GLOBAL HEALTH PLAN

COMPREHENSIVE MEDICAL COVERAGE
PRESCRIPTION DRUG COVERAGE

EFFECTIVE DATE: JANUARY 1, 2017

IMPORTANT INFORMATION

Please be aware that the coverage made available hereunder may be prohibited or unadvisable in certain countries. The Company may be able to provide some general information or assistance in this regard, but the Company is not in a position to provide legal advice to employers or employees in such countries.

The benefits provided under the plan are provided by the Company and are paid from the general assets of the Company. Cigna Health and Life Insurance Company (CIGNA) provides claim administration services only to the plan.

The Company reserves the right at any time and for any reason to terminate, suspend, withdraw, amend or modify the plan or any of its provisions. If any material changes are made in the future, you will be notified.

Please be aware that the coverage made available hereunder may be prohibited or unadvisable in certain countries. The Company may be able to provide some general information or assistance in this regard, but the Company is not in a position to provide legal advice to employers or employees in such countries.

Contact Information: *www.cignaenvoy.com* or International access code + 1 **+ 800-441-2668 or 302-797-3100**

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Home Office: Bloomfield, Connecticut

Mailing Address: Hartford, Connecticut 06152

Cigna Health and Life Insurance Company

a CIGNA company (called CIGNA) certifies that it provides certain Employees for the benefits provided by the following Plan(s):

GROUP PLAN(S) — COVERAGE

05180A COMPREHENSIVE MEDICAL COVERAGE
PRESCRIPTION DRUG COVERAGE

EFFECTIVE DATE: January 1, 2017

This certificate describes the main features of the coverage.
This certificate takes the place of any other issued to you on a prior date which described the coverage.

Shermona Mapp, Corporate Secretary

GM6000 C2 **CER7V23**

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, a separately provided document made a part of this plan, is a brief outline of your maximum benefits which may be payable under your coverage. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

Patient Protection and Affordable Care Act

The group contract or certificate is amended as stated below.

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

Definitions
"Emergency medical condition" means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions or (3) serious dysfunction of any bodily organ or part.

"Emergency services" means, with respect to an emergency medical condition: (a) a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition and (b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

"Essential health benefits" means, to the extent covered under the plan, expenses incurred with respect to covered services, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

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

"Stabilize" means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Lifetime Dollar Limits
Any lifetime limit on the aggregate dollar value of essential health benefits is deleted. Any lifetime limits on the dollar value of any essential health benefits are deleted.

Annual Dollar Limits
Any annual limits on the dollar value of any essential health benefits are deleted.

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

Extension of Coverage to Dependents
Dependent children are eligible for coverage through the end of the month in which they reach age 26. Any restrictions in the definition of Dependent in your plan document which require a child to be unmarried, a student or financially dependent on the employee, etc. no longer apply. If the definition of Dependent in the plan document provides coverage for a child beyond age 26, the provision and all restrictions will continue to apply starting at age 26. Any provisions related to coverage of a handicapped child continue to apply starting at age 26.

Preventive Services
In addition to any other preventive care services described in the plan documents, no deductible, co-payment or co-insurance shall apply to the following Covered Services:

(1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
(3) for infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
(4) for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration, but not including abortions or abortifacient contraceptives.

Notice of Adverse Determination

In addition to the description provided in your plan documents, a notice of adverse benefit determination will also include information sufficient for you to identify the claim and information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process. In the case of a final adverse benefit determination, your notice will include a discussion of the decision.

Right to Appeal
You have the right to appeal any decision or action taken to deny, reduce or terminate the provision of or payment for healthcare services covered by your plan or to rescind your coverage. When a requested service or payment for the service has been denied, reduced or terminated based on a judgment as to the medical necessity, appropriateness, healthcare setting, level of care or effectiveness of the healthcare service, you have the right to have the decision reviewed by an independent review organization not associated with CIGNA.

Except where life or health would be seriously jeopardized, you must first exhaust the internal appeal process set forth in your plan documents before your request for an external independent review will be granted. If the plan does not strictly adhere to all internal claim and appeals processes, you can be deemed to have exhausted the internal appeal process.

Your appeal rights are outlined in your plan documents. In addition, before a final internal adverse benefit determination is issued, if applicable, you will be provided, free of charge, any new or additional evidence considered, or rationale relied upon, in sufficient time to allow you the opportunity to respond before the final notice is issued.

Emergency Services
Emergency Services, as defined above, are covered without the need for any prior authorization determination and without regard as to whether the healthcare provider furnishing such services is a participating provider. Emergency Services, as defined above, provided by a Non-Participating Provider will be covered as if the services were provided by a Participating Provider.

Direct Access to Obstetricians and Gynecologists
You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, visit *www.cignaenvoy.com* or contact customer service at the phone number listed on the back of your ID card.

Special Plan Provisions

When you select a Participating Provider, this Plan pays a greater share of the costs than if you select a Non-Participating Provider. Participating Providers include Physicians, Hospitals and Other Healthcare Professionals and Other Healthcare Facilities. You can access a list of Participating Providers in your area at *www.cignaenvoy.com*. 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 paragraphs describe helpful services available in conjunction with your medical plan. You can access these services by calling the toll-free number shown on your ID card.

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Case Management
Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or 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 that 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 healthcare 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

number shown on 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.

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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.

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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 form at *www.cignaenvoy.com* or from your Benefit Plan Administrator. All fully completed claim forms and bills should be sent directly to your servicing Cigna Service Center.

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

Hospital Confinement

If possible, get your Group Medical 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 Cigna Service Center.

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 EMPLOYEE ID WHEN YOU FILE CIGNA CLAIM FORMS OR WHEN YOU CALL THE CIGNA SERVICE CENTER.
- YOUR EMPLOYEE ID AND ACCOUNT NUMBER ARE BOTH 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.

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Accident and Health Provisions

Claims

Notice of Claim

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

Claim Forms

When CIGNA receives the notice of claim, it will give to the claimant, or to the policyholder for the claimant, the claim forms which it uses for filing proof of loss. If the claimant does not get these claim forms within 15 days after CIGNA receives notice of claim, he will be considered to meet the proof-of-loss requirements of the Plan if he submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be given to CIGNA within 90 days after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be

invalidated or reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

Physical Examination

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

Legal Actions

Where CIGNA has followed the terms of the Plan, no action at law or in equity will be brought to recover on the Plan until at least 60 days after proof of loss has been filed with CIGNA. No action will be brought at all unless brought within three years after the time within which proof of loss is required.

GM6000 CLA43V6

Eligibility — Effective Date

Eligibility for Employee Coverage

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

- you are an active, full-time employee (as defined by your Employer) earning wages from an Employer that offers Plan coverage to one or more Classes of Eligible Employees.
- you normally work at least 20 hours a week.

If you were previously covered and your coverage ceased, you must satisfy the New Employee Group Waiting Period to become covered again. If your coverage 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 coverage 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 Coverage

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

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

Waiting Period

As determined by your Employer.

Classes of Eligible Employees

The following Classes of Employees are eligible for this coverage:

All full-time U.S. Expatriate and Retirees as identified by the policyholder.

"Expatriate" means an Employee who is working outside his country of citizenship.

Persons for whom coverage is prohibited under applicable law will not be considered eligible under this plan.

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Employee Coverage

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

Effective Date of Your Coverage

You will become covered on the date you elect the coverage by signing an approved payroll deduction form, but no earlier than the date you become eligible. If you are a Late Entrant, your coverage will not become effective until CIGNA agrees to cover you. You will not be denied enrollment for Medical Coverage due to your health status.

You will become covered on your first day of eligibility, following your election, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status.

Late Entrant — Employee

You are a Late Entrant if:

- you elect the coverage more than 31 days after you become eligible or
- you again elect it after you cancel your payroll deduction.

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ELI7V82

Dependent Coverage

For your Dependents to be covered, you may have to pay part of the cost of Dependent Coverage.

Effective Date of Dependent Coverage

Coverage 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 Coverage. All of your Dependents as defined will be included.

If you are a Late Entrant for Dependent Coverage, the coverage for each of your Dependents will not become effective until CIGNA agrees to insure that Dependent. Your Dependent will not be denied enrollment for Medical Coverage due to health status.

Your Dependents will be covered only if you are covered.

Late Entrant — Dependent

You are a Late Entrant for Dependent Coverage if:

- you elect that coverage more than 31 days after you become eligible for it or

- you again elect it after you cancel your payroll deduction.

Exception for Newborns

Any Dependent child born while you are covered for Medical Coverage will become covered for Medical Coverage on the date of his birth if you elect Dependent Medical Coverage no later than 60 days after his birth. If you do not elect to insure your newborn child within such 60 days, coverage for that child will end on the 61st day. No benefits for expenses incurred beyond the 61st day will be payable.

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Exception to Late Entrant Definition

A person will not be considered a Late Entrant 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 60 days after losing or exhausting prior coverage. In addition, a Dependent Spouse or minor child enrolled within 60 days following a court order of such coverage will not be considered a Late Entrant.

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 60 days of such event. Coverage will be effective, on the date of marriage, birth, adoption or placement for adoption.

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Comprehensive Medical Coverage

Please see separate Schedule of Benefits.

Certification Requirements For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement in the United States

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 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 will not include the first $300 of 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 after the date of admission.

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 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 CIGNA has contracted.

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

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 covered for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by CIGNA. **Any applicable Co-insurance, Co-payments, Deductibles or limits are shown in The Schedule.**

- 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 Limit shown in the Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Healthcare Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Healthcare Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Healthcare Facility Daily Limit shown in The Schedule.
- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.

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- charges made for an annual Papanicolaou laboratory screening test.
- charges made for an annual prostate-specific antigen test (PSA).
- charges for appropriate counseling, medical services connected with surgical therapies, including vasectomy and tubal ligation.
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.

- charges made for Sterilization, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices and other medical services.
- charges made for visits for routine preventive care of a Dependent child through age 17, including immunizations. Coverage includes developmental screenings at nine, eighteen and thirty months, which include any developmental screening tool favorably mentioned by the American Academy of Pediatrics Committee on Children with Disabilities.
- charges made for routine preventive care for adults ages 18 and over, including immunizations. Routine preventive care means healthcare assessments, wellness visits and any related services.
- charges made for or in connection with travel immunization for Employees and Dependents.
- surgical or non-surgical treatment of TMJ dysfunction.

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

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FLX108V748

- charges made for or in connection with mammograms including: (a) a baseline mammogram for asymptomatic women at least age 35; (b) a mammogram every one or two years for asymptomatic women ages 40-49, but no sooner than two years after a woman's baseline mammogram; (c) an annual mammogram for women age 50 and over and (d) when prescribed by a Physician, a mammogram, anytime, regardless of the woman's age.
- charges made for CA-125 monitoring of ovarian cancer subsequent to treatment for ovarian cancer. Coverage is not provided for routine screening.
- charges made for or in connection with one baseline lead poison screening test for Dependent children at or around 12 months of age.
- charges made for or in connection with lead poison screening and diagnostic evaluations for Dependent children under the age of six years who are at high risk for lead poisoning according to guidelines set by the Division of Public Health.
- charges made for children from birth through age 18 for immunization against: (a) diphtheria; (b) hepatitis B; (c) measles; (d) mumps; (e) pertussis; (f) polio; (g) rubella; (h) tetanus; (i) varicella; (j) Haemophilus influenzae B and (k) hepatitis A.
- charges for hearing loss screening tests of newborns and infants provided by a Hospital before discharge.
- charges made for scalp hair prostheses worn due to alopecia areata.
- charges made for Diabetic supplies as recommended in writing or prescribed by a Participating Physician or Other Participating Healthcare Professional, including insulin pumps and blood glucose meters.
- nutritional formulas, low protein modified food products or other medical foods consumed or administered enterally (via tube or orally) which are medically necessary for the therapeutic treatment of inherited metabolic diseases, such as phenylketonuria (PKU), maple syrup urine disease, urea cycle disorders, tyrosinemia and homocystinuria, when administered under the direction of a Physician.

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- orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, provided:
  - the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
  - the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease or
  - the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

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

GM6000 06BNR10

- charges made for colorectal cancer screening for persons 50 years of age or older to include: (a) a screening with an annual fecal occult blood test (three specimens); (b) a flexible sigmoidoscopy every five years; (c) a colonoscopy every ten years; (d) a double contrast barium enema every five years or (e) any combination of the most reliable, medically recognized screening tests available. Coverage for persons who are deemed at high risk for colon cancer because of family history of familial adenomatous polyposis or hereditary nonpolyposis colon cancer, chronic inflammatory bowel disease, family history of breast, ovarian, endometrial, colon cancer or polyps, or a background, ethnic or lifestyle, such that the healthcare provider treating the participant or beneficiary believes he or she is at elevated risk, shall include a screening by a

colonoscopy, barium enema or any combination of the most reliable, medically recognized screening tests available.

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- charges made for medical and surgical services for the treatment or control of clinically severe (morbid) obesity as defined below and if the services are demonstrated, through existing peer-reviewed, evidence-based, scientific literature and scientifically based guidelines, to be safe and effective for the treatment or control of the condition. Clinically severe (morbid) obesity is defined by the National Heart, Lung and Blood Institute (NHLBI) as a Body Mass Index (BMI) of 40 or greater without comorbidities, or a BMI of 35–39 with comorbidities. The following items are specifically excluded:
  - medical and surgical services to alter appearances or physical changes that are the result of any medical or surgical services performed for the treatment or control of obesity or clinically severe (morbid) obesity and
  - weight-loss programs or treatments, whether or not they are prescribed or recommended by a Physician or under medical supervision.

GM6000 06BNR1 V1

Clinical Trials

- charges made for routine Patient Services associated with clinical trials for treatment of life-threatening diseases approved and sponsored by the federal government. In addition, the following criteria must be met:
  - the clinical trial is listed on the National Institutes of Health website *www.clinicaltrials.gov* as being sponsored by the federal government.
  - the subject or purpose of the trial must be the evaluation of an item or service that falls within the covered benefits of the Plan and is not specifically excluded from coverage.
  - the trial must not be designed exclusively to test toxicity or disease pathophysiology.
  - the trial must have therapeutic intent.
  - trials of therapeutic interventions must enroll the patients with diagnosed disease.
  - the principal purpose of the trial is to test whether the intervention potentially improves the participant's health outcomes.
  - the trial is well supported by available scientific and medical information or it is intended to clarify or establish the health outcomes of interventions already in common clinical use.
  - the trial does not unjustifiably duplicate existing studies.
  - the trial is in compliance with federal regulations relating to the protection of human subjects.
  - the person meets all inclusion criteria for the clinical trial and is not treated "off-protocol."
  - the trial is approved by the Institutional Review Board of the institution administering the treatment.

Routine Patient Services do not include and reimbursement will not be provided for:

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

Genetic Testing

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

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Nutritional Evaluation

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

Internal Prosthetic/Medical Appliances

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

GM6000 05BPT2 V1

Home Health Services

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

  Home Health Services are provided only if CIGNA has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for non-skilled care and/or custodial services (e.g., bathing, eating and toileting), Home Health Services will be provided for you only during times when there is a family member or caregiver present in the home to meet your non-skilled care and/or custodial services needs.

  Home Health Services are those skilled healthcare services that can be provided during visits by Other Healthcare Professionals. The services of a home health aide are covered when rendered in direct support of skilled healthcare services provided by Other Healthcare Professionals. A visit is defined as a period of two hours or less. Home Health Services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Healthcare Professionals in providing Home Health Services are covered. Home Health Services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Healthcare Professional. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations. Physical, occupational and other Short-Term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Short-Term Rehabilitative Therapy Maximum shown in The Schedule.

GM6000 05BPT104

Hospice Care Services

- charges made for a person who has been diagnosed as having six months or fewer to live, 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;
  - by a Hospice Facility for services provided on an outpatient basis;
  - by a Physician for professional services;
  - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
  - for pain relief treatment, including drugs, medicines and medical supplies;
  - by an Other Healthcare Facility for:
    - part-time or intermittent nursing care by or under the supervision of a Nurse;
    - part-time or intermittent services of an Other Healthcare Professional;

GM6000 CM34 FLX124V26

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

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 or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the Plan;
- for services or supplies that are primarily to aid you or your Dependent in daily living.

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Mental Health and Substance Abuse Services

Mental Health Services are services 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 Dependent is

confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Partial Hospitalization and Mental Health Residential Treatment Services.

Partial Hospitalization sessions are services that are provided for not less than four hours and not more than 12 hours in any 24-hour period.

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

GM6000 INDEM9 V71

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

Outpatient Mental Health Services

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

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

GM6000 INDEM10 V60

Inpatient Substance Abuse Rehabilitation Services

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

Partial Hospitalization sessions are services that are provided for not less than four hours and not more than 12 hours in any 24-hour period.

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

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

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

Outpatient Substance Abuse Rehabilitation Services

Services provided 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, a group or a Substance Abuse Intensive Outpatient Therapy Program.

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 Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

GM6000 INDEM11 V78

Substance Abuse Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. CIGNA 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 Plan or agreement.
- treatment of 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.

GM6000 INDEM12V48

Durable Medical Equipment

- charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by CIGNA for use outside a Hospital or Other Healthcare Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

  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, respirators, wheelchairs and dialysis machines.

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

- **Bed-Related Items:** bed trays, over-the-bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including non-power mattresses, custom mattresses and posturepedic mattresses.
- **Bath-Related Items:** bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, handheld showers, paraffin baths, bath mats and spas.
- **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll-about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized — manual hydraulic lifts are covered if patient is two-person transfer) and auto tilt chairs.
- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
- **Car/Van Modifications.**
- **Air Quality Items:** room humidifiers, vaporizers, air purifiers and electrostatic machines.
- **Blood/Injection Related Items:** blood pressure cuffs, centrifuges, nova pens and needleless injectors.
- **Other Equipment:** heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

GM6000 05BPT3

External Prosthetic Appliances and Devices

- charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect. Coverage for External Prosthetic Appliances is limited to the most appropriate and cost-effective alternative as determined by the utilization review Physician.

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

Prostheses/Prosthetic Appliances and Devices

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

- basic limb prostheses;
- terminal devices such as hands or hooks and
- speech prostheses.

Orthoses and Orthotic Devices

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

orthoses and other orthoses as follows:

- non-foot orthoses — only the following non-foot orthoses are covered:
  - rigid and semirigid custom fabricated orthoses;
  - semirigid prefabricated and flexible orthoses and
  - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- custom foot orthoses — custom foot orthoses are only covered as follows:
  - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
  - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g., amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect and
  - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

GM6000 06BNR5

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- orthoses primarily used for cosmetic rather than functional reasons and
- orthoses primarily for improved athletic performance or sports participation.

Braces

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

The following braces are specifically excluded: Copes scoliosis braces.

Splints

A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

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

- replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered;
- replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.

Coverage for replacement is limited as follows:

- no more than once every 24 months for persons 19 years of age and older and
- no more than once every 12 months for persons 18 years of age and under and
- replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:

- external and internal power enhancements or power controls for prosthetic limbs and terminal devices and
- myoelectric prostheses peripheral nerve stimulators.

GM6000 05BPT5

Short-Term Rehabilitative Therapy

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

The following limitations apply to short-term rehabilitative therapy:

- to be covered, all therapy services must be restorative in nature. Restorative therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of Injury or Sickness. Restorative therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the Injury or Sickness.
- services are not covered if they are custodial, instructional, educational or developmental in nature.
- occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.

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

- sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;

- treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury and
- maintenance or preventive treatment consisting of routine, long-term or Non-Medically Necessary care provided to prevent recurrences or to maintain the patient's current status.

GM6000 06BNR8 (2)

Chiropractic Care Services

- charges made for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

The following are specifically excluded from chiropractic care services:

- to be covered, all therapy services must be restorative in nature. Restorative therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of Injury or Sickness. Restorative therapy services do not include therapy designed to acquire levels of function that has not been previously achieved prior to the Injury or Sickness;
- services are not covered if they are considered custodial, instructional, developmental or educational in nature;
- occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness;
- services of a chiropractor which are not within his scope of practice, as defined by state law;
- charges for care not provided in an office setting;
- maintenance or preventive treatment consisting of routine, long-term or Non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status and
- vitamin therapy.

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Transplant Services

- charges made for human organ and tissue transplant services which include solid organ and bone marrow/stem cell procedures.

This coverage is subject to the following conditions and limitations:

- transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human-to-human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel, liver or multiple viscera.
- coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Breast Reconstruction and Breast Prostheses

- charges made for reconstructive surgery following a mastectomy; benefits include: (a) surgical services for reconstruction of the breast on which surgery was performed; (b) surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance; (c) postoperative breast prostheses and (d) mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Reconstructive Surgery

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: (a) the surgery or therapy restores or improves function; (b) reconstruction is required as a result of Medically Necessary, non-cosmetic surgery or (c) the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

GM6000 05BPT2 V2

Prescription Drug Benefits (purchased outside the U.S.)

- charges made for Prescription Drugs and Related Supplies, subject to the Co-insurance and Limits shown in the Medical Schedule, except that the following Prescription Drugs, by way of example, but not of limitation are excluded:
  - drugs or medications available over-the-counter that do not require a prescription by federal or state law, and any drug or medication that is equivalent (in strength, regardless of form) to an over-the-counter drug or medication;
  - any drugs that are labeled as experimental or investigational;
  - 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 vitamins (other than prenatal vitamins), dietary supplements and fluoride products;
  - prescription 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);
  - prescription smoking cessation products; or
  - any non-prescription drugs.

Telehealth Services

- charges made for Telehealth services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient's health care by a health care provider practicing within his or her scope of practice as would be practiced in-person with a patient, and legally allowed to practice in the state, while such patient is at an originating site and the health care provider is at a distant site.

Prescription Drug Coverage

The Schedule

This section describes coverage for Prescriptions obtained *inside the United States only*.
Prescriptions obtained outside of the United States are covered under the Comprehensive Medical Coverage section of this Schedule.

For You and Your Dependents
This plan provides Prescription Drug Coverage for Prescription Drugs and Related Supplies provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Coverage, you and your Dependents may be required to pay a portion of the Covered Expenses for Prescription Drugs and Related Supplies. That portion is the Co-insurance. **There is no Deductible.**

Co-insurance
The term Co-insurance means the percentage of charges for covered Prescription Drugs and Related Supplies that you or your Dependent is required to pay under this plan.

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
Prescription Drugs — per 30-day prescription order or refill		
Generic*	$15 co-payment, not subject to plan deductible	50% co-insurance, not subject to plan deductible
Preferred Brand Name *	$35 co-payment, not subject to plan deductible	50% co-insurance, not subject to plan deductible
Non-Preferred Brand Name*	$50 co-payment, not subject to plan deductible	50% co-insurance, not subject to plan deductible
Mail-Order Drugs – per 90 day prescription order or refill		
Generic*	$45 co-payment, not subject to plan deductible	In-network coverage only
Preferred Brand Name*	$105 co-payment, not subject to plan deductible	In-network coverage only
Non-Preferred Brand Name*	$150 co-payment, not subject to plan deductible	In-network coverage only

* Designated as per generally accepted industry sources and adopted by CIGNA

Prescription Drug Coverage
For You and Your Dependents

Covered Expenses

If you or any one of your Dependents, while covered for Prescription Drug Coverage, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, CIGNA will provide coverage for those expenses as shown in the Schedule. Coverage also includes Medically Necessary 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.

Limitations

Each Prescription Order or refill shall be limited to:

- a dosage and/or dispensing limit as determined by the Pharmaceuticals & Therapeutics Committee.

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GM6000 PHARM85 PHARM122

Your Payments

Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy is subject to the Co-payment or Co-insurance shown in the Schedule. Please refer to the Schedule for any required Co-payments, Co-insurance or Maximums if applicable.

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

In no event will the Co-payment for the Prescription Drug or Related Supply exceed the amount paid by the plan to the Pharmacy or the Pharmacy's Usual and Customary (U&C) charge. Usual & Customary (U&C) means the established Pharmacy retail cash price, less all applicable customer discounts that Pharmacy usually applies to its customers regardless of the customer's payment source.

GM6000 PHARM129

Exclusions

No payment will be made for the following expenses:

- drugs available over-the-counter that do not require a prescription by federal or state law;
- 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;
- injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician-supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents;
- any drugs that are experimental or investigational as described under the Medical "Exclusions" section of your certificate;
- Food and Drug Administration (FDA)-approved 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 non-prescription supplies (such as ostomy supplies), devices and appliances other than Related Supplies;
- implantable contraceptive products;
- contraceptives are not covered (except for certain oral contraceptives) unless deemed as medically necessary only to treat an illness;
- dietary supplements and fluoride 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);
- prescription smoking cessation products;
- biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications;
- 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 Medical "Exclusions" section.

GM6000 PHARM88 PHARM104V16
GM6000 PHARM89
GM6000 PHARM105

Reimbursement/Filing a Claim

When you or your Dependents purchase your Prescription Drugs or Related Supplies through a retail Participating Pharmacy, you pay any applicable Co-payment or Co-insurance shown in the Schedule at the time of purchase. You do not need to file a claim form.

To purchase Prescription Drugs or Related Supplies from a Non-Participating Retail Pharmacy, you pay the full cost at the time of purchase. You must submit a claim form in order to be reimbursed for the amount payable by the plan. You may get the required claim forms at *www.cignaenvoy.com* or from your Benefit Plan Administrator.

To purchase Prescription Drugs or Related Supplies from a mail-order Participating Pharmacy, see your Benefits Kit for details, or contact member services for assistance.

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Emergency Evacuation or Repatriation Benefits

Notification

International SOS, acting as CIGNA's evacuation coordinator, must approve any evacuation or repatriation.

If you need an emergency evacuation or repatriation as the result of an Injury or Sickness, International SOS or CIGNA must be notified by the end of the first scheduled workday after the Injury or Sickness.

Expenses incurred for your evacuation or repatriation without the approval and authorization of International SOS will not be considered Covered Expenses (See General Limitations/Exclusions for Evacuation Benefits.)

GM6000 NOT32 V2

Covered Expenses

If you suffer an Injury or sudden, life-threatening Illness, and International SOS determines that adequate medical facilities are not available locally, International SOS will arrange for an emergency evacuation or repatriation to the nearest facility capable of providing adequate care. Although International SOS will be providing the service, to access International SOS, you must call the Cigna Service Center at 1-800-441-2668 (inside the U.S. and Canada) or outside the U.S. and Canada, call collect at 1-302-797-3100.

In making their determinations, they will consider the nature of the emergency, your condition and ability to travel, as well as other relevant circumstances, including airport availability, weather conditions and distance to be covered. Transportation will be provided by private medically equipped aircraft, helicopter, commercial airline, train or ambulance. All evacuations or repatriations are carried out under the medical authorization or intervention of International SOS.

Following an approved medical evacuation, CIGNA will pay, based on recommendation of International SOS, for *one* of the following:

- if it is deemed Medically Necessary, you will be transferred to your permanent residence via a one-way economy airfare. If your transportation needs to be medically supervised, a qualified medical attendant will escort you or
- a one-way economy airfare will be provided to return to the point of evacuation or original work location.

Emergency Family Travel Arrangements and Confinement Visitation

If family members need to join you when you are evacuated, and subsequently hospitalized, emergency travel arrangements for your family members will be coordinated. The costs of the travel services, however, are the responsibility of you or your family members.

If you require hospitalization in excess of seven days at the location to which you were evacuated, an economy round-trip airfare will be provided to the place of hospitalization for an individual chosen by you. If your Dependent child is evacuated, one economy round-trip airfare will be provided to a parent or legal guardian regardless of the number of days that the Dependent child is hospitalized.

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Return of Dependent Children

If Dependent children are left unattended as a result of your Injury or Sickness, a one-way economy airfare will be provided to their place of residence. Furthermore, the accompaniment of a qualified attendant will be provided at no charge, if required.

Repatriation of Mortal Remains

The costs associated with the transportation of mortal remains from the place of death to the home country will be covered. In addition, assistance will be provided for organizing and obtaining the necessary clearances for the repatriation of mortal remains.

Return of Traveling Companion

If you are hospitalized or evacuated, and a traveling companion's air ticket is no longer usable, a one-way economy airfare will be provided to the original point of departure.

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General Limitations/ Exclusions for Evacuation Benefits

No payment will be made for charges for:

- services rendered without the authorization or intervention of International SOS;
- non-emergency, routine or minor medical problems, tests and exams where there is no clear or significant risk of death or imminent serious Injury or harm to you;
- a condition which would allow for treatment at a future date convenient to you and which does not require emergency evacuation or repatriation;
- expenses incurred if the original or ancillary purpose of your trip is to obtain medical treatment;
- services provided for which no charge is normally made;
- expenses incurred while serving in the armed forces of another country;
- transportation for your vehicle and/or other personal belongings involving intercontinental and/or marine transportation;
- service provided other than those indicated in this certificate;
- injury or Sickness caused by war, or an act of war, whether declared or undeclared, riot, civil commotion or police action;
- death caused by war, or an act of war, whether declared or undeclared, riot, civil commotion or police action or
- for claim payments that are illegal under applicable law.

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Exclusions, Expenses Not Covered and General Limitations

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

- expenses for supplies, care, treatment or surgery that are not Medically Necessary;
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness;
- for or in connection with an Injury or Sickness which is due to war, declared or undeclared, riot, civil commotion or police action which occurs in the Employee's country of citizenship;
- for claim payments that are illegal under applicable law;
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan;
- assistance in the activities of daily living, including, but not limited to, eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care;
- for or in connection with experimental, investigational or unproven services;

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other healthcare technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:

  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section of this plan or
  - the subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of this plan.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance;
- regardless of clinical indication for macromastia or gynecomastia surgeries; abdominoplasty/panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions;

- for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an Injury to sound natural teeth; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; (c) charges made by a Free-Standing Surgical Facility or the outpatient department of a Hospital in connection with surgery;
- medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity and weight-loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision;
- unless otherwise covered in this plan, for reports, evaluations, physical examinations or hospitalization not required for health reasons, including, but not limited to, employment, insurance or government licenses and court-ordered, forensic or custodial evaluations;
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan;
- 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 are also excluded from coverage;
- reversal of male and female voluntary sterilization procedures;
- elective termination of pregnancy by any method;
- charges made for certain U.S. FDA approved prescription contraceptive drugs and devices and for outpatient contraceptive services, including consultations, exams, procedures and medical services related to the use of contraceptives and devices; except when deemed medically necessary to treat an illness;
- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery;
- any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy and premature ejaculation;
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan;
- non-medical counseling or ancillary services, including, but not limited to, Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back to school, return-to-work services, work hardening programs, driving safety and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation;
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to, routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected;
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to, bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan;
- private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision;
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements and other articles which are not for the specific treatment of an Injury or Sickness;
- artificial aids, including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets and dentures;
- wigs other than for scalp hair prostheses worn due to alopecia areata or for individuals undergoing cancer treatment;
- hearing aids;
- aids or devices that assist with non-verbal communications, including, but not limited to, communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books;
- medical benefits for eyeglasses or contact lenses or 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;
- charges made for or in connection with eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn;
- all non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan;
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary;

- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs;
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease;
- dental implants for any condition;
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion, the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery;
- blood administration for the purpose of general improvement in physical condition;
- cosmetics, dietary supplements and health and beauty aids;
- nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism;
- medical treatment when payment is denied by a Primary Plan because treatment was received from a non-participating provider;
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit;
- massage therapy;
- for charges which would not have been made if the person had no coverage;
- to the extent that they are more than Maximum Reimbursable Charges;
- charges made by any covered provider who is a member of your family or your Dependent's family;
- to the extent of the exclusions imposed by any certification requirement shown in this plan.

GM6000 05BPT14 V143
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GM6000 07BNR10

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. For claims incurred within the United States, you should file all claims under each Plan. For claims incurred outside the United States, if you file claims with more than one Plan, you must indicate, at the time of filing a claim under this Plan, that you also have or will be filing your claim under another Plan.

Definitions

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

Plan

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

(1) Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.

(2) Coverage under Medicare and other governmental benefits as permitted by law, except Medicaid and Medicare supplement policies.

(3) Medical benefits coverage of group, group-type and individual automobile contracts.

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

Closed Panel Plan

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

Primary Plan

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

Secondary Plan

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

GM6000 COB11

Allowable Expense

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

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

- an expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense;
- if 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;

- 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;
- 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;
- if your benefits are reduced under the Primary Plan (through the imposition of a higher co-payment amount, higher co-insurance 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 Plan or any date before this section or any similar provision takes effect.

GM6000 COB12

Reasonable Cash Value

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

Order of Benefit Determination Rules

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

(1) The Plan that covers you as an enrollee or an employee shall be the Primary Plan, and the Plan that covers you as a Dependent shall be the Secondary Plan;

(2) If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;

(3) If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:

(a) first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;

(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.

GM6000 COB13

(4) The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as a laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

(5) The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

(6) If one of the Plans that covers you is issued out of the state whose laws govern this Plan, determines the order of benefits based upon the gender of a parent and, as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered 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 100% of the total of all Allowable Expenses.

GM6000 COB14

Recovery of Excess Benefits

If CIGNA pays charges for benefits that should have been paid by the Primary Plan, or if CIGNA pays charges in excess of those for which we are obligated to provide under the Plan,

CIGNA will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

CIGNA 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 must 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

CIGNA, 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. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

GM6000 COB15

Expenses for Which a Third Party May Be Liable

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

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

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

GM6000 CCP7
CCL7

Payment of Benefits — Medical Benefits

To Whom Payable

All Medical Benefits are payable to you. However, at the option of CIGNA, 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 CIGNA. CIGNA 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 CIGNA, 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, CIGNA 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, CIGNA 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 CIGNA from all liability to the extent of any payment made.

Time of Payment

Benefits will be paid by CIGNA when it receives due proof of loss.

Recovery of Overpayment

When an overpayment has been made by CIGNA, CIGNA 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

CIGNA, 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.

GM6000 TRM366

Termination of Coverage

Employees

Your coverage will end if any one of these things happens:

- You no longer work as an active, full-time employee for the Employer that offers Plan coverage.
- You retire and your Employer does not offer Plan coverage to its retirees.
- The Company or your Employer stops offering the Plan.
- Required contributions are not paid when due. Your Employee coverage will not end just because You do not pay contributions for Dependents coverage.
- You are eligible for Medicare and Medicare pays first before this Plan pays. See the "Coordination of Benefits" section.

If You are no longer an active full-time employee, check with your Employer at once to find out if You can continue your Plan coverage.

Dependents

Your dependents will lose coverage if any one of these things happens:

- You lose your Coverage for any reason except that You became eligible for Medicare coverage.
- Your Spouse or Child is no longer an Eligible Dependent.
- The Company or your Employer stops offering the Plan.
- Your Employer stops offering coverage to dependents.
- Required contributions are not paid when due.
- Your Spouse or Child becomes eligible for Medicare and Medicare pays first.

If your dependents lose coverage for any reason, call your Employer at once to find out if they can continue coverage.

A. Important Notice Requirement

You must report changes to coverage eligibility for You and your Covered Dependents immediately. Failure to report could be interpreted as fraud or intentional misrepresentation as provided by the federal healthcare reform law known as the Affordable Care Act (ACA). Policies and procedures have been adopted incorporating ACA guidance. You may make unnecessary contribution payments that may not be refundable in accordance with those policies and procedures, and your coverage may be subject to rescission.

B. Continued Coverage for Covered Dependents after Your Death

If You die while covered under the Plan, your Covered Dependents may continue their Plan coverage. This continued coverage will end when any one of these things happens:

Your dependent is no longer an Eligible Dependent.

Your dependent becomes eligible for benefits under any other group medical plan.

The Plan stops offering Dependents Coverage.

Your Employer or the Plan stops offering group medical plans.

Required contributions are not paid when due.

Your Spouse or Child becomes covered under Medicare and Medicare pays first.

C. Continuation Coverage for You and Your Covered Dependents

Some Employers allow You and your Covered Dependents to continue Plan coverage after it would otherwise end. This applies only if the following are true:

- Your Employer elects to offer Continuation Coverage.
- Your Employer continues to offer Plan coverage to its employees.
- You were not fired for gross misconduct, as determined by your Employer.

The maximum length of Continuation Coverage is:

- 18 months for You and your Covered Dependents if the loss of Plan coverage is because You either lost your job or You work fewer than the hours required for active, full-time employment.
- 36 months for your Spouse or Covered Dependent Child if the loss of Plan coverage is due to You and your Spouse's divorce or legal separation, or your Covered Dependent Child is no longer an Eligible Dependent.

Enrollment for Continuation Coverage. If You want Continuation Coverage, You or your Covered Dependents must:

- Get an application and other information about this coverage from your Employer.
- Apply for Continuation Coverage within 60 days after the date Plan coverage would otherwise end.

Adding Eligible Dependents to your Continuation Coverage. You may add a newborn or an adopted Child to your Continuation Coverage within 60 days after birth,

adoption or placement in your home. Also, if You get married, You may add your new Spouse and any new Eligible Dependents to your Continuation Coverage within 60 days after your marriage.

You must act promptly. If You do not, You and your dependents will not be eligible for this Continuation Coverage.

Charges for Continuation Coverage. The monthly charge for Continuation Coverage will be up to 102% of the full cost of each Covered Person's Plan coverage. Your Employer is responsible for collecting monthly charges. **You must pay these costs of coverage when due, or your Continuation Coverage will end.**

Early termination of Continuation Coverage. Continuation Coverage will end sooner than the 18 or 36 months if:

- Costs of coverage are not paid when due.
- The Covered Person becomes covered under other group medical coverage, either as an employee or dependent.
- The Covered Person becomes eligible for Medicare.
- The Plan is no longer offered.

Medical Benefits Extension

During Hospital Confinement Upon Plan Cancellation

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the Plan (except if Plan is cancelled for non-payment of monthly rates) and you or your Dependent is 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 is no longer Hospital Confined or
- 10 days from the date the Plan is cancelled.

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.

GM6000 BEX182 V11

Federal Requirements

The following pages explain your rights and responsibilities under this plan of benefits pursuant to United States federal laws and regulations. Some states may have similar requirements. If a similar applicable provision appears elsewhere in this booklet, the provision which provides the better benefit will apply. Generally speaking, the following mandates are only applicable if you are a United States citizen or permanent U.S. resident. They generally and/or specifically may not apply to non-U.S. citizens or residents, non-resident aliens, non-resident aliens with no U.S. sourced income or other foreign nationals.

FDRL1

Qualified Medical Child Support Order (QMCSO)

A. Eligibility for Coverage Under a QMCSO

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

You must notify your Employer and elect coverage for that child and yourself, if you are not already enrolled.

B. Qualified Medical Child Support Order Defined

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

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

The QMCSO may not require the health plan to provide coverage for any type or form of benefit or option not otherwise provided under the plan.

C. Payment of Benefits

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

FDRL2

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

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

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; Spouse only; Employee and Spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, Spouse and Dependent child(ren). Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage. Dependent children who were already Dependents of the Employee but not currently enrolled in the Plan are not entitled to special enrollment.
- **Loss of eligibility for State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.
- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
  - divorce or legal separation;
  - cessation of Dependent status (such as reaching the limiting age);
  - death of the Employee;
  - termination of employment;
  - reduction in work hours to below the minimum required for eligibility;
  - you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
  - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan or
  - the other plan no longer offers any benefits to a class of similarly situated individuals.
- **Termination of employer contributions (excluding continuation coverage).** If a current or former employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).
- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: (a) due to failure of the employer or other responsible entity to remit monthly rates on a timely basis; (b) when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan or (c) when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.

FDRL3 V4

Eligibility for employment assistance under State Medicaid or Children's Health Insurance Program (CHIP).

If you and/or your Dependent(s) become eligible for assistance with group health plan monthly rate payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment

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

Individuals who enroll in the Plan due to a special enrollment event will not be considered Late Entrants.

FDRL4 V3

Coverage for Maternity Hospital Stay

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

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

FDRL8

Women's Health and Cancer Rights Act (WHCRA)

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy, including lymphedema? Call Member Services at the toll free number listed on your ID card for more information.

FDRL51

Requirements of Family Medical Leave Act of 1993 (FMLA)

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 Cancelled 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 cancelled 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 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.

FDRL13

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

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave 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 you may have.

A. 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:

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

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

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

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

B. Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you

do not elect USERRA or an available conversion plan at the expiration of USERRA and you are re-employed by your current Employer, coverage for you and your Dependents may be reinstated if (a) you gave your Employer advance written or verbal notice of your military service leave and (b) the duration of all military leaves while you are employed with your current Employer does not exceed five years.

You and your Dependents will be subject to only the balance of a 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.

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

FDRL58

When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "you," "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted; and "Physician reviewers" are licensed Physicians or licensed Dentists depending on the care, treatment or service under review.

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

Start with Member Services

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

Cigna
ATTN: Appeals Department
P.O. Box 15800
Wilmington, DE 19850

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

CIGNA has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing 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 to register your appeal by telephone. Call our toll-free number or write to us at the address above.

GM6000 APL330

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 healthcare 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 (decision). We will respond 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 function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. CIGNA's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

GM6000 APL758

Level Two Appeal

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

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

For level two appeals we will acknowledge in writing that we have received your request and schedule a Committee review.

For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review timeframes above if the Committee does not approve the requested coverage.

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

GM6000 APL759

Independent Review Procedure

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

There is no charge for you to initiate this independent review process. CIGNA will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by CIGNA. 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 CIGNA's level-two appeal review denial. CIGNA 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 CIGNA's Physician reviewer, the review shall be completed within three days.

The Independent Review Program is a voluntary program arranged by CIGNA.

GM6000 APL760

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; (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 judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

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 or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

GM6000 APL334

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled workdays 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 workdays if you were in Active Service on the preceding scheduled workday.

DFS1

Bed and Board

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

DFS14

Co-insurance

The term Co-insurance means the percentage of charges for Covered Expenses that a covered person is required to pay under the Plan.

DFS17

Custodial Services

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

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

DFS1812

Dependent

Dependents are:

- Your Spouse of the opposite sex to whom you were married in a civil or religious ceremony as defined in this plan booklet and
- any child of yours
  - through the end of the month in which they reach age 26.
  - age 26 or over 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 CIGNA within 31 days after the date the child ceases to qualify above. During the next two years CIGNA may, from time to time, require proof of the continuation of such condition and dependence. After that, CIGNA may require proof no more than once a year.
- Your child means:
  - Your or Your Spouse's natural (biological) child.
  - Your or Your Spouse's legally adopted child or a child placed in your home for adoption.
  - Your or Your Spouse's stepchild or foster child.
  - Your or Your Spouse's grandchild who is dependent on you for support and maintenance.
  - A child for whom You or Your Spouse must provide healthcare by court order or order of a state agency authorized to issue National Support Notices under federal law.
  - A child for whom You or Your Spouse are legal guardian or managing conservator

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

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

Emergency Services

Emergency Services are medical, psychiatric, surgical, Hospital and related healthcare 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.

DFS1533

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 20 hours a week for the Employer.

DFS1427

Employer

The term Employer means the entity you work for or which sponsors you and that makes this Plan available to you.

DFS212

Expense Incurred

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

DFS60

Free-Standing Surgical Facility

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

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

DFS682

Hospice Care Program

The term Hospice Care Program means:

- a coordinated, interdisciplinary program 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.

DFS70

Hospice Care Services

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

DFS599

Hospice Facility

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

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

DFS72

Hospital

The term Hospital means:

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

DFS1693

Hospital Confinement or Confined in a Hospital

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

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

DFS1815

In-Network/Out-of-Network

The term In-Network refers to the Designated Provider Benefits which are only payable for services and supplies that are received from a Participating Provider, including Emergency Services (as defined herein); and Services/Supplies received from others when pre-authorized by a Participating Provider and the Provider Organization.

The term Out-of-Network refers to care which does not qualify as In-Network.

DFS651

Injury

The term Injury means an accidental bodily injury.

DFS147

Maximum Out-of-Pocket limit

The term Maximum Out-of-Pocket limit means the amount a Covered Person or Family must pay for International, In-Network U.S., and Out-of-Network U.S. Covered Expenses in a calendar year before the plan pays 100%.

Maximum Reimbursable Charge

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

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

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

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

DFS1997

Medicaid

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

DFS192

Medically Necessary/Medical Necessity

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

- required to diagnose or treat an illness, injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other healthcare provider and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining the least intensive setting.

DFS1813

Medicare

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

DFS149

Necessary Services and Supplies

The term Necessary Services and Supplies includes:

- any charges, except 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.

DFS151

Nurse

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

DFS155

Ophthalmologist

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

DFS156

Optometrist

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

DFS157

Other Healthcare Facility

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

DFS1686

Other Health Professional

The term Other Health 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 Professionals include, but are not limited to, physical therapists, registered nurses and licensed practical nurses.

DFS1685

Participating Pharmacy

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

DFS1937

Participating Provider

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

DFS1910

Pharmacy

The term Pharmacy means a retail pharmacy or a mail-order pharmacy.

DFS1934

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 Plan 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.

DFS164

Prescription Drug

Prescription Drug means: (a) a drug which has been approved by the Food and Drug Administration for safety and efficacy; (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

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 Plan 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

Related Supplies

Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the pharmacy plan and spacers for use with oral inhalers.

DFS1710

Review Organization

The term Review Organization refers to an affiliate of CIGNA or another entity to which CIGNA 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 care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

DFS187

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

Spouse

A person of the opposite sex to whom You are married at the relevant time by a religious or civil ceremony effective under the laws of the state in which the marriage was contracted.

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.

DFS197

Urgent Care

Urgent Care is medical, surgical, Hospital or related healthcare services and testing which are not Emergency Services, but which are determined by CIGNA, 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 covered person should not travel due to any medical condition.

DFS1534