit reserve, we shall use the benefit reserve recorded for you to pay up to one hundred (100%) percent of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve shall return to zero (0) and a new benefit reserve shall be calculated for each new Claim Determination Period.

D. Recovery of Excess Benefits

If we provide Services and Supplies that should have been paid by the Primary Plan or if we



VI. Other Sources of Payment for Services and Supplies

provide services in excess of those for which we are obligated to provide under this Agreement, we shall have the right to recover the actual payment made or the Reasonable Cash Value of any services.

We shall have the sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments were made; any insurance company; health care Plan or other organization. If we request, you shall execute and deliver to us such instruments and documents as we determine are necessary to secure its rights.

E. Right to Receive and Release Information

We, without consent of or notice to you, may obtain information from and release information to any Plan with respect to you in order to coordinate your benefits pursuant to this section. You shall provide us with any information we request in order to coordinate your benefits pursuant to this section.

F. Coordination of Benefits with Medicare

If you, your spouse, or your Dependent are covered under this Plan and qualify for Medicare, federal law determines which plan is the primary payer and which is the secondary payer. The primary payer always determines covered benefits first, without considering what any other coverage will pay. The secondary payer determines its coverage only after the primary plan has completed its determination.

When Medicare is the Primary Payer

Medicare will be the primary payer and this Plan will be the secondary payer, even if you don't elect to enroll in Medicare or you receive services from a provider who does not accept Medicare payments, in the following situations:

- COBRA or State Continuation: You, your spouse, or your covered Dependent qualify for Medicare for any reason and are covered under this Plan due to COBRA or state continuation of coverage.
- Retirement or Termination of Employment: You, your spouse, or your covered Dependent qualify for Medicare for any reason and are

covered under this Plan due to your retirement or termination of employment.

- Disability: You, your spouse, or your covered Dependent qualify for Medicare due to a disability, you are an active Employee, and your Employer has fewer than 100 employees.
- Age: You, your spouse, or your covered Dependent qualify for Medicare due to age, you are an active Employee, and your Employer has fewer than 20 employees.
- End Stage Renal Disease (ESRD): You, your spouse, or your covered Dependent qualify for Medicare due to End Stage Renal Disease (ESRD) and you are an active or retired Employee. This plan will be the primary payer for the first 30 months. Beginning with the 31st month, Medicare will be the primary payer.

When This Plan is the Primary Payer

This Plan will be the primary payer and Medicare will be the secondary payer in the following situations:

- Disability: You, your spouse, or your covered Dependent qualify for Medicare due to a disability, you are an active Employee, and your Employer has 100 or more employees.
- Age: You, your spouse, or your covered Dependent qualify for Medicare due to age, you are an active Employee, and your Employer has 20 or more employees.
- End Stage Renal Disease (ESRD): You, your spouse, or your covered Dependent qualify for Medicare due to End Stage Renal Disease (ESRD) and you are an active or retired Employee. This plan is the primary payer for the first 30 months. Beginning with the 31st month, Medicare will be the primary payer.

Domestic Partners

Under federal law, when Medicare coverage is due to age, Medicare is always the primary payer and this Plan is the secondary payer for a person covered under this Plan as a Domestic Partner. However, when Medicare coverage is due to

disability, the Disability payer explanations above will apply.

IMPORTANT: If you, your spouse, or your Dependent do not elect to enroll in Medicare Parts A and/or B when first eligible, or you receive services from a provider who does not accept Medicare payments, this Plan will calculate payment based on what should have been paid by Medicare as the primary payer if the person had been enrolled or had received services from a provider who accepts Medicare payments. A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective.

Failure to Enroll in Medicare

If you, your spouse, or your Dependent do not enroll in Medicare Parts A and/or B during the person's initial Medicare enrollment period, or the person opts out of coverage, the person may be subject to Medicare late enrollment penalties, which can cause a delay in coverage and result in higher Medicare premiums when the person does enroll. It can also result in a reduction in coverage under Medicare Parts A and B. If you are planning to retire or terminate employment and you will be eligible for COBRA, state Continuation, or retiree coverage under this Plan, you should enroll in Medicare before you terminate employment to avoid penalties and to receive the maximum coverage under Medicare. Please consult Medicare or the Social Security Administration for more information.

Assistance with Medicare Questions

For more information on Medicare's rules and regulations, contact Medicare toll-free at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. You may also contact the Social Security Administration toll-free at 1-800-772-1213, at www.ssa.gov, or call your local Social Security Administration office.

Section VII. Termination of Your Coverage

We may terminate your coverage for any of the reasons stated below.

Termination For Cause

Upon written notice to the Group and you, we may terminate your coverage or your Membership Unit's coverage for cause if any of the following events occur:

1. You omit, misrepresent, or provide materially false information in the Enrollment Application; in which case, we may render coverage of a Membership Unit to be null and void from the effective date of coverage;
2. You permit a non-Member to use your Cigna HealthCare ID card or to falsely obtain services and supplies;
3. You obtain or attempt to obtain services and supplies by means of false, misleading or fraudulent information, acts or omissions;
4. You fail to pay any Copayment, or any other amount due as a result of receiving services and supplies;
5. You fail to establish a satisfactory Physician/patient relationship with any Participating Physician after we assist you in establishing such a relationship;
6. Your behavior, in our sole opinion, is disruptive, unruly, abusive or uncooperative to such an extent that we are seriously impaired in our ability to provide services to you or to any other Member; or
7. You threaten the life or wellbeing of any Healthplan employee, Participating Provider, or another Member.

In no event, however, will we terminate your coverage due to health status or utilization of services and supplies.

Termination By Reason of Ineligibility

When you fail to meet the eligibility criteria in "Section II. Enrollment and Effective Date of Coverage" as either a Subscriber or Dependent, your coverage under this Agreement shall cease. Coverage of all Members within a Membership Unit shall cease when the Subscriber fails to meet the eligibility criteria. The

Group shall notify us of all Members who fail to meet the eligibility criteria.

Unless otherwise provided by law, if you fail to meet the eligibility criteria your coverage shall cease at midnight of the day that the loss of eligibility occurs, and we shall have no further obligation to provide Services and Supplies.

Termination By Termination of This Agreement

This Agreement may be terminated for any of the following reasons:

1. Termination for Non-Payment of Fees. We may terminate this Agreement for the Group's non-payment of any Prepayment Fees owed to us.
2. Termination on Notice. The Group, without cause, may terminate this Agreement upon sixty (60) days prior written notice to us. We, without cause, may terminate this Agreement upon either: (i) ninety (90) days prior written notice to the Group of our decision to discontinue offering this particular type of coverage; or (ii) one hundred eighty (180) days prior written notice to the Group of our decision to discontinue offering all coverage in the applicable market. If coverage is terminated in accordance with (i) above, the Group may purchase a type of coverage currently being offered in that market.
3. Termination for Fraud or Misrepresentation. We may terminate this Agreement upon thirty (30) days prior written notice to the Group if, at any time, we determine that the Group has performed an act or practice that constitutes fraud or has intentionally misrepresented a material fact.
4. Termination for Violation of Contribution or Participation Rules. We may terminate this Agreement upon thirty (30) days prior written notice to the Group if, after the initial twelve (12) month or other specified time period, it is determined that the Group is not in compliance with the participation and/or contribution requirements as established by us.
5. Termination Due to Association Membership Ceasing. If this Agreement covers an association, we may terminate this Agreement in accordance with applicable state or federal law as to a member

VII. Termination of Your Coverage

of a bona fide association if the member is no longer a member of the bona fide association.

6. Termination in Accordance with State and/or Federal law. We may terminate this Agreement upon prior notice to the Group in accordance with any applicable state and/or federal law.

Termination Effective Date. Coverage under this Agreement shall terminate at midnight of the date of termination provided in the written notice, except in the case of termination for non-payment of fees, in which case this Agreement shall terminate immediately upon our notice to the Group.

Notice of Termination to Members. If this Agreement is terminated for any reason in this section, the Group shall notify you of the termination effective date and any applicable rights you may have.

Responsibility for Payment. The Group shall be responsible for the payment of all Prepayment Fees due through the date on which coverage ceases. You shall be financially responsible for all services rendered after that date. The Group shall be responsible for providing appropriate notice of cancellation to all Members in accordance with applicable state law. If the Group fails to give written notice to you prior to such date, the Group shall also be financially responsible for, and shall submit to us, all Prepayment Fees due until such date as the Group gives proper notice.

Rescissions

Your coverage may not be rescinded (retroactively terminated) by the Healthplan or the plan sponsor unless: (1) the plan sponsor or an individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud; or (2) the plan sponsor or individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

Certification of Creditable Coverage Upon Termination

We will issue you a Certification of Creditable Group Health Plan Creditable Coverage as required by law and based on information provided to us by the Group at the following times:

1. When your coverage is terminated for cause or by reason of ineligibility or you otherwise become

covered under "Section VIII. Continuation of Coverage";

2. When your continuation coverage, if you elected to receive it, is exhausted;
3. When you make a request within twenty-four (24) months after the date coverage expires under either of the above two situations; and
4. When you make a request while you are covered under this Agreement.

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Section VIII. Continuation of Coverage

Continuation of Group Coverage under COBRA

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document from the Plan Administrator.

The Plan Administrator information is provided on the page titled "ERISA Summary Plan Description," if applicable. Please contact the Plan Administrator for the name, address and phone number of the Plan's COBRA Administrator.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the

Plan because either one of the following qualifying events happens:

- 1) Your hours of employment are reduced, or
- 2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- 1) Your spouse dies;
- 2) Your spouse's hours of employment are reduced;
- 3) Your spouse's employment ends for any reason other than his or her gross misconduct;
- 4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- 5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- 1) The parent-employee dies;
- 2) The parent-employee's hours of employment are reduced;
- 3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
- 4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- 5) The parents become divorced or legally separated; or
- 6) The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides retiree health coverage

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse and

VIII. Continuation of Coverage

dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan. Coverage will continue until: (a) for you, your death; and (b) for your Dependent surviving spouse or Dependent child, up to 36 months from your death.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), or, if the Plan provides retiree coverage, commencement of a proceeding in bankruptcy with respect to the Employer, the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to your Employer.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months from the date of the qualifying event.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months from the date of the qualifying event. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months from the date of the initial qualifying event. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the Plan Administrator. You must provide a copy of the Social Security Administration's determination. Termination of coverage for all covered persons during the additional 11 months will occur if the disabled person is found by the Social Security Administration to be no longer disabled. Termination for this reason will occur on the first day of the month beginning no more than 30 days after the date of the final determination. Please refer to "Early Termination of COBRA Continuation" below for additional circumstances under which COBRA continuation may terminate before the end of the maximum period of coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months from the initial qualifying event. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator.**



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Early Termination of COBRA Continuation

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, if a covered employee enrolls in Medicare, or if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

Cost of COBRA Continuation Coverage

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150%). If you or your dependents experience a qualifying event, the Plan Administrator will send you a notice of continuation rights, which will include the required premium.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (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 Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY 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.

Conversion Available Following Continuation

If the Plan provides for a conversion privilege, the plan must offer this option within 180 days following the maximum period of continuation. However, no conversion will be provided if the qualified beneficiary

does not maintain COBRA continuation coverage for the maximum allowable period or does not otherwise meet the eligibility requirements for a conversion plan.

Service Area Restrictions

This plan includes a service area restriction which requires that all enrolled participants and beneficiaries receive services in the Employer's service area. This restriction also applies to COBRA continuation coverage. If you or your Dependents move outside the Employer's service area, COBRA continuation coverage under your current plan in your new location will be limited to emergency services only. To obtain coverage for non-emergency services, you must obtain such services from a network provider in the Employer's service area. If your Employer offers other benefit options that are available in your new location, you may be allowed to obtain COBRA continuation coverage under that option. If you or your Dependent is moving outside the Employer's service area, please contact your Employer for information on the availability of other plan options.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

IMPORTANT NOTICE

COBRA BENEFITS WILL ONLY BE ADMINISTERED ACCORDING TO THE TERMS OF THE CONTRACT. THE HEALTHPLAN WILL NOT BE OBLIGATED TO ADMINISTER OR



VIII. Continuation of Coverage

FURNISH ANY COBRA BENEFITS AFTER THE CONTRACT HAS TERMINATED.

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Conversion to Non-Group (Individual) Coverage

If you have properly elected and completed any COBRA continuation or other continuation coverage (i.e. completed the maximum coverage period under the continuation coverage), and are not eligible for other individual insurance coverage on a guarantee issue basis, you may apply to the Healthplan for conversion to non-group (individual) coverage. If you do not elect, fail to properly elect or fail to complete any COBRA continuation coverage or other continuation coverage for which you are eligible, and are eligible for other individual coverage on a guarantee issue basis, conversion to non-group coverage is not available to you.

You must continue to reside in the Service Area in order to be eligible for non-group (individual) coverage. You may apply for non-group (individual) coverage as follows:

A. Conversion After Loss of Subscriber Eligibility

If you, as the Subscriber, are no longer eligible for coverage under this Agreement for any reason other than the reasons stated in the "Termination for Cause" or "Termination By Termination of Agreement" provisions of "Section VII. Termination of Your Coverage," and are not eligible for other individual coverage on a guarantee issue basis, you may apply for conversion to non-group (individual) coverage. You must apply and pay the applicable prepayment fee within thirty-one (31) days of the loss of group coverage. At the time of conversion to non-group (individual) coverage, you may also apply for non-group (individual) coverage for Dependents who were Members at the time of your loss of eligibility. If your application and all non-group fees, including all fees for the period since the termination of group coverage, are submitted within thirty-one (31) days of the loss of group coverage, your non-group (individual) coverage will be effective as of the date of such termination.

B. Conversion Upon Death or Divorce of Subscriber

If you are a Dependent who has lost eligibility for coverage under this Agreement due to the death or divorce of the Subscriber, and are not eligible for other individual coverage on a guarantee issue basis, you may apply for conversion to non-group (individual) coverage under the provisions of paragraph A of this section.

C. Conversion Upon Meeting Age Limitation

If you are a Dependent who has lost eligibility for coverage under this Agreement due to your attainment of an age limitation identified in the Agreement, and are not eligible for individual coverage on a guarantee issue basis, you may apply for conversion to non-group (individual) coverage under the provisions of paragraph A of this section.

D. Conversion After Expiration of COBRA or Other Continuation Coverage

A Member whose COBRA or other continuation coverage has expired after the maximum coverage period, and are not eligible for other individual coverage on a guarantee issue basis, may apply for conversion to non-group (individual) coverage under the provisions of paragraph A of this section.

The services and supplies, terms and conditions of the non-group (individual) coverage, including premiums, Copayments and deductibles, if any, shall be in accordance with the rules of Healthplan in effect at the time of conversion and will not necessarily be identical to the services and supplies provided under this Agreement.

Continuation of Coverage Under FMLA

If the Group is subject to the requirements of the federal law known as the Family and Medical Leave Act of 1993, as amended (FMLA), the Subscriber shall have coverage under this Agreement during a leave of absence if the Subscriber is an eligible employee under the terms of FMLA and the leave of absence qualifies as a leave of absence under FMLA.

In such a case, the Subscriber shall pay to the Group the portion of the Prepayment Fee, if any, that the Subscriber would have paid had the Subscriber not taken leave and the Group shall pay the Healthplan the



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Prepayment Fee for the Subscriber as if the Subscriber had not taken leave.

NOTICE OF FEDERAL REQUIREMENTS - UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to military leaves of absence. These requirements apply to medical coverage for you and your Dependents.

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.

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Continuation of Coverage

You may continue coverage for yourself and your Dependents as follows:

You may continue benefits, by paying the required premium 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 apply or return to work; and
- the date the policy cancels.

Your employer may charge you and your Dependents up to 102% of the total premium.

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your Agreement.

Reinstatement of Benefits

If your coverage ends during the leave because you do not elect USERRA, or an available conversion plan at the expiration of USERRA, and you are reemployed 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 a Pre-existing Conditions Limitation (PCL) or waiting period, if any, that was not yet satisfied

Section IX. Miscellaneous**Additional Programs**

We may, from time to time, offer or arrange for various entities to offer discounts, benefits or other consideration to our Members for the purpose of promoting the general health and well being of our Members. We may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Group. Contact us for details regarding any such arrangements.

Administrative Policies Relating to this Agreement

We may adopt reasonable policies, procedures, rules and interpretations that promote orderly administration of this Agreement.

Assignability

The benefits under this Agreement are not assignable unless agreed to by the Healthplan. The Healthplan may, at its option, make payment to the Subscriber for any cost of any Covered Services and Supplies received by the Subscriber or Subscriber's covered Dependents from a non-Participating Provider. The Subscriber is responsible for reimbursing the non-Participating Provider.

Clerical Error

No clerical error on the part of the Healthplan shall operate to defeat any of the rights, privileges or benefits of any Member.

Entire Agreement

This Agreement constitutes the entire Agreement between the Healthplan, the Group, and Members and supersedes any previous agreement. Only an officer of the Healthplan has authority to waive any conditions or restrictions of this Agreement, extend the time for making payment, or bind the Healthplan by making any promise or representation, or by giving or receiving any information. No change in this Agreement shall be valid unless stated in a Rider or an amendment attached hereto signed by an officer of the Healthplan. In the event of any direct conflict between information contained in the Group Service Agreement and other collaterals, the terms of the Group Service Agreement shall govern.

No Implied Waiver

Failure by the Healthplan, the Group, or a Member to avail themselves of any right conferred by this Agreement shall not be construed as a waiver of that right in the future.

Notice

The Healthplan, the Group, and the Member shall provide all notices under this Agreement in writing, which shall be hand-delivered or mailed, postage pre-paid, through the United States Postal Service to the addresses set forth on the Cover Sheet.

Records

The Healthplan maintains records regarding Members, but the Healthplan shall not be liable for any obligation dependent upon information from the Group prior to receipt by the Healthplan in a form satisfactory to the Healthplan. Incorrect information furnished by the Group may be corrected, if the Healthplan shall not have acted to its prejudice by relying on it. All records of the Group and the Healthplan that have a bearing on coverage of a Member shall be open for review by the Healthplan, the Group or the Member at any reasonable time.

Service Marks

The Cigna HealthCare 24 Hour Health Information LineSM and Cigna LifeSOURCE Transplant Network[®] are registered service marks of Cigna Corporation.

Severability

If any term, provision, covenant or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of this Agreement shall remain in full force and effect and shall in no way be affected, impaired, or invalidated.

Successors and Assigns

This Agreement shall be binding upon and shall inure to the benefit of the successors and assigns of the Group and the Healthplan, but shall not be assignable by any Member.

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Covered Services and Supplies	Copayments
<p>Inpatient Hospital Services</p> <ul style="list-style-type: none"> Semi Private Room and Board Laboratory, Radiology and other Diagnostic and Therapeutic Services Administered Drugs, Medications, Biologicals and Fluids Special Care Units Operating Room, Recovery Room Anesthesia Inhalation Therapy Radiation Therapy and Chemotherapy 	<p>\$ZZZ Copayment per admission after Plan Deductible</p> <p>The Inpatient Hospital Copayment will be waived if you are readmitted to a Participating Hospital or Skilled Nursing Facility for the same condition within 10 - 30 days of a Hospital admission</p>
<p>Physician and Surgeon Charges</p>	<p>No Charge</p>
<p>Outpatient Facility Services</p> <ul style="list-style-type: none"> Operating Room, Recovery Room, Procedures Room, and Treatment Room including: Laboratory and Radiology Services Administered Drugs, Medications, Biologicals and Fluids Anesthesia Inhalation Therapy 	<p>\$AAA Copayment per facility use after Plan Deductible</p>
<p>Physician and Surgeon Charges</p>	<p>No Charge</p>
<p>Emergency and Urgent Care Services</p> <ul style="list-style-type: none"> Physician's Office Hospital Emergency Room Urgent Care Facility or Outpatient Facility 	<p>Same as Physician Office Visit Copayment</p> <p>\$BBB Copayment per visit</p> <p>The emergency room Copayment will be waived if you are admitted to a participating hospital directly from the emergency room</p> <p>\$CC Copayment per visit</p> <p>The urgent care facility Copayment will be waived if you are admitted to a participating hospital directly from the urgent care facility</p>
<p>Ambulance Services</p>	<p>No Charge</p>
<p>Diabetic Services and Supplies</p>	

Covered Services and Supplies	Copayments
Self Management Courses and Training	Same as Physician Office Visit Copayment
Supplies	(Provided under the Supplemental Prescription Drug Pharmacy Rider if employer Group has purchased the Rider)
Equipment	Same as Durable Medical Equipment Copayment per item
Insulin	Provided under the Supplemental Prescription Drug Pharmacy Rider if employer Group has purchased the Rider
Durable Medical Equipment	No Charge
External Prosthetic Appliances and Devices	No Charge
Family Planning Services for Men	
Office Visits (Tests, Counseling)	Same as Physician Office Visit Copayment
Surgical Sterilization Procedures	Same as Inpatient Hospital, Outpatient Facility or Physician Office Visit Copayment, depending on facility used
Family Planning Services for Women	
Office Visits (Tests, Counseling)	No Charge
Surgical Sterilization Procedures	No Charge
Home Health Care Services	No Charge
60 day maximum per Member per Contract Year, the limit is not applicable to Mental Health and Substance Use Disorder conditions. Maximum of 16 hours in total per day	
Hospice Services	
Inpatient Services	No Charge after Plan Deductible
Outpatient Services	No Charge
Inpatient Services at Other Participating Health Care Facilities	
60 days maximum per Member per Contract Year	

Covered Services and Supplies	Copayments
Rehabilitation Hospital	No Charge after Plan Deductible
Skilled Nursing Facility and Sub-Acute Facilities	No Charge after Plan Deductible
Outpatient Laboratory and Radiology Services	
Advanced Radiological Imaging (MRIs, MRAs, CAT scans, PET scans, etc.)	\$DDD Copayment per Scan Type (charges include all views per Scan Type per day) after Plan Deductible
Other Laboratory and Radiology Services	
Outpatient Hospital Facility	No Charge after Plan Deductible
Independent Facility	No Charge
Maternity Care Services	
Initial Office Visit to Confirm Pregnancy	Same as Physician's Office Visit Copayment
All Other Office Visits	No Charge
Delivery	Same as Inpatient Hospital
Mental Health**	
Inpatient Services (i.e. acute inpatient and residential treatment)	Same as Inpatient Hospital
Outpatient Services	
Office Visit (i.e. individual, family and group psychotherapy, medication management, and Virtual Care Behavioral consultation, etc.)	\$XX Copayment per office visit
All Other Outpatient Services (i.e. partial hospitalization, intensive outpatient services, and Virtual Care Behavioral consultation, etc.)	No Charge after Plan Deductible
Substance Use Disorder**	

Covered Services and Supplies	Copayments
<p>Inpatient Services (i.e. acute inpatient detoxification, acute inpatient rehabilitation and residential treatment)</p>	Same as Inpatient Hospital
<p>Outpatient Services</p>	
<p>Office Visit (i.e. individual, family and group psychotherapy, medication management, and Virtual Care Behavioral consultation, etc.)</p>	\$XX Copayment per office visit
<p>All Other Outpatient Services (i.e. partial hospitalization, intensive outpatient services, and Virtual Care Behavioral consultation, etc.)</p>	No Charge after Plan Deductible
<p>Nutritional Evaluation 3 visit maximum per Member per Contract Year Visit limit will not apply to the treatment of diabetes and/or to Mental Health and Substance Use Disorder conditions</p>	No Charge
<p>Genetic Counseling 3 visits per person for Genetic Counseling for both pre- and post-genetic testing; however, the 3 visit limit will not apply to Mental Health and Substance Use Disorder conditions</p>	Same as Physician’s Office Visit Copayment
<p>Gene Therapy Includes prior authorized gene therapy products and services directly related to their administration, when Medically Necessary Gene therapy must be received at an In-Network facility specifically contracted with Cigna to provide the specific gene therapy. Gene therapy at other In-Network facilities is not covered.</p>	
<p>Inpatient Services</p>	Same as Inpatient Hospital Copayment
<p>Outpatient Facility Services</p>	Same as Outpatient Facility Services Copayment

Covered Services and Supplies	Copayments
Operating Room, Recovery Room, Procedures Room, and Treatment Room including: Laboratory and Radiology Services Administered Drugs, Medications, Biologicals and Fluids Anesthesia Inhalation Therapy	
Office Visit	Same as Physician's Office Visit Copayment
Physician and Surgeon Charges	No Charge
Gene Therapy Travel Maximum	No Charge
\$10,000 per episode of gene therapy (available only for travel when approved by the Healthplan Medical Director and received at a facility that is designated by the Healthplan to provide the specific gene therapy service)	
Obesity Surgery & Treatment (Bariatric) Services	
Lifetime Maximum \$8,000 (applies to surgery only)	
Surgical Procedure	Place of Service copayment depending on facility used
Other Treatment	Place of Service copayment depending on facility used
Transplant Travel Services Maximum	
\$10,000 per transplant	
Outpatient Therapy Services, Cardiac Rehabilitation Services	\$EE Copayment per office visit
Chiropractic Care Services	\$FF Copayment per office visit
Services provided on an outpatient basis are limited to a 30 day maximum per Member per Contract Year	
Virtual Care - Medical	\$GG Copayment per office visit

Schedule of Copayments

Plan Deductible	
Individual Deductible	\$HHH
Family Deductible	\$III

Plan Deductible - The following are not subject to the Plan Deductible provision. Copayments do not apply to the Plan Deductible:

- Office visits
- Inpatient professional charges
- Outpatient professional charges
- Emergency and urgent care services
- Ambulance services
- Durable medical equipment
- External prosthetic appliances
- Home health care services; and
- Hospice outpatient services

Total Copayment Maximum *	
Individual Member Total Copayment Maximum	\$JJJJ per Contract Year
Membership Unit Total Copayment Maximum	\$KKKK per Contract Year

*All Copayments identified in this Schedule of Copayments and the Plan Deductible which have been paid by a Member for Covered Services and Supplies apply to the Total Copayment Maximum. When the Total Copayment Maximum shown above is reached, all Covered Services and Supplies, are payable by the benefit plan at 100%.

**Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized and will not count toward any plan limits that are shown in the Schedule for mental health and substance use disorder services including in-hospital services. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance use disorder expense will be determined by the Healthplan Medical Director in accordance with the applicable mixed services claim guidelines.

Supplemental Rider

Prescription Drugs

This Supplemental Rider is a part of the Cigna HealthCare Inc. Group Service Agreement ("the Agreement") and subject to all of the terms, conditions and limitations contained therein. In consideration for an additional monthly fee incorporated into the Prepayment Fee, the following supplemental Prescription Drug benefit is added to the Agreement.

I. Definitions

Biologic means a virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, protein (except any chemically synthesized polypeptide), or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound), used for the prevention, treatment, or cure of a disease or condition of human beings, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

Biosimilar means a Biologic that is highly similar to the reference Biologic product notwithstanding minor differences in clinically inactive components, and has no clinically meaningful differences from the reference Biologic in terms of its safety, purity, and potency, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 7002 (2010), and as may be amended thereafter).

Brand Drug means a Prescription Drug Product that the Healthplan identifies as a Brand Drug product across its book-of-business, principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or Biologics as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, Pharmacy, or Your Physician may be classified as a Brand Drug under the Healthplan.

Business Decision Team means a committee comprised of voting and non-voting representatives across various business units such as clinical, medical and business leadership that is duly authorized by the Healthplan to make decisions regarding coverage treatment of Prescription Drug Products or Medical Pharmaceuticals based on clinical findings provided by the P&T Committee, including, but not limited to, decisions regarding tier placement and application of utilization management to Prescription Drug Products or Medical Pharmaceuticals.

Copayment means the amount shown in the Prescription Drug Schedule of Copayments that you must pay for Prescription Drug Products. The Copayment may be a fixed dollar amount or a percentage the Healthplan charges the group with respect to the Prescription Drug Charge for a Prescription Drug Product.

Designated Pharmacy means a Network Pharmacy that has entered into an agreement with the Healthplan, or with an entity contracting on the Healthplan's behalf, to provide Prescription Drug Products or services, including, without limitation, specific Prescription Drug Products, to Healthplan enrollees on a preferred or exclusive basis. For example, a Designated Pharmacy may provide enrollees certain Specialty Prescription Drug Products that have limited distribution availability, provide enrollees with an extended days' supply of Prescription Drug Products or provide enrollees with Prescription Drug Products on a preferred cost share basis. The fact that a Pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic Drug means a Prescription Drug Product that the Healthplan identifies as a Generic Drug product at a book-of-business level principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or Biologics (including Biosimilars) as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, Pharmacy or Your Physician may be classified as a Generic Drug under the Healthplan. A Biosimilar may be classified as a Generic Drug for the purposes of benefits under the Healthplan even if it is identified as a "brand name" drug by the manufacturer, Pharmacy or Your Physician.

Home Delivery Pharmacy means a home delivery Network Pharmacy owned and operated by licensed Pharmacy affiliates of Cigna HealthCare Inc..

Maintenance Drug Product means a Prescription Drug Product that is prescribed for use over an extended period of time for the treatment of chronic or long-term conditions such as asthma, hypertension, diabetes and heart disease, and is identified principally based on consideration of available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source and clinical factors. For the purposes of benefits, the list of Your Healthplan's Maintenance Drug Products does not include compounded medications, Specialty Prescription Drug Products or Prescription Drug Products, such as certain narcotics that a Pharmacy cannot dispense above certain supply limits per Prescription Drug Order or Refill under applicable federal or state law. You may determine whether a drug is a Maintenance Drug Product by calling member services at the telephone number on Your ID card.

Medical Pharmaceutical means an FDA-approved prescription pharmaceutical product, including a Specialty Prescription Drug Product, typically required to be administered in connection with a covered service by a Physician or other health care provider within the scope of the provider's license. This definition includes certain pharmaceutical products whose administration may initially or typically require Physician oversight but may be self-administered under certain conditions specified in the product's FDA labeling. This definition does not include any charges for mobile, web-based or other electronic applications or software, even if approved for marketing as a prescription product by the FDA.

Network Pharmacy means a retail or home delivery Network Pharmacy that has:

- Entered into an agreement with the Healthplan or an entity contracting on the Healthplan's behalf to provide Prescription Drug Products to Healthplan enrollees.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated as a Network Pharmacy for the purposes of coverage under your Healthplan.

New Prescription Drug Product means a Prescription Drug Product, or new use or dosage form of a previously FDA-approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or newly-approved use or dosage form becomes available on the market following approval by the U.S. Food and Drug Administration (FDA) and ending on the date the Business Decision Team makes a Prescription Drug List coverage status decision.

[Non-PPACA] Preventive Medications are certain Prescription Drug Products used to prevent a disease that has not yet manifested itself or not yet become clinically apparent or to prevent the reoccurrence of a disease from which a person has recovered, such as Prescription Drug Products with demonstrated effectiveness in primary or secondary disease prevention. The term Non-PPACA Preventive Medication does not include medications covered at 100% as required as preventive care services by PPACA, the terms of coverage for which are addressed separately in this plan.

Pharmacy means a duly licensed pharmacy that dispenses Prescription Drug Products in a retail setting or via home delivery. A home delivery Pharmacy is a Pharmacy that primarily provides Prescription Drugs through Home Delivery.

Pharmacy & Therapeutics (P&T) Committee means a committee comprised of both voting and non-voting clinicians, Medical Directors and Pharmacy Directors that are employed by the Healthplan, and non-employees such as Participating Providers that represent a range of clinical specialties. The committee regularly reviews Prescription Drug Products, including New Prescription Drug Products, for safety and efficacy, the findings of which clinical reviews inform coverage status decisions made by the Business Decision Team. The P&T Committee's review may be based on consideration of, without limitation, U.S. Food and Drug Administration-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.

Prescription Drug List means a list that categorizes Prescription Drug Products covered under the Healthplan's Prescription Drug Benefits into coverage tiers. This list is

developed by Cigna based on clinical factors communicated by the P&T Committee, and adopted by the Group as part of the Healthplan. The list is subject to periodic review and change, and is subject to the limitations and exclusions of the Healthplan. You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.mycigna.com or by calling customer service at the telephone number on your ID card.

Prescription Drug Product means a drug, Biologic (including a Biosimilar), or other product that has been approved by the U.S. Food and Drug Administration (FDA), certain products approved under the Drug Efficacy Study Implementation review, or products marketed prior to 1938 and not subject to review and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a drug, Biologic or product that, due to its characteristics, is approved by the FDA for self-administration or administration by a non-skilled caregiver. For the purpose of benefits under the Plan, this definition also includes:

- The following diabetic supplies: alcohol pads, swabs, wipes, Glucagon/Glucagen, injection aids, insulin pump accessories (but excluding insulin pumps), needles including pen needles, syringes, test strips, lancets, urine glucose and ketone strips;
- Needles and syringes for self-administered medications or Biologics covered under the Plan's Pharmacy Benefit; and
- Inhaler assistance devices and accessories, peak flow meters.

This definition does not include any charges for mobile, web-based or other electronic applications or software, even if approved for marketing as a prescription product by the FDA.

Prescription Order or Refill means the lawful directive to dispense a Prescription Drug Product issued by a Physician whose scope of practice permits issuing such a directive.

Specialty Prescription Drug Product means a Prescription Drug Product considered by the Healthplan to be a Specialty Prescription Drug Product based on consideration of the following factors, subject to applicable law: whether the Prescription Drug Product is prescribed

and used for the treatment of a complex, chronic or rare condition; whether the Prescription Drug Product has a high acquisition cost; and, whether the Prescription Drug Product is subject to limited or restricted distribution, requires special handling and/or requires enhanced patient education, provider coordination or clinical oversight. A Specialty Prescription Drug Product may not possess all or most of the foregoing characteristics, and the presence of any one such characteristic does not guarantee that a Prescription Drug Product will be considered a Specialty Prescription Drug Product. Specialty Prescription Drug Products may vary by Healthplan benefit assignment based on factors such as method or site of clinical administration, or by tier assignment or utilization management requirements based on factors such as acquisition cost. You may determine whether a medication is a Specialty Prescription Drug Product through the internet at www.mycigna.com or by calling member services at the telephone number on your ID card.

Therapeutic Alternative means a Prescription Drug Product that is of the same therapeutic or pharmacological class, and usually can be expected to have similar outcomes and adverse reaction profiles as, another Prescription Drug Product or over-the-counter medication

Therapeutic Equivalent means a Prescription Drug Product that is a pharmaceutical equivalent to another Prescription Drug Product or over-the-counter medication.

Usual and Customary (U&C) Charge means the usual fee that a Pharmacy charges individuals for a Prescription Drug Product (and any services related to the dispensing thereof) without reference to reimbursement to the Pharmacy by third parties. The Usual and Customary (U&C) Charge includes a dispensing fee and any applicable sales tax.

II. Services and Benefits

Prescription Drug Benefits

Your Healthplan provides benefits on the Prescription Drug List for Prescription Drug Products dispensed by a Pharmacy. Details regarding your Healthplan's Covered Expenses, which for the purposes of the Prescription Drug Benefit include Medically Necessary Prescription Drug Products ordered by a Physician, limitations and exclusions are provided below and/or in your Schedule of Copayments.

Introduction

Prescription Drug List Management

The Prescription Drug List (or formulary) offered under your Group's Healthplan is managed by the Business Decision Team. Your Healthplan's coverage tiers may contain Prescription Drug Products that are Generic Drugs, Brand Drugs or Specialty Prescription Drug Products. The Business Decision Team makes the final assignment of a Prescription Drug Product to a certain coverage tier and decides whether utilization management requirements or other coverage conditions should apply to a Prescription Drug Product by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, assessments on the cost effectiveness of the Prescription Drug Product and available rebates. When considering a Prescription Drug Product for tier placement or other coverage conditions, the Business Decision Team reviews clinical and economic factors regarding enrollees as a general population across its book-of-business. Whether a particular Prescription Drug Product is appropriate for you or any of your Dependents regardless of its eligibility coverage under your Healthplan is a determination that is made by you (or your Dependent) and the prescribing Physician.

The coverage status of a Prescription Drug Product may change periodically for various reasons. For example, a Prescription Drug Product may be removed from the market, a New Prescription Drug Product in the same therapeutic class as a Prescription Drug Product may become available, or other market events may occur. Market events that may affect the coverage status of a Prescription Drug Product include, but are not limited to, an increase in the acquisition cost of a Prescription Drug Product. As a result of coverage changes, for the purposes of benefits the Healthplan may require you to pay more or less for that Prescription Drug Product, to obtain the Prescription Drug Product from a certain Pharmacy(ies) for coverage, or try another covered Prescription Drug Product(s). Please access www.mycigna.com through the Internet or call member services at the telephone

number on your ID card for the most up-to-date tier status, utilization management, or other coverage limitations for a Prescription Drug Product.

Benefits for Prescription Drug Products

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy for Medically Necessary Prescription Drug Products ordered by a Physician, your plan will provide coverage for those expenses as shown in the Schedule of Copayments. Your benefits may vary depending on which of the Prescription Drug List tiers the Prescription Drug Product is listed, or the Pharmacy that provides the Prescription Drug Product.

Coverage under your Healthplan's Prescription Drug Benefits also includes Medically Necessary Prescription Drug Products dispensed pursuant to a Prescription Order or Refill issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a Dependent is issued a Prescription Order or Refill for Medically Necessary Prescription Drugs Products as part of the rendering of emergency services and the Healthplan determines that it cannot reasonably be filled by a Network Pharmacy, the prescription will be covered pursuant to the, as applicable, Copayment or Coinsurance for the Prescription Drug Product when dispensed by a Network Pharmacy.

Any Prescription Drug Product not listed on the Prescription Drug List that is not otherwise excluded and the Healthplan or its Review Organization approves as Medically Necessary shall be covered at the coverage tier with the highest cost-share requirement as set forth in the Schedule.

The amount you or your Dependent pays for any excluded Prescription Drug Product or other product or service will not be included in calculating any applicable Healthplan Out-of-Pocket Maximum. You are responsible for paying 100% of the cost (the amount the Pharmacy charges you) for any excluded Prescription Drug Product or other product, and any negotiated Prescription Drug Charge will not be available to you.

Reimbursement/Filing a Claim

Retail Pharmacy



Prescription Drug Rider

When you or your Dependents purchase your Prescription Drug Products through a retail Network Pharmacy, you pay any applicable Copayment or Deductible shown in the Schedule of Benefits at the time of purchase. You do not need to file a claim form unless you purchase a Prescription Drug Product at a non-Network Pharmacy.

Home Delivery Pharmacy

To purchase Prescription Drug Products from a home delivery Network Pharmacy, see your home delivery drug introductory kit for details, or contact member services for assistance.

Prior Authorization Requirements

Coverage for certain Prescription Drug Products prescribed to you requires your Physician to obtain prior authorization from the Healthplan or its Review Organization. The reason for obtaining prior authorization from the Healthplan is to determine whether the Prescription Drug Product is Medically Necessary in accordance with the Healthplan's coverage criteria. Coverage criteria for a Prescription Drug Product may vary based on the clinical use for which the Prescription Order or Refill is submitted, and may change periodically based on changes in, without limitation, clinical guidelines or practice standards, or market factors.

If the Healthplan or its Review Organization reviews the documentation provided and determines that the Prescription Drug Product is not Medically Necessary or otherwise excluded, your Healthplan will not cover the Prescription Drug Product. The Healthplan, or its Review Organization, will not review claims for excluded Prescription Drug Products or other services to determine if they are Medically Necessary, unless required by law.

When Prescription Drug Products that require prior authorization are dispensed at a Pharmacy, you or your prescribing Physician are responsible for obtaining prior authorization from the Healthplan. If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed by the Pharmacy, you can ask us to consider reimbursement after you pay for and receive the Prescription Drug Product. You will need to pay for the Prescription Drug Product at the Pharmacy prior to submitting a reimbursement request.

When you submit a claim on this basis, you will need to submit a paper claim using the form that appears on www.mycigna.com.

Step Therapy

Certain Prescription Drug Products are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products you are required to try a different Prescription Drug Product(s) first, unless you satisfy the coverage exception criteria. You may identify whether a particular Prescription Drug Product is subject to step therapy requirements through the Internet at www.mycigna.com or by calling member services at the telephone number on your ID card.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the Schedule of Benefits. For a single Prescription Order or Refill, you may receive a Prescription Drug Product up to the stated supply limit.

Some products are subject to additional supply limits, quantity limits or dosage limits based on coverage criteria that the Healthplan has approved based on consideration of the P&T Committee's clinical findings. Coverage criteria is subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a dispensing supply limit or similar limit or requirement at www.mycigna.com or by calling customer services at the telephone number on your ID card.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products. If you require Specialty Prescription Drug Products, the Healthplan may direct you to a Designated Pharmacy with whom the Healthplan has an arrangement to provide those Specialty Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you will not receive coverage for that Specialty Prescription Drug Product.

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug

Products, the Healthplan may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will not receive coverage for that Prescription Drug Product.

Coupons, Incentives and Other Communications

At various times, the Healthplan or its designee may send mailings to you or your Dependents or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you or your Dependents, at your discretion, to purchase the described Prescription Drug Product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a particular medication is appropriate for your medical condition. The Healthplan and its affiliates are not responsible in any way for any decision you make in connection with any coupon, incentive, or other offer you may receive from a pharmaceutical manufacturer or Physician.

New Prescription Drug Products

The Business Decision Team may or may not place a New Prescription Drug Product on a Prescription Drug List tier upon its market entry. The Business Decision Team will use reasonable efforts to make a tier placement decision for a New Prescription Drug Product within six months of its market availability. The Business Decision Team's tier placement decision shall be based on consideration of, without limitation, the P&T Committee's clinical review of the New Prescription Drug Product and economic factors. If a New Prescription Drug Product not listed on the Prescription Drug List is approved by the Healthplan or its Review Organization as Medically Necessary in the interim, the New Prescription Drug Product shall be covered at the applicable coverage tier as set forth in The Schedule.

III. Limitations

Each Prescription Order or refill shall be limited as follows:

- to up to a consecutive thirty (30) day supply at a retail Network Pharmacy, unless limited by the drug manufacturer's packaging; or
- to up to a consecutive ninety (90) day supply at a home delivery Participating Pharmacy, unless limited by the drug manufacturer's packaging; or
- to a dosage and/or dispensing limit as determined by the P&T Committee.

IV. Member Payments

Covered Prescription Drug Products purchased at a Pharmacy are subject to any applicable Copayments or Coinsurance shown in The Schedule of Copayments, as well as any limitations or exclusions set forth in this plan. Please refer to The Schedule of Copayments for any required Copayments or Coinsurance.

Copayment

Your plan requires that you pay a Copayment for covered Prescription Drug Products as set forth in the Prescription Drug Schedule of Copayments.

After satisfying the applicable annual Deductible set forth in the Prescription Drug Schedule of Copayments, your costs for a covered Prescription Drug Product dispensed by a Participating Pharmacy and that is subject to a fixed dollar Copayment requirement, will be the lowest of the following amounts:

- the fixed dollar Copayment for the Prescription Drug Product set forth in the Prescription Drug Schedule of Copayments; or
- the Prescription Drug Charge; or
- the Network Pharmacy's submitted Usual and Customary (U&C) Charge, if any.

Payments

Any reimbursement due to you under this plan for a covered Prescription Drug Product dispensed by a Pharmacy may be determined by applying the Deductible, if any, and/or Pharmacy Coinsurance amount set forth in The Schedule to the average wholesale price (or "AWP"), or other benchmark price the Healthplan applies, for a Prescription Drug Product dispensed by a Pharmacy. Your reimbursement, if any, for a covered Prescription Drug Product dispensed by a Pharmacy will never exceed the

average wholesale price (or other benchmark price applied by the Healthplan) for the Prescription Drug Product.

When a treatment regimen contains more than one type of Prescription Drug Products that are packaged together for you, or your Dependent's, convenience, any applicable Copayment may apply to each Prescription Drug Product.

You will need to obtain prior approval from the Healthplan or its Review Organization for any Prescription Drug Product not listed on the Prescription Drug List that is not otherwise excluded. If the Healthplan or its Review Organization approves coverage for the Prescription Drug Product because it meets the applicable coverage exception criteria, the Prescription Drug Product shall be covered at the applicable coverage tier as set forth in The Schedule.

The amount you or your Dependent pays for any excluded Prescription Drug Product or other product or service will not be included in calculating any applicable plan Out-of-Pocket Maximum. You are responsible for paying 100% of the cost (the amount the Pharmacy charges you) for any excluded Prescription Drug Product or other product.

Reimbursement/Filing a Claim

When you or your Dependents purchase your Prescription Drug Product through a Participating Pharmacy, you pay any applicable Copayment or Deductible shown in Prescription Drug Schedule of Copayments at the time of purchase. You do not need to file a claim form for a Prescription Drug Product obtained at a Participating Pharmacy unless you pay the full cost of a Prescription Drug Product at a Participating Pharmacy and later seek reimbursement for the Prescription Drug Product under the Healthplan or you dispute the accuracy of your payment. For example, if you must pay the full cost of a Prescription Drug Product to the retail Participating Pharmacy because you did not have your ID card, then you must submit a claim to the Healthplan for any reimbursement or benefit you believe is due to you. If, under this example, your payment to the retail Participating Pharmacy for the covered Prescription Drug Product exceeds any applicable fixed dollar Copayment, then you will be reimbursed the difference, if any, between the applicable fixed dollar Copayment and the Prescription Drug Charge for the Prescription Drug Product.

You can obtain a claim form through the website shown on your ID card or by calling member services at the telephone number on your ID card.

Important Information

Rebates and Other Payments

This Healthplan or its affiliates may receive rebates or other remuneration from pharmaceutical manufacturers in connection with certain medications covered under the Agreement's medical benefit by the Healthplan and Prescription Drug Products included on the Prescription Drug List. These rebates or remuneration are not obtained on you or your Group's behalf or for your benefit.

This Healthplan and its affiliates are not obligated to pass these rebates on to you, or apply them to your Deductible if any or take them into account in determining your Copayments. Healthplan and its affiliates or designees may also conduct business with various pharmaceutical manufacturers separate and apart from the benefits set forth in this this Rider or other medication benefits offered under the Agreement. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Rider or the Agreement. Healthplan and its affiliates are not required to pass on to you, and do not pass on to you, such amounts.

V. Exclusions

Except as otherwise set forth in this Rider, coverage for Prescription Drug Products is subject to the exclusions and limitations set forth in the "Exclusions and Limitations" Section of the Agreement. In addition, any services or benefits related to Prescription Drug Products, which are not described in this Supplemental Rider, are excluded from coverage under the Agreement. By way of example, but not of limitation, the following are specifically excluded services and benefits:

Coverage for Prescription Drug Products for the amount dispensed (days' supply) which exceeds the applicable supply limit, or is less than any applicable supply minimum, set forth in the Schedule of Copayments, or quantity limit or dosage limit set by the P&T Committee.

- More than one Prescription Order or Refill for a given prescription supply period for the same Prescription Drug Product prescribed by one or more Physicians and dispensed by one or more Pharmacies.

- Prescription Drug Products dispensed outside the jurisdiction of the United States, except as required for emergency or urgent care treatment.
- Prescription Drug Products which are prescribed, dispensed or intended to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home, rehabilitation facility, or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceutical products
- Prescription Drug Products furnished by the local, state or federal government (except for a Network Pharmacy owned or operated by a local, state or federal government).
- Medications available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless state or federal law requires coverage of such medications or the Healthplan has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product.
- Certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to an over-the-counter drug(s), or are available in over-the-counter form. Such determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision.

Injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised injectable drugs: injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents.

- Any drugs that are experimental or investigational, within the meaning set forth in the Agreement.

Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, Substance Use Disorder or other health care technologies, supplies, treatments, procedures,

drug or Biologic therapies or devices that are determined by the utilization review Physician to be:

- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
- 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;
- the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this plan; or
- the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this plan.

In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by the Healthplan or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

- Prescription and non-prescription supplies other than supplies covered as Prescription Drug Products.
- Implantable contraceptive products covered under your Plan's Medical Benefits.
- Any fertility product prescribed to treat infertility.
- Prescription Drug Products used for the treatment of male or female sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmia, hypoactive sexual desire disorder and decreased libido.

- Vitamins, except prenatal vitamins that require a Prescription Order or Refill, unless coverage for such product(s) is required by federal or state law.
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of sickness or injury, unless coverage for such product(s) is required by federal or state law.
- Medications used for cosmetic or anti-aging purposes, including, without limitation, medications used to reduce wrinkles, medications used to promote hair growth, or medications used to control perspiration and fade cream products.
- Any Prescription Drug Product prescribed for the purpose of appetite suppression (anorectics) or weight loss.
- Immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis [unless specifically identified on the Prescription Drug List.
- Replacement of Prescription Drug Products due to loss or theft.
- Prescription Drug Products used to enhance athletic performance.
- Prescriptions more than one year from the original date of issue
- Any ingredient(s) in a compounded Prescription Drug Product that has not been approved by the U.S. Food and Drug Administration (FDA)
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if the Healthplan determines that a provider or Pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Covered Expense (as shown on The Schedule of Copayments) without the Healthplan's express consent, then the Healthplan in its sole discretion shall have the right to deny the

payment of benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, the Healthplan shall have the right to require you to provide proof sufficient to the Healthplan that you have made your required cost share payment(s) prior to the payment of any benefits by the Healthplan. This exclusion includes, but is not limited to, charges of a non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received. [Provided further, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a prescription medication or other product, the Healthplan may, in its sole discretion, reduce the benefits provided under the plan in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any plan Deductible or Out-of-Pocket Maximum the value of any coupon applied to any Copayment, Deductible and/or Coinsurance you are required to pay.]

RX-3 & 4 TIER-D

(1/20)

Prescription Drug Schedule of Copayments

Certain Specialty Prescription Drug Products are only covered when dispensed by a home delivery Network Pharmacy,. Specialty Prescription Drug Products are limited to up to a consecutive 30-day supply per Prescription Order or Refill.

Maintenance Drug Products

Maintenance Drug Products may be filled in an amount up to a consecutive 90 day supply per Prescription Order or Refill at a retail Designated Pharmacy.

In this context, a retail Designated Pharmacy is a retail Network Pharmacy that has contracted with the Healthplan for dispensing of covered Prescription Drug Products, including Maintenance Drug Products, in 90-day supplies per Prescription Order or Refill. Please see our website at www.CIGNA.com or call the Member Services number on your ID card for a list of retail Designated Pharmacies that offer a 90-day supply of Prescription Drug Products.

SAMPLE DOCUMENT

**Pharmacy Schedule
(Schedule of Copayments)**

Type of Drug	Copayment		
	Retail Network Pharmacy Copayment (applies to each 30 day supply.)	Retail Designated Pharmacy Copayment (applies to each 90 day supply)	Home Delivery Network Pharmacy Copayment (applies to each 90 day supply.)
Tier 1 Generic Drugs on the Prescription Drug List.	\$ LL	\$OO	\$RR
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	\$MM	\$PP	\$SS
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List.	\$NN	\$QQ	\$TT

Out-of-Network Certificate

SAMPLE DOCUMENT

The benefits described in the pages to follow are underwritten by Connecticut General Life Insurance Company.

*Home Office: Bloomfield, Connecticut
Mailing Address: Hartford, Connecticut 06152*

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

a Cigna company (called CG) certifies that it insures certain Employees for the benefits provided by the following policy:

POLICYHOLDER: SAMPLE PLAN

GROUP POLICY(S) - COVERAGE
MEDICAL EXPENSE INSURANCE

SAMPLE DOCUMENT

Corporate Secretary

GM6000 C2

V-2
CER7 M

POS-TITLE

11/01

Notice of Federal Requirements

COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY

When a person insured for benefits under this certificate who has had a mastectomy at any time, decides to have breast reconstruction, based on consultation between the attending Physician and the patient, the following benefits will be subject to the same coinsurance and deductibles which apply to other plan benefits:

- surgical services for reconstruction of the breast on which the mastectomy was performed;
- surgical services for reconstruction of the non-diseased breast to produce a symmetrical appearance;
- post-operative breast prostheses; and
- mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic replacement needs.

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

If you have any questions about your benefits under this Plan, please call the number on your ID card or contact your Employer.

MATERNITY HOSPITAL STAY

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law 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 issuer 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 your and your Dependents.

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

The Schedule

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

Schedule of Out-of-Network Medical Benefits

For You and Your Dependents

Covered Expenses	Payments
Contract Year Maximum	Unlimited
Individual Out-of-Pocket Maximum	\$AAAA
Family Out-of-Pocket Maximum (See section entitled "Full Payment Area")	\$BBBB
Major Medical Deductible	
Individual	\$CCCC
Family	\$DDDD
<p>After Major Medical Deductibles totaling the amount shown at right have been applied in a Contract Year for either (a) you and your Dependents or (b) your Dependents, any Medical Deductible will be waived for your family for the rest of that Contract Year.</p> <p>Listed below are the Deductibles paid by you and the Benefit Percentage paid by CG for Covered Expenses incurred for:</p>	
Inpatient Hospital	\$EEE per admission Deductible then 60% after Major Medical Deductible
Outpatient Facility	\$FF per visit Deductible then 60% after Major Medical Deductible
Durable Medical Equipment	Not Covered
External Prosthetic Appliances	Not Covered
Home Health Care Maximum	60% after Major Medical Deductible
40 days per Contract Year	
Laboratory and Radiology Outpatient Services	
Outpatient Advanced Radiological Imaging (Scan Types: MRIs, MRAs, CAT scans, PET scans etc.) <small>GM6000 06BNR4</small>	\$GGG per Scan Type (charges include all views per Scan Type per day) then 60% after Major Medical Deductible
Other Laboratory and Radiology Services	60% after Major Medical Deductible
Mental Health and Substance Abuse	

Out-of-Network Medical Benefits

Services**	
Inpatient Mental Health Maximum	Same as Inpatient Hospital
Outpatient Individual Mental Health Maximum	60% after Major Medical Deductible
Outpatient Group Mental Health Maximum	60% after Major Medical Deductible
Mental Health Intensive Outpatient Therapy Program GM6000 SCH35	60% after Major Medical Deductible
Inpatient Substance Abuse Rehabilitation Maximum	Same as Inpatient Hospital
Outpatient Individual Substance Abuse Rehabilitation Maximum	60% after Major Medical Deductible
Substance Abuse Intensive Outpatient Therapy Program GM6000 SCH35	60% after Major Medical Deductible
Substance Abuse Detoxification Services	
Inpatient	Same as Inpatient Hospital
Outpatient	60% after Major Medical Deductible
Prescription Drugs	Not Covered
Skilled Nursing Facility Maximum 60 days per Contract Year	60% after Major Medical Deductible
All Other Covered Expenses	60% after Major Medical Deductible

The day limits, visit limits and dollar maximums (other than Out-of-Pocket Maximums) shown in this Schedule will be reduced by the number of days, visits or equivalent dollar amounts for which you receive Basic Benefits in the same Contract Year.

Maximum Reimbursable Charge - In-Network covered services are paid based on the fee agreed upon with the provider. Out-of-network covered services are paid based on the Maximum Reimbursable Charge. For this plan, the Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or

supply or the 70th percentile of charges made by providers of such service or supply in the geographic area as compiled in a database that CG has selected. The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by CG. Additional information about how we determine the Maximum Reimbursable Charge is available upon request.

Note: Providers may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to any applicable deductibles, copayments and coinsurance.

****Treatment Resulting From Life Threatening Emergencies**

Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized and will not count toward any plan limits that are shown in the Schedule for mental health and substance abuse services including in-hospital services. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.

GM6000 06BNR4

POS-SOC

11/02

POS-SOC-A

7/10

SAMPLE DOCUMENT

Medical Care Benefits

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review Requirements

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 requires treatment in a Hospital or Other Health Care Facility as a registered bed patient. PAC and CSR are performed through a utilization review program by a Review Organization with which CG has contracted.

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital or Other Health Care Facility as described above. 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 or Other Health Care Facility confinement.

Covered Expenses incurred for which benefits would otherwise be payable under this plan for Hospital or Other Health Care Facility charges listed below will be reduced by 50% for:

- Hospital or Other Health Care Facility charges for Bed and Board, for treatment listed above for which PAC was not performed.

Expenses incurred for which benefits would otherwise be payable under this plan will not include:

- Hospital or Other Health Care Facility charges for Bed and Board, during a Hospital or Other Health Care Facility Confinement for which PAC is performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- any Hospital or Other Health Care Facility charges made during any Hospital or Other Health Care Facility Confinement as a registered bed patient: (a) for which PAC was performed; but (b) which was not certified as medically necessary.

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.

Pre-authorization Requirement:

Prior-authorization should be requested by you or your Dependent at least 14 days prior to the performance of diagnostic or surgical services performed at an Outpatient Surgical Facility and for magnetic resonance imaging.

Amounts for expenses incurred, which would otherwise be payable under this plan, will be reduced to 50% for services described above for which pre-authorization was not obtained.

POS-PAC(01)

1/05

How to File a Claim

If you receive out-of-network services you are responsible for filing a claim. The prompt filing of any required claim form will result in faster payment of your claim.

How to Obtain a Claim Form

You may request a claim form from Cigna HealthCare's website at myCigna.com or by calling the customer service number on the back of your Cigna HealthCare ID card. In some cases, your employer may be able to provide you with a claim form.

Doctor's Bills and Other Medical Expenses

Most providers that are not contracted to provide services under your Cigna HealthCare plan will require that you pay for services at the time services are rendered. In these cases, you will need to complete a claim form and mail in the completed form along with your receipts and itemized bills to the address on your Cigna HealthCare ID card. You will receive an Explanation of Benefits (EOB) from Cigna HealthCare describing the costs covered by your plan and the charges you pay.

Some non-contracted providers may prefer to seek payment directly from Cigna HealthCare rather than from you, in which case the provider's staff may ask you to complete a form authorizing Cigna HealthCare to pay the provider directly. The office staff will send this form, a completed hard-copy claim form and the provider's bill directly to Cigna HealthCare, and Cigna HealthCare will then send payment for covered services directly to the provider. Remember, regardless of how the provider is reimbursed, you will be responsible for paying the provider a co-payment or coinsurance, and the appropriate deductible.

Out-of-Network Medical Benefits

Your claim should be filed as soon as you have incurred covered expenses. If you have any additional bills after the first treatment, you may file them periodically.

Hospital Confinement

If possible, obtain your claim form before you are admitted to the Hospital. This form will make your admission easier and often the cash deposit usually required will be waived.

Urgent and Emergency Care

These services are covered at in-network benefit levels, though you are responsible for submitting a claim if services were received from a facility that is not contracted under your benefit plan.

POS-CLM(01)

7/06

Eligibility and Effective Date of Coverage

Who is Eligible

For Employee Insurance

You will become eligible for insurance on the later of:

your Employer's Participation Date; or

- the date you become a member of a Class of Eligible Employees.

For Dependent Insurance

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

the day you become eligible for yourself; or

- the day you acquire your first Dependent.

CLASSES OF ELIGIBLE EMPLOYEES

Each Employee who is enrolled for Basic Benefits.

Effective Date of Coverage

Employee Insurance

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

Effective Date of Your Insurance

You will become insured on the date you become eligible; provided you have agreed to make the required contribution toward the cost of Employee Insurance, if any, by signing an approved payroll deduction form.

Dependent Insurance

For your Dependents to be insured, you may 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 become eligible for Dependent Insurance for that Dependent; provided you have agreed to make the required contribution toward the cost of that insurance, if any, by signing an approved payroll deduction form. All of your Dependents, as defined, who are enrolled for Basic Benefits, will be included.

Your Dependents will be insured only if you are insured.

Exception for Newborns

Any Dependent child born while you are insured for Dependent Insurance will be insured from his date of birth.

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.

POS-ELIG(01)

11/01

Requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA'93)

These health coverage requirements do not apply to any benefits for loss of life, dismemberment or loss of income.

Any other provisions in this certificate that provide for: (a) the definition of an adopted child and the effective date of eligibility for coverage of that child; and (b) eligibility requirements for a child for whom a court order for medical support is issued; are superseded by these provisions required by the federal Omnibus Budget Reconciliation Act of 1993, where applicable.

A. Eligibility for Coverage under a Qualified Medical Child Support Order

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as

Out-of-Network Medical Benefits

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 within 31 days of the court order being issued.

Qualified Medical Child Support Order

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 requirement above.

The Qualified Medical Child Support Order may not require the health insurance policy to provide coverage for any type or form of benefit not otherwise provided under the policy.

B. 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.

The provisions in the "Exceptions for Newborns" section of this certificate that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

Any "Pre-existing Condition Limitation" in this certificate will be waived for an adopted child or a child placed for adoption.

POS-ELIG(02)

1/05

Major Medical Benefits

For You and Your Dependents

If, while insured for these benefits, you or any one of your Dependents, incurs Covered Expenses, CG will pay an amount determined as follows:

The Benefit Percentage of Covered Expenses incurred as shown in The Schedule, if any, provided that: (1) the Hospital Deductible shown in The Schedule will first be deducted from the Covered Expenses incurred for charges made by a Hospital for each separate admission as a registered bed patient; (2) the Skilled Nursing Facility Deductible shown in The Schedule, if any, will first be deducted from the Covered Expenses incurred for charges made by a Skilled Nursing Facility for each separate confinement in a Skilled Nursing Facility; (3) the Outpatient Facility Deductible shown in the Schedule, if any, will first be deducted from the Covered Expenses incurred for charges made by an Outpatient Facility for each separate visit to an Outpatient Facility; and (4) the Major Medical Deductible shown in The Schedule will first be deducted from all Covered Expenses incurred for a person in each Contract Year.

- Payment of any benefits will be subject to the Maximum Benefit Provision.

Full Payment Area

When the amount of Covered Expenses incurred by a person in a Contract Year for which no payment is provided because of plan Coinsurance and Deductibles, exclusive of the Major Medical Deductible, equals the Individual Out-of-Pocket Maximum shown in The

Out-of-Network Medical Benefits

Schedule, benefits for Covered Expenses incurred during the rest of that Contract Year will be payable at the rate of 100%.

When the combined amount of Covered Expenses incurred in a Contract Year by you and at least one of your Dependents or at least two of your Dependents for which no payment is provided because of plan Coinsurance and Deductibles, exclusive of the Major Medical Deductible, equals two or three times the Individual Out-of-Pocket Maximum shown in The Schedule, benefits for you and all of your Dependents for Covered Expenses incurred during the rest of that Contract Year will become payable at the rate of 100%, subject however to any applicable deductible amount not yet satisfied by you or any of your Dependents in that Contract Year.

Any Hospital Deductible will continue to apply even though the rate at which benefits are payable changes. The Major Medical Deductible, if not yet satisfied, will continue to apply until it is satisfied.

Maximum Benefit Provision

The total amount of Major Medical Benefits payable for all expenses incurred for a person in his lifetime will not exceed the Maximum Benefit shown in The Schedule.

Inpatient Mental Health and Substance Abuse Maximum

If Inpatient Mental Health and/or Substance Abuse coverage is provided, the total amount of Major Medical Benefits payable for all expenses incurred for a person while he is Confined in a Hospital for or in connection with mental illness, alcohol and drug abuse will not exceed the Inpatient Mental Health and Substance Abuse Maximum shown in The Schedule.

Outpatient Mental Health and Substance Abuse Maximum

If Outpatient Mental Health and/or Substance Abuse coverage is provided, the total amount of Major Medical Benefits payable for all expenses incurred for a person for or in connection with mental illness, alcohol or drug abuse while he is not Confined in a Hospital will not exceed the Outpatient Mental Health and Substance Abuse Maximum shown in The Schedule.

POS-BEN(01)

1/06

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 recommended by a Physician and are Medically Necessary, as determined by CG, for the care and treatment of an Injury or a Sickness:

- by a Hospital or Other Health Care Facility, on its own behalf, for Bed and Board and other Necessary Services and Supplies and for medical care and treatment received as an outpatient; except that, for any day of Hospital Confinement in a private room, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Hospital's most common daily rate for a semi-private room; nor will Covered Expenses include charges for any day of confinement in excess of the Maximum, if any, shown in the Schedule.
- by a Physician for professional services.
- by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.
- for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatments; chemotherapy; blood and blood products; and physical therapy provided by a licensed physical therapist.
- for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- for drugs and medicines lawfully dispensed only on the written prescription of a Physician, excluding vitamins; provided that benefits for Prescription Drugs are included in your Employer's Plan as determined from The Schedule. In any event, drugs prescribed while a person is Confined in a Hospital will be covered.

POS-BEN(02)

11/01

Breast Reconstruction and Breast Prostheses

Following a mastectomy, the following services and supplies are covered:

- 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;
- post operative breast prostheses; and
- mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs.

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

Diabetic Services and Supplies

Diabetic services and supplies for the treatment of individuals with: (1) complete insulin deficiency or Type I diabetes; (2) insulin resistance with partial insulin deficiency or Type II diabetes; and (3) elevated blood glucose levels induced by pregnancy or gestational diabetes. Medically Necessary Diabetic Services and Supplies are limited to the following:

- equipment, including blood glucose monitors; blood glucose monitors for the legally blind; insulin pumps; infusion devices & related accessories, including those adaptable for the legally blind; medical supplies for use with insulin pumps and insulin infusion pumps to include infusion sets, cartridges, syringes, skin preparation, batteries and other disposable supplies needed to maintain insulin pump therapy;
- supplies, including insulin; insulin syringes, including pen-like insulin injection devices, pen needles for pen-like insulin injection devices and other disposable parts required for insulin injection aides; pre-filled insulin cartridges for the blind; oral blood sugar control agents; glucose test strips; visual reading ketone strips; urine test strips; injection aids including those adapted for the legally blind; lancet devices and lancets for monitoring glycemic control;
- training provided by a certified, registered or licensed health care professional with recent education in diabetes management and which is part of a diabetes self-management training program that is accepted by CG, but limited to the following:

- (a) visits prescribed by the Physician upon the diagnosis of diabetes;
- (b) visits following a Physician diagnosis that represents a significant change in symptoms or condition that warrants change in self-management;
- (c) visits when reeducation or refresher training is prescribed by the Physician; and
- (d) medical nutrition therapy related to diabetes management.

Genetic Testing

Genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is only covered if:

- you have symptoms or signs of a genetically-linked inheritable disease;
- it has been determined that you are 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
- 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, 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 you are undergoing approved genetic testing or if you have an inherited disease and are a potential candidate for genetic testing. Genetic counseling is limited to three (3) visits per Contract Year for both pre and post genetic testing.

Home Health Services

Charges made for Home Health 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 Services are provided only if CG has determined that the home is a medically appropriate setting.

Home Health 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 and/or Custodial Services (e.g. bathing, eating, toileting), Home Health 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 and/or Custodial Services needs.

Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals. A visit is defined as a period of 2 hours or less. Necessary consumable medical supplies, and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health Services are covered. Home Health Services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Health Care Professional. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations. Physical, occupational, and other short-term rehabilitative therapy services provided in the home are not subject to the Home Health Services benefit limitation in the Schedule, but are subject to the benefit limitations described under "Short-term Rehabilitative Therapy" shown in The Schedule.

GM6000 05BPT104

Maternity Hospital Stay

Coverage for a mother and her newly born child shall be available for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section.

Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician in consultation with the mother.

Substance Abuse Services

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.

Substance Abuse Detoxification Services

Detoxification and related medical ancillary services 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.

Excluded Substance Abuse Services

The following are specifically excluded from 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 Agreement;
- counseling for occupational problems;
- residential care; and
- custodial care.

Orthognathic Surgery

Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct; provided:

- the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement, or;
- the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease, or

- the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, there is a high probability of significant additional improvement as determined by the utilization review Physician.

GM6000 06BNR10

Reconstructive Surgery

Reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by function deficit (other than abnormalities of the jaw or related to TMJ disorder) provided that:

- the surgery or therapy restores or improves function; or
- reconstruction is required as a result of medically necessary, non-cosmetic surgery; or
- the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part.

Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by CG.

Short-term Rehabilitative Therapy

Short-term rehabilitative therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following limitation applies to short-term rehabilitative therapy:

- occupational therapy provided only for purposes of enabling insured's to perform the activities of daily living after an illness or an injury.

Short-term Rehabilitative Therapy services that are not covered include, but are not limited to:

- sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
- treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or injury; and
- maintenance or preventive treatment consisting of routine, long-term or non-Medically Necessary care provided to prevent recurrences or to maintain the patient's current status.

Services that are provided by chiropractic Physicians are not covered. These services include the management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

Outpatient Cardiac Rehabilitation Services

Phase II cardiac rehabilitation is provided on an outpatient basis following diagnosis of a qualifying cardiac condition when Medically Necessary. Phase II is a Hospital-based outpatient program following an inpatient Hospital discharge. The Phase II program must be Physician directed with active treatment and EKG monitoring.

Phase III and Phase IV cardiac rehabilitation is not covered. Phase III follows Phase II and is generally conducted at a recreational facility, primarily to maintain the patient's status achieved through Phases I and II. Phase IV is an advancement of Phase III which includes more active participation and weight training.

GM6000 06BNR7

POS-BEN(03)

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Expenses Not Covered

Any services and supplies which are not described as "Covered Expenses" or in an attached Rider or are specifically excluded in "Covered Expenses" or an attached Rider are not covered under this policy.

Out-of-Network Medical Benefits

In addition, the following are specifically excluded services and supplies:

1. any services or supplies for which you or your Dependents receive Basic Benefits;
2. care for health conditions that are required by state or local law to be treated in a public facility;
3. care required by state or federal law to be supplied by a public school system or school district;
4. care for military service disabilities treatable through government services if you are legally entitled to such treatment and facilities are reasonably available;
5. treatment of an illness or injury which is due to war, declared or undeclared;
6. charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this policy;
7. 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;
8. any services and supplies 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 CG to be:
 - not demonstrated, through existing peer-review, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed; or
 - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or
 - the subject of review or approval by an Institutional Review Board for the proposed use; or
 - the subject of an ongoing clinical trial that meets the definition of a phase I, II or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight.

9. Cosmetic surgery or therapy. 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.
10. The following services are excluded from coverage regardless of clinical indication:
 - Macromastia or Gynecomastia Surgeries,
 - Surgical treatment of varicose veins,
 - Abdominoplasty,
 - Panniculectomy,
 - Rhinoplasty,
 - Blepharoplasty,
 - Redundant skin surgery,
 - Removal of skin tags,
 - Acupressure,
 - Craniosacral/cranial therapy,
 - Dance therapy, movement therapy,
 - Applied kinesiology,
 - Rolfing,
 - Prolotherapy, and
 - Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
11. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within 6 months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
12. Medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearances or

Out-of-Network Medical Benefits

- 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.
13. Unless otherwise covered as a basic benefit, 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.
 14. Court ordered treatment or hospitalization, unless such treatment is being sought by a Physician or otherwise covered under "Covered Expenses".
 15. Infertility services, infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
 16. Reversal of male or female voluntary sterilization procedures.
 17. Transsexual surgery, including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
 18. Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
 19. Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the policy.
 20. 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.
 21. 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.
 22. 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 "Covered Expenses".
 23. Private hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- GM6000 05BPT105
24. 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 illness or injury.
 25. Artificial aids, including, but not limited to, corrective orthopedic shoes, arch supports, orthotics, elastic stockings, garter belts, corsets, dentures and wigs.
 26. Hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
 27. Aids or devices that assist with non-verbal 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.
 28. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).

Out-of-Network Medical Benefits

29. Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
30. All injectable prescription drugs, non-injectable prescription drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Covered Expenses".
31. Routine footcare, 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.
32. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
33. Genetic screening or preimplantation 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.
34. Dental implants for any condition.
35. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in CG's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
36. Blood administration for the purpose of general improvement in physical condition.
37. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
38. Cosmetics, dietary supplements and health and beauty aids.
39. All nutritional supplements and formulae are excluded except infant formula needed for the treatment of inborn errors of metabolism which is covered as a Basic Benefit.
40. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
41. Treatment by acupuncture.
42. Telephone, e-mail and internet consultations and telemedicine.
43. Procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) stabilize periodontally involved teeth; or (c) restore occlusion.
44. Medical and surgical services for or in connection with the treatment of temporomandibular joint (TMJ) disorders.
45. For or in connection with transplant services, including but not limited to, immunosuppressive medication; organ procurement costs; or donor's medical costs.
46. Services provided for the management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.
47. Massage Therapy.
48. Services which satisfy a Deductible shown in The Schedule.
49. Durable Medical Equipment and External Prosthetic Appliances.
50. Benefits not payable according to the "General Limitations" section.
51. For or in connection with an Injury or a Sickness which is a Pre-existing Condition, unless those expenses are incurred after a continuous, one-year period during which a person is satisfying a waiting period and/or is insured for these benefits.
52. For or in connection with Mental Health and Substance Abuse Services.

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7/06

Pre-Existing Condition

A Pre-existing Condition is an Injury or a Sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a Physician during the 90 days before the earlier of the date that person: begins

an eligibility waiting period, or becomes insured for these benefits.

Exceptions to Pre-existing Condition Limitation

Pregnancy and genetic information with no related treatment, will not be considered Pre-existing conditions.

A newborn child, an adopted child, or a child placed for adoption before age 18 will not be subject to any Pre-existing Condition Limitation. If such child was covered within 30 days of birth, adoption or placement for adoption. Such waiver will apply only if less than 63 days elapse between coverage during a prior period of Creditable Coverage and coverage under this plan.

Credit for Coverage under Prior Plan

If a person was previously covered under a plan which qualifies as Creditable Coverage, the following will apply, provided he notifies the Employer of such prior coverage, and fewer than 63 days elapse between coverage under the prior plan and coverage under this plan, exclusive of any waiting period.

If you and/or your Dependent enrolled or re-enrolled in COBRA continuation coverage or state continuation coverage under the extended election period allowed in the American Recovery and Reinvestment Act of 2009 ("ARRA"), this lapse in coverage will be disregarded for the purposes of determining Creditable Coverage.

CG will reduce any Pre-existing Condition limitation period under this policy by the number of days of prior Creditable Coverage you had under a creditable health plan or policy, up to 12 months for a timely enrollee and 18 months for a Late Entrant.

Certification of Prior Creditable Coverage

You must provide proof of your prior Creditable Coverage in order to reduce a Pre-existing Condition limitation period. You should submit proof of prior coverage with your enrollment material. Certification, or other proofs of coverage which need to be submitted outside the standard enrollment form process for any reason, may be sent directly to: Eligibility Services, Cigna HealthCare, P.O. Box 9077, Melville, NY 11747-9077. You should contact the plan administrator or Cigna Customer Service Representative if assistance is needed to obtain proof of prior Creditable Coverage. Once your prior coverage records are reviewed and

credit is calculated, you will receive a notice of any remaining Pre-existing condition limitation period.

Creditable Coverage

Creditable Coverage will include coverage under: a self-insured employer group health plan; individual or group health insurance indemnity or HMO plans; state or federal continuation coverage; individual or group health conversion plans; Part A or Part B of Medicare; Medicaid, except coverage solely for pediatric vaccines; the Indian Health Service; the Peace Corps Act; a state health benefits risk pool; a public health plan; health coverage for current or former members of the armed forces and their Dependents; medical savings accounts; and health insurance for federal employees and their Dependents.

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.

POS-EXCL(02)

3/09

General Limitations - Medical Benefits

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

- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which would not have been made if the person had no insurance;
- to the extent that they are more than the Maximum Reimbursable Charge;

- for charges for unnecessary care, treatment or surgery, except as specified in any certification requirement shown in the PAC/CSR Requirements and Pre-Authorization section, of the Medical Care Benefits section;
- for or in connection with Custodial Services, education or training;
- 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;
- for charges made by an assistant surgeon in excess of 20 percent of the surgeon's allowable charge; or for charges made by a co-surgeon in excess of the surgeon's allowable charge plus 20 percent; (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.);
- for charges made by a Physician for or in connection with surgery which exceed the following maximum when two or more surgical procedures are performed at one time: the maximum amount payable will be the amount otherwise payable for the most expensive procedure, and ½ of the amount otherwise payable for all other surgical procedures;
- for charges made by any covered provider who is a member of your family or your Dependent's family.
- **Circumstance Beyond CG's Control.** To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within our control results in our facilities, personnel, or financial resources being unavailable to provide or arrange for the provision of a basic or supplemental health service or supplies in accordance with this agreement, we will make a good faith effort to provide or arrange for the provision of the services or supplies, taking into account the impact of the event.
- to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with:
 - a. "no-fault" insurance law; or

- b. an uninsured motorist insurance law.

CG will take into account any adjustment option chosen under such part by you or any one of your Dependents.

for or in connection with an elective abortion unless:

- a. the Physician certifies in writing that the pregnancy would endanger the life of the mother; or
- b. the expenses are incurred to treat medical complications due to the abortion.

POS-GL(01)

11/01

Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan (not including the Plan of Basic Benefits) 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:

- (1) Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- (2) Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.
- (3) 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 benefits provided 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 determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover the Reasonable Cash Value of any services it provided to you.

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments that are 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:

- (1) 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.
- (2) If you are 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.
- (3) If you are 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.
- (4) If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- (5) If your 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 you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Examples of Plan provisions are second surgical opinions and precertification of admissions or services.

Claim Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this Policy or any date before this section or any similar provision takes effect.

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 by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

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 the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- (1) The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- (2) If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- (3) If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
 - (a) first, if a court decree states that one parent is responsible for the child's healthcare 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;

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- (b) then, the Plan of the parent with custody of the child;
 - (c) then, the Plan of the spouse of the parent with custody of the child;
 - (d) then, the Plan of the parent not having custody of the child, and
 - (e) finally, the Plan of the spouse of the parent not having custody of the child.
- (4) The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid off or retired employee (or as that employee's Dependent) 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.
- (5) The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) 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.
- (6) If one of the Plans that cover you is issued out of the state whose laws govern this Policy, and 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 you 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 one hundred percent (100%) of the total of all Allowable Expenses.

The difference between the benefit payments 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 you. CG will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

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

- (1) CG's obligation to provide services and supplies under this policy;
- (2) whether a benefit reserve has been recorded for you; and
- (3) whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, CG will use the benefit reserve recorded for you to pay up to one hundred percent (100%) of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero (0) and a new benefit reserve shall be calculated for each new Claim Determination Period.

Recovery of Excess Benefits

If CG pays charges for benefits that should have been paid by the Primary Plan, or if CG pays charges in excess of those for which we are obligated to provide under this Policy, CG will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

CG will have the sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments were made by any insurance company, health care Plan or other organization. If we request, you shall execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

CG, without consent or notice to you, may obtain information from and release information to any other Plan

with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section.

POS-COB(01)-A

1/05

Expenses for Which a Third Party May Be Liable

This policy does not cover expenses for which another party may be responsible as a result of having caused or contributed to the Injury or Sickness. If you incur a Covered Expense for which, in the opinion of CG, another party may be liable:

1. CG shall, to the extent permitted by law, be subrogated to all rights, claims or interests which you may have against such party and shall automatically have a lien upon the proceeds of any recovery by you from such party to the extent of any benefits paid under the Policy. You or your representative shall execute such documents as may be required to secure CG's subrogation rights.
2. Alternatively, CG may, at its sole discretion, pay the benefits otherwise payable under the Policy. However, you must first agree in writing to refund to CG the lesser of:
 - a. the amount actually paid for such Covered Expenses by CG; or
 - b. the amount you actually receive from the third party for such Covered Expenses;

At the time that the third party's liability is determined and satisfied, whether by settlement, judgment, arbitration or award or otherwise.

POS-COB(02)

11/01

Payment of Benefits

To Whom Payable

All Medical Benefits are payable to you. However, at the option of CG and with the consent of the Policyholder, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

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 unpaid, CG may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; 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 when 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.

POS-PMT(01)

11/01

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 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.

Dependents

Your 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.

POS-TRM(01)

11/01

Continuation of Coverage

Continuation of Group Coverage under COBRA

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plans' Summary Plan Description or get a copy of the Plan Document from the Plan Administrator.

The Plan Administrator is provided on the page titled "ERISA Summary Plan Description", if applicable. Please contact the Plan Administrator for the name, address and phone number of the Plan's COBRA Administrator.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

1. your hours of employment are reduced, or
2. your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

1. your spouse dies;
2. your spouse's hours of employment are reduced;
3. your spouse's employment ends for any reason other than his or her gross misconduct;
4. your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. you become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. the parent-employee dies;
2. the parent-employee's hours of employment are reduced;
3. the parent-employee's employment ends for any reason other than his or his gross misconduct;
4. the parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. the parents become divorced or legally separated; or
6. the child stops being eligible for coverage under the Plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), or, if

the Plan provides retiree coverage, commencement of a proceeding in bankruptcy with respect to the Employer, the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to your Employer.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months from the date of the qualifying event. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

If the Plan provides retiree health coverage:

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan. Coverage will continue until: (a) for you, your death; and (b) for your Dependent surviving spouse or Dependent child, up to 36 months from your death.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months from the date of the initial qualifying event. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the Plan Administrator. You must provide a copy of the Social Security Administration's determination. Termination of coverage for all covered persons during the additional 11 months will occur if the disabled person is found by the Social Security Administration to be no longer disabled. Termination for this reason will occur on the first day of the month beginning no more than 30 days after the date of the final determination. Please refer to "Early Termination of COBRA Continuation" below for additional reasons COBRA continuation may terminate before the end of the maximum period of coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months from the initial qualifying event. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator.**

Early Termination of COBRA Continuation

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, if a covered employee enrolls in Medicare, or if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

Cost of COBRA Continuation Coverage

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150%). If you or your dependents experience a qualifying event, the Plan Administrator will send you a notice of continuation rights which will include the required premium.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (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 Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY 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

Conversion Available Following Continuation

If the Plan provides for a conversion privilege, the plan must offer this option within the 180 days following maximum period of continuation. However, no conversion will be provided if the qualified beneficiary

does not maintain COBRA continuation coverage for the maximum allowable period applicable (18-, 29- or 36-months) or does not meet the eligibility requirements for a conversion plan.

Service Area Restrictions

This plan includes a service area restriction which requires that all enrolled participants and beneficiaries receive services in the Employer's service area. This restriction also applies to COBRA continuation coverage. If you or your Dependents move outside the Employer's service area, coverage under your current plan in your new location will be limited to out-of network services only. To obtain in-network coverage, services must be obtained from a network provider in the Employer's service area. If your Employer offers other benefit options that are available in your new location, you may be allowed to obtain COBRA continuation under that option. If you or your Dependent is moving outside the Employer's service area, please contact your Employer for information on the availability of other plan options.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

IMPORTANT NOTICE

COBRA benefits will only be administered according to the terms of the contract. CG will not be obligated to administer or furnish any COBRA benefits after the contract has terminated.

POS-CONT(01)-A

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Continuation under Utah Law

If you continue to reside in the Service Area, you may be eligible for Continuation of Coverage if you have lost coverage under the Policy for any of the following reasons:

1. termination of your employment or membership, except for gross misconduct or non-payment of premiums;
2. your spouse or Dependent ceases to be a qualified family member; or
3. your death.

If you were continuously insured for at least six months prior to the date your coverage is terminated, you may be eligible to continue coverage, provided you are not eligible for Medicare or similar coverage under another medical plan.

Eligibility for continued coverage cannot be denied to a child because the child does not live with you, or because the child is solely dependent on your former spouse rather than on you.

You must be notified of your right to continue coverage within thirty (30) days after coverage is terminated. To exercise the continuation option, you must request continued coverage and pay the required premium within thirty (30) days of the date you received notice of termination of coverage. The amount of the required premium shall not be more than the amount of the Prepayment Fee payable under the Policy for coverage.

If you elect continuation coverage, coverage will continue until the earliest of the following dates:

1. the end of six (6) months after coverage ended;
2. you fail to pay the required premium;
3. the date on which the Policy is terminated;
4. you become eligible for similar coverage under another group policy; or
5. you violate a material condition of the Policy.

At the end of such continuation period, you may apply for conversion coverage in accordance with the "Medical Conversion Privilege" provision. This section does not apply to persons eligible for COBRA continuation or any extension of coverage required by federal law.

Medical Conversion Privilege

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy). A Converted Policy will be issued by CG only to a person who is Entitled to Convert, and only if he applies in writing and pays the first premium for the Converted Policy to CG within 60 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled To Convert

You are Entitled To Convert Medical Expense Insurance for yourself and all of your Dependents who were insured when your insurance ceased, except a Dependent who is eligible for Medicare or would be Overinsured, but only if:

you have been insured for at least three consecutive months under the policy or under it and a prior policy issued to the Policyholder;

- your insurance ceased because you were no longer in Active Service or no longer eligible for Medical Expense Insurance; or the policy cancelled;
- you are not eligible for Medicare;
- you would not be Overinsured.

If you retire you may apply for a Converted Policy within 31 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

Dependents Entitled To Convert

The following Dependents are also Entitled to Convert:

a child whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;

- a spouse whose insurance under this plan ceases due to divorce, annulment of marriage or your death;
- your Dependents, if you are not Entitled to Convert solely because you are eligible for Medicare.

but only if that Dependent: (a) was insured when your insurance ceased; (b) is not eligible for Medicare; and (c) would not be Overinsured.

Overinsured

A person will be considered Overinsured if either of the following occurs:

- his insurance under this plan is replaced by similar group coverage within 31 days;
- the benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on CG's underwriting standards for individual policies. Similar Benefits are: (a) those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; or (b) those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or (c) those available for the person by or through any state, provincial or federal law.

Converted Policy

The Converted Policy will be one of CG's current offerings at the time the first premium is received based on its rules for Converted Policies. It will comply with the laws of the jurisdiction where the group medical policy is issued. However, if the applicant for the Converted Policy resides elsewhere, the Converted Policy will be on a form which meets the conversion requirements of the jurisdiction where he resides. The Converted Policy offering may include medical benefits on a group basis. The Converted Policy need not provide major medical coverage unless it is required by the laws of the jurisdiction in which the Converted Policy is issued.

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you may convert. If you are not Entitled to Convert and your spouse and children are, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: (a) class of risk and age; and (b) benefits.

The Converted Policy may not exclude any pre-existing condition not excluded by this plan. During the period of the Medical Benefits Extension of this plan, the amount

payable under the Converted Policy will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan.

CG or the Policyholder will give you, on request, further details of the Converted Policy.

POS-CONV(01)

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Requirements of Family and Medical Leave Act of 1993

Any provisions of the policy 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 your Employer or in part by you and your Employer.

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 (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any Pre-existing Condition Limitation to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993.

Notice Of Federal Requirements - Uniformed Services Employment And Reemployment Rights Act Of 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to military leaves of absence. These requirements apply to medical coverage for you and your Dependents.

Continuation of Coverage

You may continue coverage for yourself and your Dependent as follows:

You may continue benefits, by paying the required premium 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 apply or return to work; and
- the date the policy cancels.

Your employer may charge you and your Dependents up to 102% of the total premium.

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your certificate.

Reinstatement of Benefits

If your coverage ends during the leave because you do not elect USERRA, or an available conversion plan at the expiration of USERRA, and you are reemployed 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 a Pre-existing Conditions Limitation (PCL) or waiting period, if any, 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.

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Policy 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 Policyholder 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 meet the proof of loss requirements of the policy 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 nor 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.

Legal Actions

No action at law or in equity will be brought to recover on the policy until at least 60 days after proof of loss has been filed with CG. No action will be brought at all unless brought within 3 years after the time within which proof of loss is required.

POS-PROV(01)

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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 a full-time basis 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.

Basic Benefits

The term Basic Benefits means the group coverage provided by Cigna HealthCare under its Group Service Agreement with the Employer.

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.

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

Contract Year

The term Contract Year is as defined for Basic Benefits under the Group Service Agreement.

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 not required to be performed by trained or skilled medical or paramedical personnel.

Days

Calendar days; not 24 hour periods unless otherwise expressly stated.

Deductible

The term Deductible means the expenses to be paid by you or your Dependent for services rendered. Deductibles are in addition to any other expenses incurred for which no benefits are payable because of any coinsurance factor.

Dependent

Dependents are any one of the following persons who are enrolled for Basic Benefits:

Your lawful spouse; and

- any unmarried child of yours who is:
 - less than 19 years old and primarily supported by you;
 - 19 years but less than the limiting age for Basic Benefits, enrolled in school as a full-time student and primarily supported by you; and
 - 19 or more years old and 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, including that child from the first day of placement in your home. It also includes a stepchild who lives with you.

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

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

Employee

The term Employee means a full-time employee of the Employer.

Employer

The term Employer means an employer participating in the fund which is established under the agreement of Trust for the purpose of providing insurance.

Home Health Care Plan

The term Home Health Care Plan means a plan for care and treatment of a person in his home. To qualify, the plan must be established and approved in writing by a Physician who certifies that the person would require confinement in a Hospital or Skilled Nursing Facility if he did not have the care and treatment stated in the plan.

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 or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals; or
- an institution which: (a) specializes in treatment of mental health, substance abuse or other related illnesses; (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.

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;

- an outpatient in a Hospital because of: (a) chemotherapy treatment; (b) surgery; or (c) planned tests ordered by a Physician before inpatient admission to the same Hospital;
- receiving emergency care in a Hospital for an Injury, on his first visit as an outpatient within 48 hours after the Injury is received; or
- partially Confined for treatment of mental illness, alcohol or drug abuse or other related illness. Two days of being Partially Confined will be equal to one day of being Confined in a Hospital.

The term Partially Confined means continually treated for at least 3 hours but not more than 12 hours in any 24-hour period.

Injury

The term Injury means an accidental bodily injury.

Maximum Reimbursable Charge

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.

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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.

Medical Services

Professional services of Physicians or Other Health Professionals (except as limited or excluded by this policy),

including medical, psychiatric, surgical, diagnostic, therapeutic, and preventive services.

Medically Necessary/Medical Necessity

Medically Necessary Covered Expenses are those determined by CG to be:

- required to diagnose or treat an illness, injury, disease or its symptoms; and
- in accordance with generally accepted standards of medical practice; and
- clinically appropriate in terms of type, frequency, extent, site and duration; and
- not primarily for the convenience of the patient, Physician, or other health care provider; 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.

Medicare

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

Necessary Services and Supplies

The term Necessary Services and Supplies includes:

- any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement;
- any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and
- any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

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

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."

Other Health Care Facility

Other Health Care Facilities are any facilities 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 sub-acute facilities.

Other Health Care Professional

An individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver Medical Services. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses.

Outpatient Surgical Facility

The term Outpatient Surgical Facility means a licensed institution which: (a) has a staff that includes Registered Graduate Nurses; (b) has a permanent place equipped for performing Surgical Procedures; and (c) gives continuous Physician services on an outpatient basis.

Participation Date

The term Participation Date means the later of:

the Effective Date of the policy; or

- the date on which your Employer becomes a participant in the plan of insurance authorized by the agreement of Trust.

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 in the locality where the policy is issued 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.

Qualified Medical Child Support Order

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 requirement above.

Review Organization

The term Review Organization refers to an affiliate of CG or 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.

Schedule

The section of this agreement that identifies applicable Coinsurance, Deductibles and maximums.

Sickness

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

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.

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Miscellaneous

Additional Programs

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

Assignability

The benefits under this Policy are not assignable unless agreed to by CG. CG may, at its option, make payment to the insured for any cost of any Covered Expense received by the insured or insured's covered dependents from a provider. The insured is responsible for reimbursing the non-participating provider.

POS-MISC(01)

11/01



ERISA Summary Plan Description

ERISA REQUIRED INFORMATION

The name of the Plan is: SAMPLE PLAN

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

Employer Identification Number (EIN): SAMPLE EIN

Plan Number: 001

The name, address, ZIP code and business telephone number of the Plan administrator is: SAMPLE NAME and ADDRESS

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

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

The cost of the Plan is: EMPLOYEE CONTRIBUTES FOR ALL

The Plan's fiscal year ends on: XX/XX

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

Plan Trustees

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

Plan Type

The Plan is a healthcare benefit plan.

Collective Bargaining Agreement

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.

Discretionary Authority

The Plan Administrator delegates to the Healthplan 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, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the 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 the Healthplan 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 to, at any time, 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 other 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 which the eligibility of classes of Employees may be changed or terminated, or by which part or 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) due to your or your Dependent's total disability which began prior to and has continued beyond the date the policy(s) terminates will not be affected by the Plan termination. Rights to purchase limited amounts of life and 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 date you leave Active Service;
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute, or;
- 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:

Receive Information About Your Plan and Benefits

examine, without charge, at the Plan Administrators office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and 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 available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- obtain, upon written request to the Plan Administrator, copies of documents governing the plan, including insurance contracts and 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 participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

continue health care coverage for yourself, spouse or 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 preexisting 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 issuer 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, in whole or in part, 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. 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.

Enforce Your Rights

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.

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:

ERISA Summary Plan Description

Certain services require prior authorization in order to be covered. This prior authorization is called a "preservice medical necessity determination." The Agreement 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 Agreement, 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 Agreement, 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, the Healthplan shall 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 the Healthplan's control, the Healthplan 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 the Healthplan within 45 days after receiving the notice. The determination period will be suspended on the date the Healthplan 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, the Healthplan will make the preservice determination on an expedited basis. The

Healthplan Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. The Healthplan will notify you or your representative of an expedited determination within 72 hours after receiving the request. However, if necessary information is missing from the request, the Healthplan 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 the Healthplan within 48 hours after receiving the notice. The Healthplan 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 the Healthplan's procedures for requesting a required preservice medical necessity determination, the Healthplan will notify you or your representative of the failure and describe the proper procedures for filing within five 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 required 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, the Healthplan will notify you or your representative of the determination within 24 hours after receiving the request.

Postservice Medical Necessity Determinations

When you or your representative requests a medical necessity determination after services have been rendered, the Healthplan 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 the Healthplan's control the Healthplan will

ERISA Summary Plan Description

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 the Healthplan within 45 days after receiving the notice. The determination period will be suspended on the date the Healthplan sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Postservice Claim Determinations

When you or your representative requests payment for services which have been rendered, the Healthplan will notify you or your representative 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 the Healthplan's control the Healthplan 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 the Healthplan within 45 days after receiving the notice. The determination period will be suspended on the date the Healthplan sends such a notice of missing information, and the determination period will 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, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; (6) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

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. The Healthplan will provide administrative services of the following nature: Claim Administration; Cost Containment; Financial; Banking and Billing Administration. Benefits provided under this Agreement are fully guaranteed by the Healthplan. This Agreement is issued by the Healthplan.

GSA-ERISA
6/05

FEDERAL REQUIREMENTS

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

Coverage of Students on Medically Necessary Leave of Absence

If your Dependent child is covered by this plan as a student, coverage will remain active for that child if the child is on a medically necessary leave of absence from a postsecondary educational institution (such as a college, university or trade school).

Coverage will terminate on the earlier of:

- (a) The date that is one year after the first day of the medically necessary leave of absence; or
- (b) The date on which coverage would otherwise terminate under the terms of the plan.

The child must be a Dependent under the terms of the plan and must have been enrolled in the plan on the basis of being a student at a postsecondary educational institution immediately before the first day of the medically necessary leave of absence.

The plan must receive written certification from the treating physician that the child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

A "medically necessary leave of absence" is a leave of absence from a postsecondary educational institution, or any other change in enrollment of the child at the institution that: (1) starts while the child is suffering from a serious illness or condition; (2) is medically necessary; and (3) causes the child to lose student status under the terms of the plan.

(GSA) Federal.1

10/09

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 State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.

- **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.
- **Eligibility for employment assistance under State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

Except as stated above, 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.

If your plan contains out-of-network benefits, individuals within that plan who enroll 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.

(GSA) Federal.2

4/09

Effect of Section 125 Tax Regulations on This Plan

If your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put 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 before each annual benefit period. However, exceptions are allowed if your Employer agrees and you enroll for or change coverage within 30 days of the following:

- the date you meet the Special Enrollment criteria described above; or
- 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:

1. change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
2. change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
3. change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
4. changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
5. change in residence of Employee, spouse or Dependent to a location outside of the Employer's network service area; and
6. 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 of the Employee or other person to cover a Dependent.

D. Medicare or Medicaid Eligibility/Entitlement

The Employee, spouse or Dependent 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 Spouse or Dependent Under Another Employer's Plan

You may make a coverage election change if the plan of your spouse or Dependent: (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) this Plan and the other plan have different periods of coverage or open enrollment periods.

SAMPLE DOCUMENT