Colby-Sawyer College

PREFERRED PROVIDER MEDICAL BENEFITS

PPO A RETIREES UNDER 65, ACTIVES, COBRA

EFFECTIVE DATE: July 1, 2003

ASO4
3206372

This document printed in February, 2004 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.
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Special Plan Provisions
When you select a Participating Provider, this plan pays a greater share of the costs than if you were to select a non-Participating Provider. Participating Providers include Physicians, Hospitals and Other Health Care Professionals and facilities. Consult your Physician Guide for a list of Participating Providers in your area. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

Services Available in Conjunction with Your Medical Plan
The following several pages describe helpful services available in conjunction with your medical plan. You can access these services simply by calling the toll-free number shown on the back of your ID card. These services are provided by Intracorp, a CIGNA Company and can help ensure that you and your covered Dependents benefit fully from your medical coverage.

CIGNA’S Toll-Free Care Line
CIGNA’s toll-free care line is a service provided through Intracorp, a CIGNA company. You can talk to a health care professional during normal business hours, Monday through Friday, simply by calling the toll-free number shown on your ID card.

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

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

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

1. You, your Dependent or an attending Physician can request Case Management services by calling the toll-free care line number shown on the back of your ID card during normal business hours, Monday through Friday. In addition, your Employer, a claim office or a utilization review program (see the PAC/CSR section of your certificate) may refer an individual for Case Management.

2. The Review Organization assesses each case to determine whether Case Management is appropriate.

3. You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.

4. Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available. (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.

5. The Case Manager arranges for alternate treatment services and supplies, as needed. (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).

6. The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed. (for example, by helping you to understand a complex medical diagnosis or treatment plan).

7. Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the
treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

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.

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:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- treatment of physical complications in all stages of mastectomy, including lymphedema; and
- mastectomy bras and external prostheses limited to the lowest cost alternative available that meets the patient's physical needs.

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

Coverage for 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 you and your Dependents.

Notice Regarding Provider/Pharmacy Directories and Provider/Pharmacy Networks

If your Plan utilizes a network of Providers/Pharmacies, you will automatically and without charge, receive a separate listing of Participating Providers/Pharmacies.

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


The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and reemployment in regard to military leaves of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage.

Continuation of Coverage

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

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

If your Employer is subject to federal continuation requirements called COBRA, you may continue benefits according to the federal continuation benefits shown in your certificate.

If your Employer is not subject to COBRA, you may continue benefits, by paying the required premium to your Employer, until the earliest of the following:

- 18 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 COBRA or USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your certificate.

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave because you do not elect COBRA or an available conversion plan at the expiration of COBRA 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 Condition Limitation (PCL) or waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

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

Time Frames for Requesting Reemployment

When a leave ends, you must report your intent to return to work as follows:

- For leaves of less than 31 days or for a fitness exam, by reporting to your Employer by the next regularly scheduled work day following 8 hours of travel time;
- For leaves of 31 days or more but less than 181 days, by submitting an application to your Employer within 14 days; and
- For leaves of more than 180 days, by submitting an application to your Employer within 90 days.

Consult your Employer for more details regarding your rights and your Employer's obligations for re-employment.

This section will be superseded in whole or in part by any richer state-required provision shown in this certificate.

Notice of Federal Requirements

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

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY COLBY-SAWYER COLLEGE WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CONNECTICUT GENERAL PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CONNECTICUT GENERAL DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CONNECTICUT GENERAL. BECAUSE THE PLAN IS NOT INSURED BY CONNECTICUT GENERAL, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CG," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN YOUR "EMPLOYER" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."
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 listed in the Table of Contents.
Effect of Section 125 Regulations on this Plan

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 pre-tax salary reduction put toward the cost of your benefits. Otherwise you will receive your taxable earnings as cash (salary).

Provisions in this certificate which allow for enrollment or coverage changes not consistent with Section 125 Regulations are superseded by this section.

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 you enroll for or change coverage within 30 days of the following:

Special Enrollment

Special Enrollment per federal requirements as described in the Section entitled "Eligibility - Effective Date/Exception to Late Entrant Definition" if included in this document.

Change in Status

A change in coverage due to the following changes in status: (a) change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation; (b) change in number of dependents due to birth, adoption, placement for adoption or death of a dependent; (c) 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 Family and Medical Leave Act (FMLA) or change in worksite; (d) changes in employment status of Employee, spouse or dependent resulting in eligibility or ineligibility for coverage; (e) change in residence of Employee, spouse or dependent; and (f) changes which cause a dependent to become eligible or ineligible for coverage.

Any changes in coverage must pertain directly to the change in status.

Court Order

A change in coverage due to and consistent with a court order of the Employee or other person to cover a dependent.

Medicare Eligibility/Entitlement

The Employee, spouse or dependent cancels or reduces coverage due to entitlement to Medicare, or enrolls or increases coverage due to loss of Medicare eligibility.

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.

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 Eligibility/Entitlement; or (c) this Plan and the other plan have different periods of coverage.

How to File Your Claim

The prompt filing of any required claim form will result in faster payment of your claim.

You may get the required claim forms from your Benefit Plan Administrator. All fully completed claim forms and bills should be sent directly to your servicing CG Claim Office.

Depending on your Group Insurance Plan benefits, file your claim forms as described below.

Hospital Confinement

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

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

Doctor's Bills and Other Medical Expenses

The first Medical Claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.
CLAIM REMINDERS

• BE SURE TO USE YOUR SOCIAL SECURITY AND ACCOUNT NUMBER WHEN YOU FILE CG'S CLAIM FORMS, OR WHEN YOU CALL YOUR CG CLAIM OFFICE.

YOUR ACCOUNT NUMBER IS THE 7-DIGIT POLICY NUMBER SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

• PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

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

Employee Insurance

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

Effective Date of Your Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction form, but no earlier than the date you become eligible. You will not be denied enrollment for Medical Insurance due to your health status.

You will become insured on your first day of eligibility, following your election, if you are in Active Service on the date, or if you are not in Active Service on that date due to your health status. However, you will not be insured for any loss of life, dismemberment or loss of income coverage until you are in Active Service.

You will not be enrolled for Medical Insurance if you do not enroll within 30 days of the date you become eligible, unless you qualify under the section of this certificate entitled "Enrollment Exception".

Eligibility - Effective Date

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

• you are in a Class of Eligible Employees; and
• you are an eligible, full-time Employee; and
• you normally work at least 30 hours a week.

If you were previously insured and your insurance ceased, you must satisfy the New Employee Group Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

Initial Employee Group: You are in the Initial Employee Group if you are employed in a class of employees on the date that class of employees becomes a Class of Eligible Employees as determined by your Employer.

New Employee Group: You are in the New Employee Group if you are not in the Initial Employee Group.

Eligibility 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.

Waiting Period

Initial Employee Group: None

New Employee Group: A period of time which ends on the first day of the calendar month following your date of hire

Classes of Eligible Employees

Each Employee as reported to the insurance company by your Employer.

Employee Insurance

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

Effective Date of Your Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction form, but no earlier than the date you become eligible. You will not be denied enrollment for Medical Insurance due to your health status.

You will become insured on your first day of eligibility, following your election, if you are in Active Service on the date, or if you are not in Active Service on that date due to your health status. However, you will not be insured for any loss of life, dismemberment or loss of income coverage until you are in Active Service.

You will not be enrolled for Medical Insurance if you do not enroll within 30 days of the date you become eligible, unless you qualify under the section of this certificate entitled "Enrollment Exception".

Enrollment Exception

A person will not be denied enrollment when enrolling outside a designated enrollment period if: he had existing coverage, and he certified in writing, if applicable, that he declined coverage due to such coverage; Employer contributions toward the other coverage have been terminated; he is no longer eligible for prior coverage; or if such prior coverage was continuation coverage and the continuation period has been exhausted and he enrolls for this coverage within 30 days after losing or exhausting prior coverage.

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption, you may enroll your eligible Dependents and yourself, if you are not already enrolled, within 30 days of such event. Coverage will be effective on the date of marriage, birth, adoption or placement for adoption.
Dependent Insurance

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

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form, but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

Your Dependent will not be denied enrollment for Medical Insurance due to health status.

Your Dependents will be insured only if you are insured.

You will not be eligible to enroll your Dependents if you do not enroll them within 30 days of the date you become eligible, unless you qualify under the section of this certificate entitled "Enrollment Exception".

Exception for Newborns

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

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 required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the Qualified Medical Child Support 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 requirements above.

The Qualified Medical Child Support Order may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except an order may require a plan to comply with States laws regarding child health care coverage.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

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.

OBRA2
# Preferred Provider Medical Benefits

## The Schedule

**For You and Your Dependents**

This plan provides medical benefits for services and supplies provided by Participating Providers and Non-Participating Providers, unless otherwise noted. To receive Preferred Provider Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.

### Coinsurance

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

### Copayments/Deductibles

Copayments are expenses to be paid by you or your Dependent for the services received. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by, Copayments. Copayments and Deductibles are in addition to any Coinsurance.

You or your Dependent can obtain the names of Participating Providers in your area by consulting your Physician Guide, or calling the toll-free number shown on the back of your I.D. card.

If you are unable to locate a Participating Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Non-Participating Provider coverage. If you obtain authorization for services provided by a Non-Participating Provider, benefits for those services will be covered at the Participating Provider benefit level.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>This Plan will Pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Participating Provider</td>
</tr>
<tr>
<td><strong>Lifetime Maximum Benefit</strong></td>
<td>$1,000,000</td>
</tr>
</tbody>
</table>

**Contract Year**

The term Contract Year means a period from July 1 to June 30 in each calendar year.
Deductibles are expenses to be paid by an Employee or Dependent for the services rendered. These Deductibles are in addition to any copayments or coinsurance.

<table>
<thead>
<tr>
<th>Deductibles</th>
<th>You Pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Participating Provider</td>
</tr>
<tr>
<td><strong>Contract Year Deductible</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Individual Deductible</strong></td>
<td>$400</td>
</tr>
<tr>
<td><strong>Family Deductible</strong></td>
<td>$800</td>
</tr>
</tbody>
</table>

After Family Medical Deductibles totaling $800 have been applied in a contract year for either (a) you and your Dependents or (b) your Dependents, your family need not satisfy any further Comprehensive Medical Deductible for the rest of that year.
Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for charges made by Participating and Non-Participating Providers for which no payment is provided because of the coinsurance factor or the Medical Deductibles (including any benefit deductible). In addition, benefits for Covered Expenses incurred for or in connection with Mental Health and Substance Abuse will accumulate toward the Out-of-Pocket Maximums and benefits for such expenses will be increased by the terms of the "Full Payment" section. However, benefits for Covered Expenses incurred for or in connection with charges made for non-compliance penalties or charges in excess of Reasonable & Customary levels will not accumulate toward the Out-of-Pocket Maximums and benefits for such expenses will not be increased by the terms of the "Full Payment" section.

<table>
<thead>
<tr>
<th></th>
<th>Participating Provider</th>
<th>Non-Participating Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Out-of-Pocket Maximum</td>
<td>$2,000 per person</td>
<td>$4,000 per person</td>
</tr>
<tr>
<td>Family Out-of-Pocket Maximum</td>
<td>$4,000 per family</td>
<td>$8,000 per family</td>
</tr>
</tbody>
</table>

Accumulation of Deductibles and Out-of-Pocket

Expenses incurred for either Participating or Non-Participating Provider charges will be used to satisfy both the Participating Provider Deductible and Out-of-Pocket and the non-Participating Provider Deductible and Out-of-Pocket.
### How this Plan Works:

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Participating Provider</th>
<th>Non-Participating Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For care other than for Mental Health and Substance Abuse</strong></td>
<td>You and your Dependent pay the Participating Provider Deductible, any Copayment and benefit deductible shown below plus any Coinsurance, then the plan pays the Benefit Percentage shown</td>
<td>You and your Dependent pay the Non-Participating Provider Deductible, any Copayment and benefit deductible shown below plus any Coinsurance, then the plan pays the Benefit Percentage shown</td>
</tr>
</tbody>
</table>

### Physician Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Participating Provider</th>
<th>Non-Participating Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician Office Visit</td>
<td>$15 copay, then 100% (90% after deductible for x-ray/lab if billed by a separate outpatient facility)</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Specialty Care Physician Office Visit/Consultation</td>
<td>$15 copay, then 100% (90% after deductible for x-ray/lab if billed by a separate outpatient facility)</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Surgery Performed in the Physician's Office</td>
<td>$15 copay, then 100% (90% after deductible for x-ray/lab if billed by a separate outpatient facility)</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Allergy Treatment/Injections</td>
<td>No charge after either the office visit copay or the actual charge, whichever is less</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Allergy Serum</td>
<td>No Charge</td>
<td>70% after deductible</td>
</tr>
</tbody>
</table>

### Preventive Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Participating Provider</th>
<th>Non-Participating Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-Child Care, for children through age 18 (including routine immunizations)</td>
<td>$15 per visit, then 100% (90% after deductible for x-ray/lab if billed by a separate outpatient facility)</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Immunizations</td>
<td>No Charge</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Contract Year Maximum: Unlimited</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Preventive Care for age 19 and above (including routine immunizations)</td>
<td>$15 per visit, then 100% (90% after deductible for x-ray/lab if billed by a separate outpatient facility)</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Contract Year Maximum: 1 exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Coverage</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Immunizations</td>
<td>No Charge</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Pap Test</td>
<td>No Charge, no deductible, if billed by a separate outpatient diagnostic facility; $15 copayment per visit for associated wellness exam</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Mammogram</td>
<td>No Charge, no deductible, if billed by a separate outpatient diagnostic facility; $15 copayment per visit for associated wellness exam</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Prostate Specific Antigen (PSA)</td>
<td>90% after deductible for x-ray/lab if billed by a separate outpatient facility; $15 copayment per visit for associated wellness exam</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Well Woman Exam for age 19 and above</td>
<td>$15 per visit, then 100%</td>
<td>70% after deductible</td>
</tr>
<tr>
<td></td>
<td>Contract Year Maximum: 1 exam</td>
<td></td>
</tr>
<tr>
<td>Second Opinions</td>
<td>(Services will be provided on a voluntary basis)</td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician Office Visit</td>
<td>$15 copay, then 100%</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Specialty Care Physician Office Visit/Consultation</td>
<td>$15 copay, then 100%</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Service</td>
<td>Primary Care Physician Office Visit</td>
<td>Specialty Care Physician Office Visit</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td></td>
<td>$15 copay, then 100% (90% after deductible for x-ray/lab if billed by a separate outpatient facility)</td>
<td>$15 copay, then 100% (90% after deductible for x-ray/lab if billed by a separate outpatient facility)</td>
</tr>
<tr>
<td></td>
<td>70% after deductible</td>
<td>70% after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Inpatient Hospital - Facility Services</th>
<th>Outpatient Surgical Facility Services</th>
<th>Inpatient Hospital Doctor's Visits/Consultations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Semi Private Room and Board</td>
<td>90% after deductible</td>
<td>Operating Room, Recovery Room, Procedure Room, and Treatment</td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Private Room</td>
<td>The Hospital's negotiated rate</td>
<td></td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Special Care Units (ICU/CCU)</td>
<td>The Hospital's negotiated rate for a semi-private room</td>
<td></td>
<td>The Hospital's negotiated rate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The Hospital's negotiated rate for an ICU/CCU room</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>70% after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Inpatient Hospital Professional Services: Surgeon Radiologist Pathologist Anesthesiologist</th>
<th>Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>90% after deductible</td>
<td>90% after deductible</td>
</tr>
<tr>
<td></td>
<td>70% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Emergency and Urgent Care Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Physician’s Office</td>
<td>$15 per visit, then 100%</td>
<td>$15 per visit, then 100% (except if not a true emergency, then 70%, after deductible)</td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
<td>$100 per visit*, then 100% *Waived if admitted</td>
<td>$100 per visit*, then 100% (except if not a true emergency, then 70%, after deductible) *Waived if admitted</td>
</tr>
<tr>
<td>Urgent Care Facility or Outpatient Facility</td>
<td>$50 per visit*, then 100% *Waived if admitted</td>
<td>$50 per visit*, then 100% (except if not a true emergency, then 70%, after deductible) *Waived if admitted</td>
</tr>
<tr>
<td>Ambulance</td>
<td>90% after deductible</td>
<td>90% after deductible (except if not a true emergency, then 70%, after deductible)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inpatient Services at Other Health Care Facilities</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes: Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Contract Year Maximum: 100 Days</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Laboratory and Radiology Services</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MRIs, MRAs, CAT Scans and PET Scans</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Routine Mammograms and Pap Smears</td>
<td>No Charge</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Other Laboratory and Radiology Services (All charges billed by an independent facility)</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Service</td>
<td>Copay/Deductible</td>
<td>Benefits</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Outpatient Short-Term Rehabilitative Therapy</td>
<td>$15 copay, then 100%</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Includes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac Rehab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contract Year Maximum:</td>
<td>90 days per contract year</td>
<td>70% after deductible for all therapies combined</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>$15 copay, then 100%</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Contract Year Maximum:</td>
<td>50 Visits</td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Contract Year Maximum:</td>
<td>100 days</td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Inpatient Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Bereavement Counseling</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Maternity</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Initial Visit to Confirm Pregnancy</td>
<td>$15 per visit, then 100%</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>All Subsequent Prenatal Visits, Postnatal Visits, and Delivery</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Delivery (Inpatient Hospital, Birthing Center)</td>
<td>Same as plan's Inpatient Hospital Facility benefit.</td>
<td>Same as plan's Inpatient Hospital Facility benefit.</td>
</tr>
<tr>
<td><strong>Abortion</strong> (Includes elective and non-elective procedures.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Inpatient</td>
<td>Same as plan's Inpatient Hospital Facility Benefit</td>
<td>Same as plan's Inpatient Hospital Facility Benefit</td>
</tr>
<tr>
<td>Outpatient Surgical Facility</td>
<td>Same as plan's Outpatient Facility Services Benefit</td>
<td>Same as plan's Outpatient Facility Services Benefit</td>
</tr>
<tr>
<td>Physician's Services</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Family Planning</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visits, Tests and Counseling</td>
<td>$15 copay, then 100% (90% after deductible for x-ray/lab if billed by a separate outpatient facility)</td>
<td>70% after deductible</td>
</tr>
</tbody>
</table>

| **Surgical Sterilization**  
**Procedures for Vasectomy/Tubal Ligations** | | |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>Same as plan's Inpatient Hospital Facility Benefit</td>
<td>Same as plan's Inpatient Hospital Facility Benefit</td>
</tr>
<tr>
<td>Outpatient Surgical Facility</td>
<td>Same as plan's Outpatient Facility Services Benefit</td>
<td>Same as plan's Outpatient Facility Services Benefit</td>
</tr>
<tr>
<td>Inpatient Physician's Services</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td>Outpatient Physician's Services</td>
<td>90% after deductible</td>
<td>70% after deductible</td>
</tr>
</tbody>
</table>
## Infertility Treatment

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Benefit Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Visit (Tests, Counseling)</td>
<td>$15 copay, then 100% (90% after deductible for x-ray/lab if billed by a separate outpatient facility)</td>
</tr>
<tr>
<td>Surgical Treatment: Limited to Procedures for Correction of Infertility (excludes In Vitro Fertilization, Artificial Insemination, GIFT, ZIFT, and similar procedures)</td>
<td>Same as plan's Inpatient Hospital Facility benefit</td>
</tr>
<tr>
<td>Inpatient Facility</td>
<td>Same as plan's Inpatient Hospital Facility benefit</td>
</tr>
<tr>
<td>Outpatient Facility</td>
<td>Same as plan's Outpatient Facility Services benefit</td>
</tr>
<tr>
<td>Physician's Services</td>
<td>90% after deductible</td>
</tr>
</tbody>
</table>

## Organ Transplants

- Includes all medically appropriate, non-experimental transplants

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Benefit Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Facility</td>
<td>100% at Lifesource center, otherwise same as plan's Inpatient Hospital Facility Benefit</td>
</tr>
<tr>
<td>Physician's Services</td>
<td>100% at Lifesource center, otherwise 90% after deductible</td>
</tr>
<tr>
<td>Travel Services Maximum</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

## Durable Medical Equipment

- Contract Year Maximum: $5,000

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Benefit Details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>90% after deductible</td>
</tr>
</tbody>
</table>

## External Prosthetic Appliances

- Contract Year Maximum: Unlimited

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Benefit Details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>90% after deductible</td>
</tr>
<tr>
<td>Dental Care</td>
<td>Physician's Office</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.</td>
<td>$15 copay, then 100%</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Temporomandibular Joint Disorder (Surgical &amp; Non-Surgical Treatment)</th>
<th>Physician's Office</th>
<th>Inpatient Facility</th>
<th>Outpatient Facility</th>
<th>Physician's Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$15 copay, then 100% (90% after deductible for x-ray/lab if billed by a separate outpatient facility)</td>
<td>Same as plan's Inpatient Hospital Facility Benefit</td>
<td>Same as plan's Outpatient Hospital Facility Benefit</td>
<td>90% after deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>70% after deductible</td>
</tr>
</tbody>
</table>
### Mental Health and Substance Abuse

<table>
<thead>
<tr>
<th></th>
<th>Participating Provider</th>
<th>Non-Participating Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health/Substance Abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient</strong></td>
<td>90% after plan deductible</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Contract Year Maximum: 50 Days</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td>$15 per visit, then 100%</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Contract Year Maximum: 50 Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Group Therapy</strong></td>
<td>$15 per visit, then 100%</td>
<td>70% after plan deductible</td>
</tr>
<tr>
<td>Contract Year Maximum: Subject to the plan’s Outpatient Mental Health/Substance Abuse benefit maximum based on a 2:1 ratio (Visits used reduce the number of Mental Health/Substance Abuse Outpatient visits available).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Preferred Provider Medical Benefits

For You and Your Dependents

Certification 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 require treatment in a Hospital:

- as a registered bed patient;
- for a Partial Hospitalization for the treatment of Mental Health or Substance Abuse;
- for the treatment of Substance Abuse in a Substance Abuse Intensive Outpatient Therapy Program;
- for Mental Health or Substance Abuse Residential Treatment Services.

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

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will be reduced by 50%:

- Hospital charges made for each separate admission to the Hospital unless PAC is received (a) prior to the date of admission; or (b) in the case of an emergency admission, within 48 hours or the date of admission;
- Hospital charges for Bed and Board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

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

Benefit Payment

If, while insured for these benefits, you or any one of your Dependents incurs Covered Expenses, CG will pay an amount shown in The Schedule:

Payment of any benefits will be subject to: (a) any applicable Copayments, Deductibles and Maximum Benefits shown in The Schedule; and (b) the Maximum Benefit Provision.

Full Payment Area-Participating Provider Out-of-Pocket Maximum

When a person has incurred Out-of-Pocket Expenses of $2,000 in a contract year, for charges made by a Participating Provider or a non-Participating Provider, benefits for that person for Covered Expenses incurred during the rest of that year will become payable at the rate of 100%.

When either (a) you and your Dependents or (b) your Dependents have incurred a combined amount of Out-of-Pocket Expenses of $4,000 in a contract year, for charges made by a Participating Provider or a non-Participating Provider, 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%.

Full Payment Area-Non-Participating Provider Out-of-Pocket Maximum

When a person has incurred Out-of-Pocket Expenses of $4,000 in a contract year, for charges made by a Participating or non-Participating Provider, benefits for that person for Covered Expenses incurred during the rest of that year will become payable at the rate of 100%.

When either (a) you and your Dependents or (b) your Dependents have incurred a combined amount of Out-of-Pocket Expenses of $8,000 in a contract year, for charges made by a Participating or non-Participating Provider, 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%.

All benefit deductibles will continue to apply. Any Deductible, if not yet satisfied, will continue to apply until it is satisfied.

Maximum Benefit Provision

The total amount of Preferred Provider Medical Benefits payable for all expenses incurred during a person's lifetime will not exceed the Maximum Benefit shown in The Schedule.
Covered Expenses
The term Covered Expenses means the 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 Medically Necessary for the care and treatment of an Injury or Sickness, as determined by CG. Any applicable Copayments, Deductibles or Maximums are shown in The Schedule.

Covered Expenses
- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limits shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-standing Surgical Facility, on its own behalf, for medical care and treatment.
- charges made by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility on its own behalf, for medical care and treatment; except that Covered Expenses will not include that portion which is in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse for professional nursing service.
- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions and blood not donated or replaced; oxygen and other gases and their administration; prosthetic appliances; and dressings;
- charges made for surgical and nonsurgical care of Temporomandibular Joint Dysfunction (TMJ) excluding appliances and orthodontic treatment.
- charges made for a mammogram for women ages thirty-five to sixty-nine, every one to two years or at any age for women at risk, when recommended by a Physician.
- charges made for an annual Papanicolaou laboratory screening test.
- charges made for an annual prostate-specific antigen test (PSA) and a digital rectal exam.
- charges made by a Physician for visits for routine preventive care of a Dependent child during the first eighteen years of that Dependent child's life, including immunizations.
- charges made for counseling and medical services connected with surgical therapies (vasectomy and tubal ligation), excluding procedures to reverse sterilization.
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for medical diagnostic services to determine the cause of erectile dysfunction, such as postoperative prostatectomy and diabetes. Psychogenic erectile dysfunction does not warrant coverage for penile implants.
- charges made for the initial purchase and fitting of external prosthetic devices which are used as replacements or substitutes for missing body parts and are necessary for the alleviation or correction of Injury or Sickness, or congenital defect. External prosthetic appliances shall include artificial arms and legs and terminal devices such as hands or hooks. Replacement of external prosthetic appliances is covered only if necessitated by normal anatomical growth.
- charges made by a Physician for Routine Preventive Care from age 19 including immunizations, not to exceed the maximum shown in the Schedule. Routine Preventive Care means health care assessments, wellness visits and any related services.
- charges for 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.

Home Health Services
- charges made for Home Health Care Services when you:
  - require skilled care;
  - are unable to obtain the required care as an ambulatory outpatient; and
  - do not require confinement in a Hospital or Other Health Care Facility.
Home Health Care Services are provided under the terms of a Home Health Care plan for the person named in that plan. If you are a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), Home Health Care Services will only be provided for you during times when there is a family member or care giver present in the home to meet your non-skilled care needs.

**Home Health Care Services** are those skilled health care services that can be provided during intermittent visits of 2 hours or less by Other Health Care Professionals. Necessary consumable medical supplies, home infusion therapy, and Durable Medical Equipment administered or used by Other Health Care Professionals in providing Home Health Care Services are covered. Home Health Care Services do not include 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. Physical, occupational, and speech therapy provided in the home are subject to the benefit limitations described under "Short-term Rehabilitative Therapy".

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- Hospice Care Services
- charges made due to Terminal Illness for the following Hospice Care Services provided under a Hospice Care Program:
  - by a Hospice Facility for Bed and Board and Services and Supplies, except that, for any day of confinement in a private room, Covered Expenses will not include that portion of charges which is more than the Hospice Bed and Board Limit shown in The Schedule;
  - by a Hospice Facility for services provided on an outpatient basis;
  - by a Physician for professional services;
  - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling, including bereavement counseling within one year after the person's death;
  - for pain relief treatment, including drugs, medicines and medical supplies;
  - by an Other Health Care Facility for:
    - part-time or intermittent nursing care by or under the supervision of a Nurse;
    - part-time or intermittent services of an Other Health Care Professional;
  - physical, occupational, or speech therapy;
  - medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent that such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses:

- for the 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;
- for any period when you or your Dependent is not under the care of a Physician;
- for services and supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent in daily living;

GM6000 CM35

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

**Inpatient Mental Health Services** are services that are provided by a Hospital while you or your Dependents are Confined in that Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Partial Hospitalization, and Mental Health Residential Treatment Services.

Inpatient Mental Health benefits are exchangeable with **Partial Hospitalization** sessions when benefits are provided for not less than 4 hours and not more than 12 hours in any 24-hour period. The benefit exchange will be two partial hospitalization sessions are equal to one day of inpatient care.
Mental Health Residential Treatment Services are services provided by a Hospital that is designated by CG 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 benefits are exchanged with Inpatient Mental Health benefits at a rate of two days of Mental Health Residential Treatment being equal to one day of Inpatient Mental Health Treatment.

GM6000 INDEM9 V23

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 subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; (c) provides 24-hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a Residential Treatment Center.

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

Outpatient Mental Health Services

Services of Providers who are qualified to treat mental health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, in an individual, group or structured group 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 and relapse prevention) and outpatient testing and assessment.

GM6000 INDEM10 V5

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

Inpatient Substance Abuse benefits are exchangeable with Partial Hospitalization sessions when benefits are provided for not less than 4 hours and not more than 12 hours in any 24-hour period. The benefit exchange will be two partial hospitalization sessions are equal to one day of inpatient care.

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

Substance Abuse Residential Treatment benefits are exchanged with Inpatient Substance Abuse benefits at a rate of two days of Substance Abuse Residential Treatment being equal to one day of Inpatient Substance Abuse Treatment.

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

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

Inpatient Substance Abuse Rehabilitation Services

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed substance abuse program. Intensive outpatient structured therapy programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

Substance Abuse Intensive Outpatient Therapy Program benefits are exchanged with Inpatient Substance Abuse benefits at a rate of three days of Substance Abuse Intensive Therapy being equal to one day of Inpatient Substance Abuse Rehabilitation Services.

Outpatient Substance Abuse Rehabilitation Services are services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, group, structured group.

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.
Exclusions
The following are specifically excluded from Mental Health and Substance Abuse Services:

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless medically necessary and otherwise covered under this policy or agreement.
- Treatment of medical disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- Counseling for activities of an educational nature.
- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness raising.
- Vocational or religious counseling.
- I.Q. testing.
- Custodial care, including but not limited to geriatric day care.
- Psychological testing on children requested by or for a school system.
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

Other limitations are shown in the "General Limitations" section.

Durable Medical Equipment

- charges made for the purchase or rental of Durable Medical Equipment which is ordered or prescribed by a provider and provided by a vendor approved by CG. Coverage for the repair, replacement or duplicate equipment is not covered except when replacement or revision is necessary due to growth or a change in medical condition.

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

Unless covered in connection with the services described in another section of this certificate, the following are specifically excluded:

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

Infertility Services

- charges made for Infertility Services, including services related to the diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed.

Infertility Services include approved surgical and medical treatment programs that have been established to have a reasonable likelihood of resulting in pregnancy.

The following are specifically excluded infertility services:

- infertility drugs;
- gamete intrafallopian transfer (GIFT), in vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), and variations of these procedures;
- any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees);
- a reversal of voluntary sterilization;
- infertility services when the infertility is caused by or related to voluntary sterilization;
- cryopreservation of donor sperm and eggs; and
any experimental or investigational infertility procedures or therapies.

Short-Term Rehabilitative Therapy

- charges made for Short-Term Rehabilitative Therapy which is a part of a rehabilitation program, including physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate inpatient or outpatient setting.

The following limitations apply to Short-Term Rehabilitative Therapy Services:

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

Chiropractic Care

- charges made for Chiropractic Care or services as follows:
  - charges for care are limited to the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment that is rendered to restore motion, reduce pain and improve function;
  - charges for office examinations including: patient history; physical examination; spinal x-rays; laboratory tests; and neuromuscular treatment and manipulation;
  - charges for lab work;
  - charges are limited to Medically Necessary care provided in an office setting;

excluding any charges for:

- services of a Chiropractor which are not within the scope of his practice, as defined by state law;
- vitamin therapy;
- Maintenance or Preventive Treatment;

Organ Transplant Services

- charges made for human organ and tissue transplant services at designated facilities through the United States. All Organ Transplant Services listed below, other than cornea, kidney and autologous bone marrow/stem cell transplants are available when received, and must be received at a qualified or provisional CIGNA Lifesource Organ Transplant Network facility.

The transplants that are covered at Participating Provider facilities, other than a CIGNA Lifesource Organ Transplant Network facility are cornea, kidney and autologous bone marrow/stem cell transplants.

All Transplants are covered when received at a Non-Participating Provider facility.

Coverage is subject to the following conditions and limitations:

Organ Transplant Services include the recipient’s medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ procurement. Organ Transplant Services are only covered when 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 small bowel/liver.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary.

Organ Transplant Travel Services

CG will pay, subject to the Organ Transplant Travel Benefit Maximum shown in the Schedule, 100% of the travel expenses incurred by you or your covered Dependent for charges for transportation, lodging and food associated with a preapproved organ/tissue transplant. All expenses must be preapproved by your Transplant Case Manager. Organ Transplant Travel Benefits are not available for cornea, kidney and autologous bone marrow/stem cell transplants. Benefits for transportation, lodging and food are available to you only if you or your covered Dependent is the recipient of a preapproved organ/tissue transplant from a CIGNA Lifesource Organ Transplant Network Facility; such benefits are not subject to any individual or family deductible shown in The Schedule. The term recipient is defined to include you or your covered Dependent receiving preapproved transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post transplant care. Additionally, this benefit is not subject to the Lifetime Maximum Benefit shown in The Schedule.

Travel expenses for the person receiving the transplant will include charges for
(1) transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility);
(2) lodging while at, or traveling to and from the transplant site; and
(3) food while at, or traveling to and from the transplant site.
By way of example, but not of limitation, travel expenses will not include any charges for:
   (a) transplant travel benefit costs incurred due to travel within 60 miles of your home;
   (b) laundry bills;
   (c) telephone bills;
   (d) alcohol or tobacco products; and
   (e) transportation charges which exceed coach class rates.
These benefits are only available if you or your Dependent is the recipient of an organ transplant. No benefits are available if you or your Dependent is a donor.
The charges associated with the items (1), (2) and (3) above will also be considered covered travel expenses for one companion to accompany you. The term companion includes a spouse, family member, legal guardian of you or your Dependent, or any person not related to you, but actively involved as your caregiver.

Breast Reconstruction and Breast Prostheses
- charges made for reconstructive surgery following a mastectomy, if the insured chooses to have surgery, and in the manner chosen by the insured and Physician. Services and benefits include:
  - 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, limited to one surgery per mastectomy;
  - postoperative breast prostheses; and
  - mastectomy bras and external prosthetic 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.

Cosmetic Surgery
Charges made for cosmetic surgery or therapy to repair or correct severe facial disfigurements or severe physical deformities that are congenital or result from developmental abnormalities (other than abnormalities of the jaw or TMJ disorder), tumors, trauma, disease or the complications of Medically Necessary non-cosmetic surgery.
Reconstructive surgery for correction of congenital birth defects or developmental abnormalities must be performed prior to your attainment of age 19. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement, as determined by CG.

Expenses Not Covered
Covered Expenses will not include, and no payment will be made for expenses incurred:
- for or in connection with cosmetic surgery or therapy unless coverage is provided under the "Covered Expenses: section of this certificate.
- for eyeglasses, hearing aids or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery.
- for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for a continuous dental treatment started within six months of an Injury to sound natural teeth; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; or (c) charges made by the outpatient department of a Hospital in connection with surgery.
- for which benefits are not payable according to the "General Limitations" section.
- for or in connection with procedures to reverse sterilization.
- for replacement of external prosthesis due to wear and tear, loss, theft or destruction; or for any biomechanical external prosthetic devices.
- for treatment of erectile dysfunction. However, penile implants are covered when an established medical condition is the cause of erectile dysfunction.
- 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.
• transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.

• for therapy to improve general physical condition if not Medically Necessary, including, but not limited to, routine, longterm chiropractic care, and rehabilitative services which are provided to reduce potential risk factors in patients in which significant therapeutic improvement is not expected.

• treatment by acupuncture.

• artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, hearing aids, dentures and wigs.

• for medical and surgical services intended primarily for the treatment or control of obesity which are not Medically Necessary. Excluded services include, but are not limited to, weight reduction procedures designed to restrict your ability to assimilate food, such as gastric bypass, gastric balloons, jaw wiring, stomach stapling and jejunal bypass.

• for court ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed under the "Covered Expenses" section of this certificate.

• for Infertility services including 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 is also excluded from coverage.

• consumable medical supplies, including but not limited to: bandages and other disposable medical supplies, skin preparations and test strips, except as provided under "Covered Expenses."

• for private Hospital rooms and/or private duty nursing unless determined by CG to be Medically Necessary.

• for routine foot care, including the paring and removing of corns and calluses or trimming of nails unless Medically Necessary.

• for membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.

• for amniocentesis, ultrasound, or any other procedures requested solely for gender determination of a fetus, unless Medically Necessary to determine the existence of a gender-linked genetic disorder.

• for genetic testing and therapy including germ line and somatic unless determined Medically Necessary by CG for the purpose of making treatment decisions.

• for 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.

• for blood administration for the purpose of general improvement in physical condition.

• for costs of biologicals that are immunizations or medications for the purpose of the travel, or to protect against occupational hazards and risks.

• for personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.

• for orthognathic treatment/surgery, including but not limited to treatment/surgery for mandibular or maxillary prognathism, microprognathism or malocclusion, surgical augmentation for orthodontics, or maxillary constriction. However, Medically Necessary treatment TMJ disorder is covered.

• for all noninjectable prescription drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in the "Covered Expenses" section of this certificate.

Second Opinion Surgical Benefits

If, as a result of an Injury of a Sickness, you or any one of your Dependents, while insured for these benefits and prior to the performance of an Elective Surgical Procedure recommended by a surgeon, asks for an opinion from another Physician who is qualified to diagnose and treat that Injury or Sickness, CG will pay the Covered Expenses incurred for the fee charged for that opinion. If a person incurs Covered Expenses for diagnostic laboratory or x-ray examinations asked for by the Physician who gives that opinion, CG will pay the Covered Expenses so incurred.

Payment will be made whether or not the Surgical Procedure is performed.

Payment will be subject to all terms of the policy except as otherwise provided in this section.
Limitations

No payment will be made for expenses incurred in connection with:

- cosmetic or dental Surgical Procedures not covered under the policy;
- minor Surgical Procedures that are routinely performed in a Physician's office, such as incision and drainage for abscess or excision of benign lesions;
- an opinion obtained more than 6 months after a surgeon has first recommended the Elective Surgical Procedure;
- an opinion rendered by the Physician who performs the Surgical Procedure.

Other Limitations are shown in the "General Limitation' Section.

No payment will be made under any other section for expenses incurred to the extent that benefits are payable for those expenses under this section.

Elective Surgical Procedure

The term Elective Surgical Procedure means a Surgical Procedure which is not considered emergency in nature and which may be avoided without undue risk to the individual.
## Prescription Drug Benefits

### The Schedule

**For You and Your Dependents**

<table>
<thead>
<tr>
<th>Pharmacy Benefits</th>
<th>How this Plan Works:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Participating Pharmacy</td>
</tr>
<tr>
<td></td>
<td>You and Your Dependents pay the amount shown below then the Plan pays the percentage shown</td>
</tr>
</tbody>
</table>

### Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for charges made by Participating and Non-Participating Providers for which no payment is provided because of the coinsurance factor and any copayment.

<table>
<thead>
<tr>
<th>Individual Out-of-Pocket Maximum (In-Network and Out-of-Network Retail and In-Network Mail Order)</th>
<th>$1,000 per person per Contract Year</th>
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<tbody>
<tr>
<td>Family Out-of-Pocket Maximum (In-Network and Out-of-Network Retail and In-Network Mail Order)</td>
<td>$3,000 per family per Contract Year</td>
</tr>
</tbody>
</table>

### Pharmacy Benefits

**Prescription Drugs**

- Prescription Drug Maximum: (No more than a 30 day supply per prescription order or refill.)
  - 30% per prescription order or refill, then 100%
  - 30% per prescription order or refill (reimbursement only)
Mail-Order Drugs

| Generic * | $20 per prescription order or refill, then 100% |
| Name-Brand * | $80 per prescription order or refill, then 100% |

Mail-Order Drug Maximum:
(No more than a 90 day supply per prescription order or refill.)

| Not Covered |

* Designated as per generally-accepted industry sources and adopted by CG

* Designated as per generally-accepted industry sources and adopted by CG
Prescription Drug Benefits

For You and Your Dependents

Covered Expenses

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, coverage will be provided for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician. Coverage also includes Prescription Drugs and Related Supplies dispensed for a prescription 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 for a Prescription Drug as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by CG, as if filled by a Participating Pharmacy.

Limitations

Each prescription order or refill shall be limited as follows:

• to up to a consecutive 30-day supply, at a retail Pharmacy;
• to up to a consecutive 90-day supply at a mail-order Participating Pharmacy;
• to a dosage and/or limit as determined by the P & T Committee.

Coverage for certain Prescription Drugs and Related Supplies requires your Physician to obtain authorization prior to prescribing. If your Physician wishes to request coverage for a Prescription Drug or Related Supply for which prior authorization is required, your Physician may call or complete the appropriate prior authorization form and fax it to CG to request a prior authorization for coverage of the Prescription Drug or Related Supply. Your Physician should make this request before writing the prescription.

If the request is approved, your Physician will receive confirmation. The authorization will be processed in our claim system to allow you to have coverage for that Prescription Drug or Related Supply. The length of the authorization will depend on the diagnosis and Prescription Drug or Related Supply. When your Physician advises you that coverage for the Prescription Drug or Related Supply has been approved, you should contact the Participating Pharmacy to fill the prescription(s).

If the request is denied, your Physician and you will be notified that coverage for the Prescription Drug or Related Supply is not authorized.

If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the Policy, by submitting a written request stating why the Prescription Drug or Related Supply should be covered.

If you have questions about a prior authorization request, you should call Member Services at the toll-free number on the ID card.

Your Payments

Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy is subject to the Copayment or Coinsurance as shown in the Schedule after you have satisfied your Prescription Drug Deductible, if applicable. In no event will any Copayment or Coinsurance exceed the cost of the Prescription Drugs and Related Supply.

When a treatment regimen contains more than one type of Prescription Drug which are packaged together for you or your Dependent's convenience, a Copayment or Coinsurance will apply to each type of Prescription Drug.

Please refer to the Schedule for any required Copayments, Coinsurance, Deductibles or Maximums if applicable.

Exclusions

No payment will be made for the following expenses:

• drugs or medications available over-the-counter that do not require a prescription by federal or state law, and any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
• a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee (such as antihistamines);
• injectable infertility drugs;
• any drugs that are labeled as experimental or investigational as described under General Limitations;
• Food and Drug Administration (FDA) approved prescription drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, the American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
• prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;

• Norplant and other implantable contraceptive products;

• any fertility drug;

• drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, and decreased libido;

• dietary supplements and flouride products;

• drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;

• diet pills or appetite suppressants (anorectics);

• immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;

• replacement of Prescription Drugs and Related Supplies due to loss or theft;

• drugs used to enhance athletic performance;

• drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, skilled nursing facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;

• prescriptions more than one year from the original date of issue;

Other limitations are shown in the "General Limitations" section.

Reimbursement/Filing a Claim

When you or your Dependents purchase your Prescription Drugs or Related Supplies through a Participating Pharmacy, you pay only the Coinsurance amount shown in the Schedule. You do not need to file a claim form.

If you or your Dependents purchase your Prescription Drugs or Related Supplies through a non-Participating Pharmacy, you pay the full cost at the time of purchase. You must submit a claim form to be reimbursed.

To purchase Prescription Drugs or Related Supplies from a mail-order Participating Pharmacy, see your mail-order drug introductory kit for details, or contact Member Services for assistance.
General Limitations

Medical Benefits

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

- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Sickness or Injury;
- 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 Reasonable and Customary Charges;
- for charges that are not Medically Necessary, except as specified in any certification requirement shown in The Schedule;
- 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;
- to the extent of the exclusions imposed by any certification requirement shown in The Schedule.
- 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 1/2 of the amount otherwise payable for all other surgical procedures;
- for or in connection with in vitro fertilization, artificial insemination or similar procedures.
- for charges made by an assistant surgeon in excess of 20 percent of the surgeon's allowable charge; or for charges made by a cosurgeon 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 for or in connection with the purchase or replacement of contact lenses except as specifically provided under "Covered Expenses"; however, the purchase of the first pair of contact lenses that follows cataract surgery will be covered;
- for charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn;
- for charges for supplies, care, treatment or surgery which are not considered essential for the necessary care and treatment of an Injury or Sickness, as determined by CG;
- for charges made for or in connection with tired, weak or strained feet for which treatment consists of routine footcare, including but not limited to, the removal of calluses and corns or the trimming of nails unless medically necessary;
- for or in connection with speech therapy, if such therapy is: (a) used to improve speech skills that have not fully developed; (b) can be considered custodial or educational; or (c) is intended to maintain speech communication; speech therapy which is not restorative in nature will not be covered;
- for charges made by any covered provider who is a member of your family or your Dependent's family.

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

- for Experimental, Investigational or Unproven Services which are medical, surgical, psychiatric, substance abuse or other healthcare technologies, supplies, treatments, procedures, drug therapies, or devices that are determined by CG, to be:

  (a) not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional journal; or

  (b) the subject of review or approval by an Institutional Review Board for the proposed use; or

  (c) 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; or

(d) not demonstrated, through existing peer-reviewed literature, to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

• for or in connection with an Injury or Sickness which is due to war, declared or undeclared.

• for expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure.

• for nonmedical ancillary services, including but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety and services, training or educational therapy for learning disabilities, developmental delays, autism or mental retardation.

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• for medical treatment for a person age 65 or older, who is covered under this policy as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a non-participating provider;

• for medical treatment when payment is denied by a Primary Plan because treatment was received from a non-participating provider;

• for 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 policy.

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• for medical and Hospital care and costs for the infant child of a Dependent, unless that infant child is otherwise eligible under the certificate.

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

• 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.

GM6000 GEN151

Coordination of Benefits

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

Definitions

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

Plan

Any of the following that provides benefits or services for medical or dental 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 or dental 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 from the Primary Plan 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 is covered in full or in part by any Plan covering you. When a
Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

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

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. Such Plan provisions include 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 contract 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;
(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 covers 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 amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for 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 the Policy, CG will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

CG will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare 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. This request may occur in connection with a submitted claim; if so, you will be advised that the “other coverage” information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment.

**Right of Reimbursement**

The Policy does not cover:
(1) Expenses for which another party may be responsible as a result of liability for causing or contributing to the injury or illness of you or your Dependent(s).

(2) Expenses to the extent they are covered under the terms of any automobile medical, automobile no fault, uninsured or underinsured motorist, workers’ compensation, government insurance, other than Medicaid, or similar type of insurance or coverage when insurance coverage provides benefits on behalf of you or your Dependent(s).

If you or a Dependent incur health care Expenses as described in (1) and (2) above, Connecticut General shall automatically have a lien upon the proceeds of any recovery by you or your Dependent(s) from such party to the extent of any benefits provided to you or your Dependent(s) by the Policy. You or your Dependent(s) or their representative shall execute such documents as may be required to secure Connecticut General’s rights. Connecticut General shall be reimbursed the lesser of:

- the amount actually paid by CG [or the HealthPlan] under the Policy; or
- an amount actually received from the third party;

at the time that the third party’s liability is determined and satisfied; whether by settlement, judgment, arbitration or otherwise.

**Payment of Benefits**

**To Whom Payable**

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

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

If you die while any of these benefits remain 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.

**Calculation of Covered Expenses**

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

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

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**Termination of Insurance**

**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.
- the last day of the calendar month in which your Active Service ends except as described below.

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

**Temporary Layoff or Leave of Absence**

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

**Injury or Sickness**

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

If your Active Service ends because you retire and you are under age 65, your insurance will be continued until the earlier of: a) the date on which your Employer cancels the insurance; or b) your 65th birthday.

Termination of Insurance - 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.

Continuation Required by Federal Law
For You and Your Dependents

The Continuation Required by Federal Law does not apply to any benefits for loss of life, dismemberment or loss of income.

Federal law enables you or your Dependent to continue health insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than for gross misconduct). Federal law also enables your Dependents to continue health insurance if their coverage ceases due to your death, divorce or legal separation, or with respect to a Dependent child, failure to continue to qualify as a Dependent. Continuation must be elected in accordance with the rules of your Employer's group health plan(s) and is subject to federal law, regulations and interpretations.

A. Employees and Dependents Continuation Provision

If you and your Dependent's insurance would otherwise cease because of a reduction in the number of hours you work or your termination of employment for any reason other than gross misconduct, you or your Dependent may continue health insurance upon payment of the required premium to the Employer. You and your Dependents must elect to continue insurance within 60 days from the later of: (a) the date of a reduction of your work hours or your termination of employment; (b) the date notice of the right to continue insurance is sent; or (c) the date the insurance would otherwise cease. You must pay the first premium within 45 days from the date you elect to continue coverage. Such insurance will not be continued by CG for you and/or your Dependents, as applicable, beyond the earliest of the following dates:

- 18 months from the date your work hours are reduced or your employment terminates, whichever may occur first;
- the date the policy cancels;
- the date coverage ends due to your failure to pay the required subsequent premium within 30 days of the due date;
- the date your Dependent ceases to qualify as an eligible Dependent;
- after you elect to continue this insurance, the date you first become entitled to Medicare, and for your Dependent, the date he first becomes entitled to Medicare;
- after you elect to continue this insurance, for you, the date you first become covered under another group health plan, unless you have a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

B. Dependent Continuation Provision

If health insurance for your Dependents would otherwise cease because of:

(1) your death;
(2) divorce or legal separation; or
(3) with respect to a Dependent child, failure to continue to qualify as a Dependent,

such insurance may be continued upon payment of the required premium to the Employer. In the case of (2) or (3) above, you or your Dependent must notify your Employer within 60 days of such event. In addition, a Dependent must elect to continue insurance within 60 days from the later of: (a) the date the insurance would otherwise cease; or (b) the date notice of the right to continue insurance is sent.

CG will not continue the health insurance of a Dependent beyond the earliest of the following dates:

- 36 months from the date of (1), (2) or (3) above, whichever may occur first;
- the date coverage ends due to failure to pay the required subsequent premium within 30 days of the due date;
- after the Dependent elects to continue this insurance, the date the Dependent first becomes entitled to Medicare;
- the date the policy cancels; or
- after the Dependent elects to continue this insurance, the date the Dependent first becomes covered under another group health plan, unless the Dependent has a condition
for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

C. Subsequent Events Affecting Dependent Coverage

If, within the initial 18-month continuation period, your Dependent would lose coverage because of an event described in (1), (2), or (3) of Section B, or because of your coverage loss due to your employment termination or reduction in work hours, your Dependent may continue coverage for up to 36 months from the date of loss of employment or reduction in work hours.

If your employment ends or your work hours are reduced within 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 36 months from the date you become entitled to Medicare.

If your employment ends or your work hours are reduced more than 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 18 months from the date your employment ends or your work hours are reduced.

Disabled Individuals Continuation Provisions

If you or your Dependent is disabled before or within the first 60 days of continuation of coverage which follow termination of employment or a reduction in work hours, the disabled person may continue health insurance for up to an additional 11 months beyond the 18-month period.

If you or your Dependents who are not disabled elect to continue coverage, such family members of the disabled person may extend coverage for up to an additional 11 months, if they otherwise remain eligible, and notice of disability is provided as described in (b), below.

To be eligible you or your Dependent must:

(a) be declared disabled as of a day before or during the first 60 days of continuation, under Title II or XVI by the Social Security Administration; and

(b) notify the plan administrator of the Social Security Administration’s determination within 60 days following the determination and within the initial 18-month continuation period, and provide the Plan Administrator with a copy of the 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 more than 30 days after the date of the final determination.

All reasons for termination described in sections A and B which apply to the initial 18 months will also apply to any or all covered persons for any additional months of coverage.

D. Effect of Employer Chapter 11 Proceedings on Retiree Coverage

If you are covered as a retiree, and a proceeding under USC Chapter 11, bankruptcy for the Employer results in a substantial loss of coverage for you or your Dependents within one year before or after such proceeding, 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.

E. Payment of Premium

This Plan may require the payment of an amount that does not exceed 102% of the applicable premium, except this Plan may require payment of up to 150% of the Applicable Premium for any extended period of continuation coverage for a covered person who is disabled. The additional 48% may only be applied to the premium for the rating category that includes the disabled individual, and only for the additional 11 months.

Applicable Premium is determined as follows:

1. if the Employee alone elects to continue coverage, the Employee will be charged the active Employee rate;
2. if a Dependent spouse alone elects to continue coverage, the spouse will be charged the active Employee rate;
3. if a Dependent child or children elect to continue coverage without a parent also electing the continuation, each child will be charged the active Employee rate;
4. if the entire family elects to continue coverage, they will be charged the family rate;
5. if the Schedule of Premium rates is set up on a step-rate basis, the active rate basis that fits the individuals who elect to continue their coverage is the rate that will be charged. If only children elect to continue coverage, each child will be charged the Employee Only rate.

Timely Payment

If Payment is made within the grace period in an amount not significantly less than the amount the Plan requires to be paid, the amount must be deemed to satisfy the Plan’s requirement. However, you must be notified and allowed at least 30 days after notice is provided for payment to be made.
F. Providing Notification of Your Status to Health Care Providers During the Grace Period

If, after you elect to continue coverage, a health care provider contacts this Plan to confirm coverage for a period for which premium has not yet been received, the Plan must give a complete and accurate response.

G. Notification Requirements

Your Employer should send you initial notification of coverage continuation rights as required by federal law; (a) when the Plan first becomes subject to federal continuation requirements; (b) when you are hired; and (c) when you add a spouse as a Dependent for benefits under the Plan. Receipt of this certificate may serve as such notice.

If you become eligible to continue coverage per federal law, your Employer must send you notification within 14 days. If the Plan has a Plan Administrator, the Employer must notify the Plan Administrator within 30 days. The Plan Administrator must notify you within 14 days, thereafter.

If eligibility to continue coverage is due to divorce, legal separation or a Dependent child losing eligibility for coverage under the Plan, you or your Dependent spouse must notify your Employer within 60 days of such event. Your Employer must notify you of the right to continue coverage within 14 days after receipt of notification of such event.

Interaction With Other Continuation Benefits

A person who is eligible to continue insurance under both (1) and (2) below may continue the insurance, upon payment of any required premium, for a period of time not to exceed the longer of: (1) the continuation required by federal law; or (2) any other continuation of insurance provided in this Certificate.

Newly Acquired Dependents

If, while your insurance is being continued under the continuation required by federal law provisions, you acquire a new Dependent, such Dependent will be eligible for this Continuation provided:

- the required premium is paid; and
- CG is notified of your newly acquired Dependent in accordance with the terms of the policy.

If events (1) or (2) of Section B should subsequently occur for your newly acquired Dependent spouse, such spouse will not be entitled to continue his insurance. However, your Dependent child will be able to continue his insurance.

If events described in Section C should subsequently occur for your child who is born, adopted or placed for adoption as a newly acquired Dependent, coverage will be continued according to that section.

COBRA10

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.

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Benefits Extension

Medical Benefits Extension During Hospital Confinement

If the Medical Benefits under this plan cease for you or your Dependent, and you or your Dependent are Confined in a Hospital on that date, Medical Benefits will be paid for Covered Expenses incurred in connection with that Hospital Confinement. However, no benefits will be paid after the earliest of:
• The date you exceed the Maximum Benefit, if any, shown in the Schedule;

• The date you are covered for medical benefits under another group plan;

• The date you or your Dependent are no longer Hospital Confined; or

• 3 months from the date your Medical Benefits cease.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when your Medical Benefits cease or your Dependent’s Medical Benefits cease.

When You Have a Complaint or an Appeal

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

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 is why we have established a process for addressing your concerns and solving your problems.

Start with Member Services

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

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

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

Appeals Procedure

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

Level One Appeal

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

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

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

Level Two Appeal

If you are dissatisfied with the level one appeal decision, you may request a second review of nonurgent care claims. To initiate a level two appeal, follow the same process required for a level one appeal except send this appeal to Colby-Sawyer College who will administer the Level Two Appeal Process.

Please contact Colby-Sawyer College at the address below for their Level Two Appeals process.

Colby-Sawyer College
541 Main Street
New London, NH 03257

For required preservice and concurrent care coverage determinations the Appeal Committee review will be completed within 15 calendar days and for post service claims, the Appeal Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, you will be notified in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Appeal Committee to complete the review. You will be notified in writing of the Committee’s decision within five business days after the...
Appeal Committee meeting, and within the Appeal Committee review time frames above if the Appeal Committee does not approve the requested coverage. The Appeal Committee refers to the organization doing the second level nonurgent care review.

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

Independent Review Procedure

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

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

In order to request a referral to an Independent Review Organization, the reason for the denial must be based on a Medical Necessity or clinical appropriateness. 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 days of your receipt of the level two appeal review denial. CG will then forward the file to the Independent Review organization.

The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your condition, as determined by CG’s Physician reviewer, the review shall be completed within three days.

The Independent Review Program is a voluntary program.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan and the claimant’s right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgement for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

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 CG until you have completed the Level One and Level Two appeal processes. If your appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

GM6000 APL260
Arbitration

This provision does not apply to dental plans.

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

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

The arbitration hearing shall be held within 30 days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses 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 his (their) decision within 30 days after the termination of the arbitration hearing. To the extent permitted by law, the decision of the arbitrator, or the decision of any two arbitrators if there are three arbitrators, shall be binding upon both parties conclusive of the controversy in question, and enforceable in any court of competent jurisdiction.

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

ERISA Required Information

The name of the Plan is:
Colby-Sawyer College Health Benefits

The name, address, ZIP code and business telephone number of the sponsor of the Plan is:
Colby-Sawyer College
541 Main Street
New London, NH 03257
(603) 526-3740

Employer Identification Number (EIN) 020222120
Plan Number 501

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

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

The office designated to consider the appeal of denied claims is:
The CG Claim Office responsible for this Plan

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

The Plan's fiscal year ends on 06/30.

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 Agreements

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.

Type of Administration

The Administrator of the Plan shall have the full power to control and manage all aspects of the Plan in accordance with its terms and all applicable laws. The Administrator may allocate or delegate its responsibilities for the administration of the Plan to others and employ others to carry out or give advice with respect to its responsibilities under the Plan.

Various aspects of the Plan are administered by CG and subsidiaries of CIGNA Health Corporation.
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 you or your Dependents' 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 last day of the calendar month in which 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 Administrator's 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 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 person under the Plan with a copy of this summary financial 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 preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

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:

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

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

Preservice Medical Necessity Determinations

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

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If the determination periods above would (a) seriously jeopardize your life or health, your ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, CG will make the preservice determination on an expedited basis. CG's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. CG 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, CG will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to CG within 48 hours after receiving the notice. CG will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If you or your representative fails to follow CG's procedures for requesting a required preservice medical necessity determination, CG 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, CG 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, CG will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond CG's control CG will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

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

Notice of Adverse Determination

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

Funding

The Plan is funded through contributions by the Employer and/or Plan Participants.

Assistance with Your Questions

If you have 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.

CG will provide administrative services of the following nature: Claim Administration; Cost Containment; Financial; Banking and Billing Administration.

Benefits provided under this plan are self-insured by the Employer.

This document is issued by:

Connecticut General Life Insurance Company
900 Cottage Grove Road
Hartford, CT 06152
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.

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.

Charges

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

Chiropractic Care

The term Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

Custodial Services

The term Custodial Services means any services which are not intended primarily to treat a specific Injury or Sickness (including Mental Health and Substance Abuse). Custodial Services include, but shall not be 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 usually be self-administered; and
• services not required to be performed by trained or skilled medical or paramedical personnel.

Dependent

Dependents are:

• your lawful spouse or your Domestic Partner; and
• any unmarried child of yours who is:
  • less than 19 years old;
  • 19 years but less than 25 years old, enrolled in school as a full-time student and primarily supported by you;
  • 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. It also includes a stepchild who lives with you; and a child who you have been assigned through a court appointed order legal guardianship. If your Domestic Partner has a child who lives with you, that child will also be included as a Dependent.

Domestic Partner

The eligible Employee and same sex Domestic Partner will be required to certify that they either are legally married or:

1. Share an exclusive, committed relationship whereby both parties holds the other out to the public as a spousal equivalent,
2. Are financially interdependent and share responsibility for each other's common welfare and financial obligations,
3. Are not legally married to anyone, or the common-law spouse of another,
4. Are not legally allowed to marry under current laws of the state in which the Employee resides,
5. Are not related by blood closer than would bar marriage in the state of New Hampshire,
6. Are both 18 years of age or older,
7. Were mentally competent to consent to contract when the domestic partnership began,
8. Are the other's sole Domestic Partner, and each intends to remain so indefinitely.

The section of this certificate entitled "Continuation Required By Federal Law" will not apply to your Domestic Partner and his or her Dependents.

**Emergency Services**

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

**Employee**

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 30 hours a week for the Employer.

**Employer**

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

**Expense Incurred**

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

**Formulary**

Formulary means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Formulary have been approved in accordance with parameters established by the P&T Committee. The Formulary is regularly reviewed and updated.

**Free-Standing Surgical Facility**

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

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

**Hospice Care Program**

The term Hospice Care Program means:

- 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;
- a program for persons who have a Terminal Illness and for the families of those persons.
Hospice Care Services
The term Hospice Care Services means any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Care Agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program.

Hospice Facility
The term Hospice Facility means an institution or part of it which:
• primarily provides care for Terminally Ill patients;
• is accredited by the National Hospice Organization;
• meets standards established by CG; and
• fulfills any licensing requirements of the state or locality in which it operates.

Hospital
The term Hospital means:
• an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses;
• an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and 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 and Substance Abuse or other related illness; (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;
• receiving treatment for Mental Health and Substance Abuse Services in a Partial Hospitalization program;
• receiving treatment for Substance Abuse in a Substance Abuse Intensive Therapy Program;
• receiving treatment in a Mental Health and Substance Abuse Residential Treatment Center.

Injury
The term Injury means an accidental bodily injury.

Maintenance Treatment
The term Maintenance Treatment means:
• treatment rendered to keep or maintain the patient's current status.

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.

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

Medically Necessary/Medical Necessity
Health care services and supplies which are determined by CG to be: (a) no more than required to meet the basic health needs of the insured; (b) consistent with the diagnosis of the condition for which they are required; (c) consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research; (d) required for purposes other than the comfort and convenience of the patient or their Physician; (e) rendered in the least intensive setting that is appropriate for the delivery of health care; and (f) of demonstrated medical value.

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

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

Other Health Care Professional

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

Participating Pharmacy

The term Participating Pharmacy means a retail pharmacy with which Connecticut General Life Insurance Company has contracted to provide prescription services to insureds; or a designated mail-order pharmacy with which CG has contracted to provide mail-order services to insureds.

Participating Provider

The term Participating Provider means:

• an institution, facility or agency which has entered into a contract with a Preferred Provider Organization (referred to as the PPO) to provide medical services at a predetermined cost in accordance with the agreement between CG and the PPO.
• a health care professional who has entered into a contract with a PPO to provide medical services at predetermined fees as negotiated by CG and that PPO.

The providers qualifying as Participating Providers may change from time to time. A list of the current Participating Providers will be provided by your Employer.

Pharmacy

The term Pharmacy means a retail pharmacy, including both Participating Pharmacies and Non-Participating Pharmacies; or a designated mail-order pharmacy.

Pharmacy & Therapeutics (P & T) Committee

A committee of CG Participating Providers, Pharmacists, Medical Directors and Pharmacy Directors, which regularly reviews Prescription Drugs and Related Supplies for safety, efficacy, cost effectiveness and value. The P & T Committee evaluates Prescription Drugs and Related Supplies for addition to or deletion from the Formulary and may also set dosage and/or dispensing limits on Prescription Drugs and Related Supplies.

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.
Prescription Drug

Prescription Drug means; (a) a drug which has been approved by the Food and Drug Administration for safety and efficacy; or (b) certain drugs approved under the Drug Efficacy Study Implementation review; or (c) drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

DFS1708

Prescription Order

Prescription Order means the lawful authorization for a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of such Physician's professional practice or each authorized refill thereof.

DFS1711

Preventive Treatment

The term Preventive Treatment means:

- Treatment rendered to prevent disease or its recurrence.

DFS1652

Psychologist

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

DFS170

Reasonable and Customary Charge

A charge will be considered Reasonable and Customary if:

- it is the normal charge made by the provider for a similar service or supply; and
- it does not exceed the normal charge made by most providers of such service or supply in the geographic area where the service is received, as determined by CG.

To determine if a charge is Reasonable and Customary, the nature and severity of the Injury or Sickness being treated will be considered.

DFS527

Related Supplies

Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under this Prescription Drug Benefit, and spacers for use with oral inhalers.

DFS1710

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.

DFS1688

Sickness - For Medical Insurance

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

DFS531

Skilled Nursing Facility

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

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

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

DFS193

Specialist

The term Specialist means a Physician who provides specialized services, and is not engaged in general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics.

DFS1429
Terminal Illness

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

Urgent Care

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by CG, in accordance with generally accepted medical standards, to 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 were 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 the insured should not travel due to any medical condition.