

Columbia University

COMPREHENSIVE MEDICAL BENEFITS
Indemnity Plan for Officers

EFFECTIVE DATE: January 1, 2010

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This document printed in April, 2010 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

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INTRODUCTION

Columbia University is pleased to provide you with this Summary Plan Description (SPD), which describes the health benefits available to you and your covered family members under the Columbia University Medical Plan. It includes summaries of:

Who is eligible

Services that are covered, called Covered Health Services

Services that are not covered, called Exclusions

How benefits are paid

Your rights and responsibilities under the Medical Plan.

This SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic SPD for this Plan – including previously released Benefits in Brief. You are responsible for using this SPD and other resources provided to you to understand your benefits.

The rest of this description provides details about how the coverage works as well as information about who is eligible, processes and events that can affect coverage, administrative information, and your rights as a participant in the Plan. Please note that the words “you” and “your” refer to eligible covered persons enrolled in the Plan.

If there is a conflict between this SPD and any summaries provided to you and/or any verbal representations, this SPD will govern in every respect and instance.

How To Use This SPD

- Please read the entire SPD and share it with your family.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments at www.hr.columbia.edu or request printed copies by contacting the Columbia University HR Benefits Service Center at 212-851-7000.

OVERVIEW OF THE MEDICAL PLANS

Columbia University offers choices of medical plans so that you can select the option that best meets the needs of you and your family.

What the Plans Cover

All the healthcare plans cover medically necessary health care services provided for the purpose of preventing, diagnosing or treating an acute sickness, injury, mental illness, substance abuse or symptoms.

Only certain preventive care services are covered. The plans do not cover treatment for chronic care or conditions. All plan coverage is subject to conditions, limits and exceptions explained in the sections, “Covered Services” and “Services Not Covered”. Columbia University and all its medical carriers administering the Plans, assumes no responsibility for the outcome of any covered services or supplies.

The Plans described in the following pages of this booklet are a benefit plan provided by Columbia University. These benefits are not insured with Aetna, CIGNA or UHC or any of their affiliates but are paid from Columbia University funds. Aetna, CIGNA and UHC provide certain administrative services under the Plan including claim determination, application of copays, coinsurance and limitations.

The Plans differ in how benefits are determined when you have covered expenses. A description of how each plan determines benefits follows in the sections, “Covered Services” and “Services Not Covered”.

Medically Necessary Services

The Plan covers only *medically necessary* services and supplies that are provided for the purpose of preventing, diagnosing or treating an acute sickness, injury, mental illness, substance abuse or symptoms subject to the terms and conditions of the selected medical plan. In addition, certain preventive care services are covered within limitations.

For a service or supply to be considered medically necessary, it must be:

Ordered by a licensed physician

Supported by national medical standards of practice and is consistent with conclusions of prevailing medical research (based on well-conducted, randomized, controlled trials or well-conducted cohort studies)

Consistent with the diagnosis of the condition

Required for reasons other than the convenience of the patient or his/her physician

Consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research or health care coverage organizations or governmental agencies that are accepted by the selected Claims Administrator.

Other than experimental or educational in nature.

The fact that a physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, illness or pregnancy does not mean that it is a medically necessary service or supply as defined above. The definition of “medically necessary” used in this SPD relates only to benefit coverage and may differ from the way you or your doctor define medical necessity.

Claim Filing Deadline

This Plan will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

You have 12 months to submit a claim for a covered service to your health plan. While most in-network providers automatically submit claims on behalf of the patient, there are many situations when this does not occur. If you

receive services from an out-of-network provider, you are responsible for submitting your claim for a covered service within the 12 months from the date of incurral.

Coverage for Maternity Hospital Stay

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

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

Group Plan Coverage Instead of Medicaid

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

Notice of Provider Directory/Networks

Notice Regarding Provider Directories and Provider Networks

If your Plan utilizes a network of Providers, you will have access to a list of Providers who participate in the network by visiting www.cigna.com; mycigna.com or by calling the toll-free telephone number on your ID card.

Your Participating Provider network consists of a group of local medical practitioners, including Hospitals, of varied specialties as well as general practice, who are employed by or contracted with CIGNA HealthCare.

Pre-Existing Conditions

There are **no** pre-existing condition limits under the Columbia University medical plans.

Preauthorization Requirements

Certain procedures, services and/or supplies require you to obtain preauthorization from your selected medical claim administrator for you to receive the maximum benefits under the plan. You must get authorization for certain procedures and treatments before the procedure is performed or before the treatment starts; otherwise, your benefits will be subject to a significant reduction in reimbursement. See the preauthorization section in Aetna, CIGNA or UHC coverage descriptions.

Financial Penalty If You Do Not Get Preauthorization

With all plans, you must obtain **preauthorization** before receiving certain services; otherwise, your benefits will be significantly reduced. Note that each health plan calls this process something different including “pre-certification”, “prior authorization”, and “Personal Health Support Notification”. If you do not obtain preauthorization as required, the Plan will significantly reduce payment for all expenses related to the condition, and your additional cost will not count toward your out-of-pocket maximum. Become familiar with the specific services that require preauthorization based on whether your plan’s claims administrator is Aetna, CIGNA or UHC. If you have questions, call your plan’s member services (phone number on your member ID card).

ADMINISTRATIVE AND LEGAL INFORMATION ABOUT THE PLAN

Medicaid and the Children's Health Insurance Program (CHIP)

Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 22, 2010. You should contact your State for further information on eligibility.

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://www.dhcs.ca.gov/Pages/default.aspx Phone: 1-800-635-2570
ALASKA – Medicaid	COLORADO – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: http://www.colorado.gov/ Medicaid Phone: 1-800-866-3513 CHIP website: http://www.CHPlus.org CHIP Phone: 303-866-3243
ARIZONA - CHIP	
Website: http://www.azahcccs.gov/applicants/default.aspx Phone: 602-417-5422	

ARKANSAS – CHIP	FLORIDA – Medicaid
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-866-762-2237
GEORGIA – Medicaid	MONTANA - Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://mediadprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
IDAHO – Medicaid and CHIP	NEBRASKA – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 208-334-5747 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
INDIANA – Medicaid	NEVADA – Medicaid and CHIP
Website: http://www.in.gov/fssa/2408.htm Phone: 1-877-438-4479	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-922-0900
IOWA – Medicaid	CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	
KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.khpa.ks.gov Phone: 1-800-635-2570	Website: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm Phone: 1-800-852-3345 x5254
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561
LOUISIANA – Medicaid	CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
Website: www.dhh.louisiana.gov/offices/?ID=92 Phone: 1-888-342-0555	
MAINE – Medicaid	NEW MEXICO – Medicaid and CHIP
Website: http://www.maine.gov/dhhs/oms/ Phone: 1-800-321-5557	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583
MASSACHUSETTS – Medicaid and CHIP	CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	

MINNEASOTA – Medicaid	NEW YORK – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MISSOURI – Medicaid	North Carolina – Medicaid
Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573-751-6944	Website: http://www.nc.gov Phone: 919-855-4100
NORTH DAKOTA – Medicaid	UTAH – Medicaid
Website: http://www.nd.gov/dhs/services.medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://health.utah.gov/medicaid/ Phone: 1-866-435-7414
OKLAHOMA – Medicaid	VERMONT – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://ovha.vermont.gov/ Phone: 1-800-250-8427
OREGON – Medicaid and CHIP	VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.oregon.gov/DHS/healthplan/index.shtml Medicaid Phone: 1-800-359-9517 CHIP Website: http://www.oregon.gov/DHS/healthplan/app_benefits/ohp4u.shtml CHIP Phone: 1-800-359-9517	Medicaid Website: http://www.famis.org/ Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	WASHINGTON – Medicaid
Website: http://www.dpw.state.pa.us/partnerproviders.medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://ihrsa.sites/DCS/COB/default.aspx Phone: 1-800-562-6136
RHODE ISLAND – Medicaid	WEST VIRGINIA - Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
SOUTH CAROLINA – Medicaid	WISCONSIN – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/	Website:

Phone: 1-800-440-0493	http://www.health.wyo.gov/healthcarefin/index.html Phone: 307-777-7531
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To see if any more States have added a premium assistance program since January 22, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

Your Privacy Rights

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all group health plans protect the confidentiality of your health information. The Plan and Columbia University will not use or further disclose information that is protected by HIPAA (referred to as protected health information or “PHI”) except as necessary for treatment, payment, health plan operations, and plan administration, or as permitted or required by law.

When you enroll in the Columbia University Medical Plan, you consent to and authorize the Plan to share your claims data when appropriate. For example, a condition management program administrator (e.g. asthma management) may be notified by your health plan when your medical claims activity suggests that you or a family member may have a chronic condition. As a result, you may be contacted to participate in voluntary condition management programs.

By law, Columbia University has required all of its business associates to also observe HIPAA’s privacy rules. The Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of Columbia University. The Plan reserves the right to modify its practices with respect to medical information.

You have certain rights under HIPAA with respect to your protected health information, including the right to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the United States Department of Health and Human Services. If you have any questions on this issue, you should contact the HIPAA Privacy Office. To exercise your HIPAA rights under Columbia University medical plans, contact:

Privacy Officer
Columbia University HR Benefits
Studebaker 4th Floor, MC 8705
615 West 131st Street
New York, NY 10027

Email: hrprivoff@columbia.edu

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

If you or your eligible Dependent(s) experience a special enrollment event as described below, you or your eligible Dependent(s) may be entitled to enroll in the Plan outside of a designated enrollment period upon the occurrence of one of the special enrollment events listed below. If you are already enrolled in the Plan, you may request

enrollment for you and your eligible Dependent(s) under a different option offered by the Employer for which you are currently eligible. If you are not already enrolled in the Plan, you must request special enrollment for yourself in addition to your eligible Dependent(s). You and all of your eligible Dependent(s) must be covered under the same option.

The special enrollment events include:

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan:
 - Employee only;
 - spouse only;
 - Employee and spouse;
 - Dependent child(ren) only; Employee and Dependent child(ren);
 - Employee, spouse and Dependent child(ren).

Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage. Dependent children who were already Dependents of the Employee but not currently enrolled in the Plan are not entitled to special enrollment.

- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
 - divorce or legal separation;
 - cessation of Dependent status (such as reaching the limiting age);
 - death of the Employee;
 - termination of employment;
 - reduction in work hours to below the minimum required for eligibility;
 - you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
 - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
 - the other plan no longer offers any benefits to a class of similarly situated individuals.
- **Termination of employer contributions (excluding continuation coverage).** If a current or former employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).
- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases:
 - due to failure of the employer or other responsible entity to remit premiums on a timely basis;
 - 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
 - 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.

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 denied enrollment. You will not be enrolled in this plan if you do not enroll within 30 days of the date you become eligible, unless you are eligible for special enrollment.

Your ERISA Rights

As a participant in the medical (including prescription drug), dental, flexible spending accounts, long-term disability and life insurance benefits described in this SPD, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA). You are entitled to receive a yearly summary of each plan's financial report. You may examine all the official documents related to the Plans in the Columbia University HR Benefits department. If you wish, you can obtain your own copies of Plan documents by writing to HR Benefits. You may have to pay a reasonable charge to cover the cost of postage and photocopying.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who administer the plans. These people are called "fiduciaries" and have a duty to act prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person or organization, may terminate you or otherwise discriminate against you in any way in order to prevent you from obtaining your Plan benefits or exercising your rights under ERISA.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case the court may require the Plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan administrator.

If you have a claim for a welfare benefit which is denied in whole or in part, you must receive a written explanation of the reason for the denial. For the medical, dental, life and long-term disability plans, the reason for the denial is explained in the Explanation of Benefits (EOB) or denial letter. (Please see the section Claim Review and Appeals Procedures under each Plan.) For the other plans covered under ERISA, you have the right to have the Plan Administrator review and reconsider the claim by submitting a request for appeal within 60 days of the denial. The request may be made by you or your authorized representative and should include the reason you are requesting a review of the claim, as well as any additional information that supports your claim. A review of your claim will take place no later than 120 days after receipt of your appeal. If your claim is still denied, you may file suit in a state or federal court. If you have any questions about your rights under ERISA, you may contact the nearest office of the U.S. Department of Labor.

Coverage for Maternity Hospital Stay

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

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.

Group Plan Coverage Instead of Medicaid

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

Obtaining a Certificate of Creditable Coverage

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

Statement of the University's Rights

This document is not a contract or agreement for employment. Employment with Columbia University is "at-will"—nothing in this document changes your right and the University's right, to end your employment at any time and for any reason. Employment at Columbia University is not guaranteed for any period of time.

The Plan Administrator has full power and discretion to resolve all issues concerning eligibility, status, entitlement to benefits, and any other interpretations under the Plan. Such interpretations or rulings will be binding on all parties. The Plan Administrator has the right to delegate some of these duties to third party providers, such as the claims administrators for the medical plans. As the Plan Administrator's delegates, the claims administrators have the authority to make decisions relating to benefit claims.

The University intends that the terms of the Plan described in this SPD, including those relating to coverage and benefits, are legally enforceable, and that the Plan is maintained for the exclusive benefit of participants, as defined by law.

Although Columbia University expects to continue the Plan, it reserves the right to amend, modify or discontinue all or any part of the Plan or any plan or coverage at any time for any or all employees including active, disabled and former employees participating in the Columbia University Medical Plan. In the event of termination of the Plan, no benefits will be paid for incidents or events occurring after the date of termination.

No oral or written communication will be effective in amending The Plan unless it is by way of a formal amendment. Complete details, terms and conditions relating to each element of the plans are contained in the relevant plan documents; the specific provision and language of these documents will govern in every respect and instance.

To the extent this SPD provides a general description of the tax results that may be applicable to coverage under the Plan, Columbia University assumes no responsibility for your own personal tax status, or for any tax consequences resulting from any claims made contrary to current tax law. Please consult your tax advisor for further information on the tax treatment of your benefits.

Plan Information

The name of the Plan is:

Columbia University Group Benefits Plan

Plan Sponsor and Administrator

Columbia University is the Plan Sponsor and Plan Administrator of the Columbia University Welfare Benefit Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Administrator – Medical Plan

Columbia University
Studebaker Bldg., MC 8703
615 West 131st Street
New York, NY 10027
(212) 851-7000

Employer Identification Plan Number (EIN): 135598093 515

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

Employer named above

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

The Claim Office of your selected health plan (e.g. Aetna, CIGNA, UHC, etc.). The phone number is listed on your member Identification card.

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

The Plan year is calendar and ends on 12/31.

Plan Trustees

A list of Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.

Plan Type

The plan is a healthcare benefit plan.

Collective Bargaining Agreements

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

Claim Administrator

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

The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the University. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of

Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Agent for Legal Process – Medical Plan
Columbia University
Studebaker Bldg., MC 8703
615 West 131st Street
New York, NY 10027
(212) 851-7000

Legal process may also be served on the Plan Administrator.

Type of Administration

The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

Plan Name:	Columbia University Welfare Benefit Plan
Plan Number:	501
Employer ID:	13-5598093
Plan Type:	Welfare benefits plan
Plan Year:	Calendar
Plan Administration:	Self-Insured
Source of Plan Contributions:	Employee and University
Source of Benefits:	Assets of the University

ELIGIBILITY FOR BENEFIT COVERAGE

Eligibility for Full-Time Officers

If you are a full-time active Columbia University Officer, you and your family are eligible for medical coverage under the Columbia University Medical Plan.

Benefits for Part-Time Officers of Administration

As a regular part-time Officer of Administration, you are eligible to participate in the Columbia University Medical Plan, provided you meet the following requirements:

- You are a regular Officer of Administration
- Your scheduled work week must be at least 20 hours per week but less than 35 hours per week
- You are a Grade 10 position or higher at Morningside, Lamont or Nevis
- You are a Grade 103 or higher at Columbia University Medical Center or Harlem Hospital
- Regular part-time positions are those without a planned end date.

Temporary part-time employees are not eligible for part-time benefits. Temporary positions are those approved for a temporary period of time and have an end date.

When Your Benefits Start

You are eligible for benefits on your date of hire. However, your benefits will commence as soon as administratively feasible after your hire date. In most cases, benefits will start 3 to 4 weeks after your date of hire due to administrative processes that must be initiated internally and with external medical insurance administrators.

In order to receive benefits, you must enroll within 31 days of your date of hire. You must select the coverage you want and whom you want to cover. If you do not enroll within 31 days of your date of hire, you will not have any medical benefit coverage for the remainder of the calendar year. You will have to wait until the Benefits Open Enrollment period held annually in the fall. The benefit choices you make at that time take effect the following January. See the section, How To Enroll.

Exception for Newborns

Any Dependent child born while you are covered under one of the Columbia University health plans (Aetna, CIGNA, UHC, HIP) will automatically be covered on the date of his or her birth for a period of 31 days. However, *you must enroll your newborn in your coverage by notifying Columbia University HR Benefits Service Center no later than 31 days after the birth.* If you do not elect to cover your newborn child within 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

Your Eligible Dependents

You can also elect to cover your dependents. Your eligible dependents include your:

- Legal Spouse
- Same-sex domestic partner or civil union partner, provided your partner is:
 - Is at least 18 years old
 - Is not related to you by blood
 - Is not legally married to another person

- In the case of a civil union partnership, is entered into a certified civil union under applicable state law that recognizes a relationship between people of the same gender or treats a relationship between people of the same gender as marriage

And meets two or more of the following requirements:

- ◆ Shares the same principal residence with you full-time and for the past 12 continuous months
 - ◆ Shares financial responsibilities with you, such as co-ownership of property, joint financial accounts, etc.
 - ◆ Has power of attorney for medical purposes
- Unmarried legally dependent children, including adopted children, foster children and stepchildren of your spouse or same-sex domestic partner, provided that you declare the child(ren) as dependents on your federal income tax return. Dependent children are covered:
 - Until the end of the calendar year in which they turn 19;
 - Over the age of 19 as long as they remain full-time students. Note coverage ends at the end of the month in which they cease to be a full-time student (e.g. graduate) or the end of the calendar year in which they turn age 26, whichever is earlier
 - If a court has appointed you legal guardian (for any child from birth to age 19, or to age 26 if a full-time student
 - At any age if they have a mental or physical disability provided he/she is incapable of self-sustaining employment and who chiefly depends upon you for support. You must either apply for continued coverage when you are initially eligible for benefits or prior to the end of the Plan (calendar) year in which the dependent turns age 19. Approval by your medical insurance carrier (Aetna, CIGNA, UHC or your HMO) is required. See How to Continue Coverage for a Disabled Child, below.

Eligible dependent children does not include:

- A dependent who lives outside the United States, unless he or she is living with you or attending a college or university full time; or
- A dependent who is in the military or similar forces anywhere; or a dependent who is employed by the University

How to Continue Coverage for a Disabled Child

Coverage for an unmarried mentally or physically disabled child who is not capable of self-sustaining employment and who depends chiefly upon you for support and maintenance may continue coverage beyond age 19:

If you're an eligible employee when your child meets this definition, you must apply for continued coverage before the end of the calendar year in which he or she turns age 19.

If you're a newly eligible employee and your disabled child is older than age 19 when you are electing coverage, you may apply to cover your child when your coverage begins.

To cover a disabled child who is over age 19, you must complete and submit the required form(s) to your medical plan carrier— Aetna, CIGNA, UHC or your HMO. Forms are available from the HR Benefits Service Center at 212-851-7000.

Your medical carrier may request that you provide proof of your child's incapacity and dependency within 31 days of the date coverage would have otherwise ended. You must supply this proof to your medical carrier within the requested timeframe or the Plan will no longer pay benefits for that child.

Who is Not Eligible for the Plan

The term "employee" in this document does not include:

Officers whose appointments are incidental to their educational program at the University

Officers who are classified as non-benefited or casual employees in accordance with University personnel policies and procedures

Officers whose terms of employment are subject to a collective bargaining agreement unless the agreement specifically provides for their participation in the Medical Plan

Any individual who has entered into an oral or written agreement with the University whereby such individual acknowledges his or her status as an independent contractor and that he or she is not entitled to participate in the University's employee benefit plans, notwithstanding that such person is later determined by a court of competent jurisdiction or the Internal Revenue Service (IRS) to be a common law employee for tax purposes.

Any individual who is performing services for the University under a leasing arrangement entered into between the University and some other person, notwithstanding the fact that he or she is later determined by a court of competent jurisdiction or the IRS to be a common law employee or a leased employee.

An employee who is a non-resident alien who received no earned income from the University that constitutes income from sources within the United States (as defined by the IRS).

Temporary employees.

You Are Responsible for Covering Only Eligible Dependents

You are responsible for ensuring that only your eligible dependents are enrolled in the Medical and Dental Plans. An employee who covers an individual whom he or she knows does not meet the definition of an eligible dependent will be subject to disciplinary action up to and including dismissal and may be liable for other punishment under the law. If the University learns that you have enrolled an ineligible dependent (such as a *former* spouse or a child over the age limit), the dependent will not be covered by the Plan for any medical and/or dental expenses incurred while he or she was ineligible.

You will be required to repay all costs to the University of providing coverage and any benefits paid to you. Also, if you don't notify the University when a dependent has become ineligible, the dependent could lose his or her ability to continue coverage under COBRA health care continuation rules.

Report Changes in Dependent Eligibility

When a dependent is no longer eligible, it is your responsibility to notify the Columbia University HR Benefits department *within 31 days of the change*. Examples of changes include, but are not limited to, divorce, child no longer a student, etc. Contact the Columbia University HR Benefits Service Center at 212-851-7000 to report any changes in the status of your dependents within 31 days.

Verify Student Status to Avoid Loss of Coverage

A full-time student is a student who is taking 12 or more credit hours at an accredited educational institution, or as defined as full-time by the institution. You must provide proof of your child's student status.

Each year, your selected health plan will request verification, which may include the following forms of proof of student status:

A signed letter from the Registrar or Dean of Students

A copy of your dependent child's current semester official class schedule

A copy of the current term tuition bill

School name

Student name

Term

Credit Hours: 12 or more (9 or more if graduate students) or indication of full-time status.

In addition, you may be asked to provide the following information:

Medical plan member ID (located on your ID card)

Medical plan account number (located on your ID card)

If you do not provide all the requested information in the timeframe designated by your medical and/or dental plan, **your child's coverage will automatically be terminated.**

Proof of Eligibility

Columbia University has a responsibility to ensure that only eligible expenses are paid from the benefit Plans. This is a requirement of the Internal Revenue Service (IRS) regulations that govern qualified benefit plans.

You must be prepared to provide satisfactory proof that your enrolled dependents meet the eligibility requirements. Audits are conducted periodically each year to ensure that all dependents continue to meet the eligibility requirements of the benefit plans. If you are selected for an audit, you will receive a letter detailing the audit process. Examples of proof of dependent eligibility include, but are not limited to, birth certificates for each covered child, a marriage license, etc. **If you cannot provide proof that your dependent is eligible for coverage, his or her coverage will be terminated.**

You Choose Who to Cover Under Your Benefits

You must select from one of the following coverage options to ensure your dependents have medical and dental benefits:

Yourself only

Yourself and your legal spouse or yourself and your same-sex domestic partner

Yourself and a child or children

Family

Qualified Medical Child Support Order (QMCSO)

Federal law requires the University to honor a QMCSO issued by a state court as part of a judgment or decree under state domestic relations law or under a law relating to medical child support. A QMCSO relates to and must specify that it arises from medical child support. You will be notified if the Plan Administrator receives a QMCSO that requires you to provide coverage for your dependent identified in the QMCSO.

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

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

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:

The order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;

The order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;

The order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;

The order states the period to which it applies; and

If the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

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

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.

If You and Your Spouse or Same-Sex Domestic Partner Work for the University

If you and your spouse work for the University and are eligible for medical coverage, you may choose your coverage in either of the following ways:

One spouse makes the medical choice for the entire family, including eligible dependent children, if any. In this case, the other spouse must select "No Coverage."

Each spouse can make his or her own medical choice. In this case, all eligible dependent children must be covered by one spouse or the other.

ENROLLMENT

How to Enroll

Newly Eligible Employee

If you are newly hired, you must enroll for benefits within 31 days of your date of hire. If you do not make your benefit elections during your first 31 days of employment, you and any eligible dependents will not receive Medical and Prescription benefit coverage from Columbia University for the remainder of the calendar year.

You will be notified of your benefits on-line enrollment opportunity via email. If you do not receive this notice within 2 weeks of your date of hire, please contact the HR Benefits Service Center at 212-851-7000.

Annual Enrollment Opportunities

After your initial enrollment, you have the opportunity to make changes each fall during the Benefits Open Enrollment period. You will receive notification from the University about this opportunity to change your health plan and the eligible dependents that you want to cover. The selections you make during annual Benefits Open Enrollment are effective the following January 1.

Making Changes to Your Benefits During the Year

After your initial enrollment, or after annual Benefits Open Enrollment, you will be able to change your benefits for the remainder of the calendar year only if you experience a “qualified life status change.” Columbia University healthcare benefits are governed by The Internal Revenue Service (Section 125), which limits when you can make changes to your benefit elections as well as the type of changes you are permitted to make.

Examples of a qualified life status change include:

Marriage, divorce

Beginning or end of a same-sex domestic partnership

Birth, adoption, or placement for adoption

Death of a dependent

Dependent loses eligibility for coverage (child reaches maximum age, spouse/domestic partner loses non-University coverage from their employer)

Change in home address that changes your provider network access

A permanent change in the way you commute to work (applies to the Transit/Parking program)

Spouse or eligible dependent called to military duty in the United States armed forces.

Job promotions and/or transfers that change the benefit offerings within job grade and/or bargained benefits.

If you experience a qualified life status change, *you must contact the Columbia University HR Benefits Service Center at 212-851-7000 within 31 days of the event.* You may be required to provide proof (e.g., marriage certificate, birth certificate) in order to make changes to your benefit selections. Your benefit changes must be consistent with the nature of your qualified life status change.

Adding Your Newborn Child

For a newborn’s hospital and medical expenses to be eligible for reimbursement, you must add your child by contacting the Columbia University HR Benefits Service Center at 212-851-7000 within 31 days of the child’s birth. In addition, if you are enrolled in CIGNA POS or an HMO, you should call your plan’s member services and provide the name of your newborn’s PCP.

Your Cost

Your Cost for Benefit Coverage

You and Columbia University share the cost of your coverage. Each year, the University determines its level of support for benefit coverage for you and your eligible dependents. Costs vary depending on the plan you choose, your annual pay and the number of eligible dependents that you cover.

Information about your share of the cost is provided with your enrollment materials when you are newly hired and is also provided to you each year during the fall annual Benefits Open Enrollment period.

Your contributions toward the cost of coverage are regularly deducted from your University paycheck on a pre-tax basis as allowed under Internal Revenue Service Section 125. Your pre-tax “premium” for healthcare coverage is based on these factors:

The plan you select

The coverage level you select (individual vs. family, etc.)

Your Annual Benefits Salary

Your **Annual Benefits Salary** is calculated as of July 1 each year and is the greater of: (1) your benefits-eligible salary or (2) your year-to-date University income, including certain approved additional and private practice compensation. If you are newly hired, your Annual Benefits Salary is calculated from your compensation at date of hire through the following July 1.

Your Cost for Same-Sex Domestic Partner/Civil Union Partner

Federal income tax rules require that your contributions toward the coverage of a same-sex domestic partner or civil union partner be deducted from your pay on an after-tax basis. In addition, University contributions toward premiums for covering your domestic or civil union partner are taxable to you.

WHEN COVERAGE ENDS

This section summarizes what happens to your medical coverage when certain events occur including:

- Your employment ends
- You become disabled
- You take a leave of absence
- You or a covered family member dies.

Generally, in situations when Columbia University-provided coverage ends, you and your eligible dependents will be provided with the opportunity to continue coverage for a period of time under COBRA continuation rules. See the section, COBRA Continuation Rights.

When Your Employment Ends

If your employment with the Columbia University ends, your Columbia University-sponsored medical coverage for you and your dependents ends after 21 days or the end of the month – whichever is greater.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, Columbia University will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

Your coverage under the Plan will end on the earliest of:

- 21 days after your employment ends or the end of the month – whichever is greater.
- the date the Plan ends;
- the last day of the month you stop making the required “premium” contributions;
- the last day of the month you are no longer eligible;

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the last day of the month you stop making the required “premium” contributions;
- the last day of the month your Dependents no longer qualify as Dependents under this Plan.

However, you may continue the medical coverage in effect for you and your eligible dependents for up to 18 months under COBRA provisions. Under COBRA, the same plans are available as under the Columbia University Medical Plan and the same rules apply for eligible dependents and qualifying changes in status. See the section, COBRA Continuation Rights.

When Your Employment Ends - Are You Eligible for Retiree Medical Benefits?

If you are separated from your job and you have 10 years of service after age 45, you may be eligible for Retiree Medical coverage sponsored by the University. You must meet any service and age requirement at the time your employment ends. Subsequent attainment of the required age after you leave the Columbia University will count toward the requirement for Columbia University Retiree Medical benefits and eligibility for medical coverage continuation under these provisions.

If you qualify for Columbia University Retiree Medical, you and your covered dependents will remain covered by your selected medical plan until the end of the month in which your employment ends or if later, the end of the month in which your severance period ends. At that point, you will move into Columbia University Retiree Medical Plan. (However, if you or your eligible dependents are eligible for Medicare due to disability or because you are age 65 or older, Medicare becomes the primary plan for the individual who is Medicare eligible.)

Contact the HR Benefits Service Center at 212-851-7000 if you think you have attained the age and service requirements.

If You Become Disabled

If you become disabled, your medical coverage can continue based on the type of disability and the length of your disability.

- If you receive salary continuance: Any “premium” contributions you make for Columbia University benefits will continue on a before-tax basis. Your coverage continues without change under the medical plan in effect when your disability began.
- If you receive temporary disability benefits: Any contributions you make for Columbia University benefits will be on an after-tax basis. Coverage continues under the medical plan in effect when your disability began.
- If you receive Long Term Disability benefits: Any “premium” contributions you make for Columbia University will be on an after-tax basis.

Coverage continues for the remainder of the calendar year under the medical plan in effect when your long term disability began. For the next two calendar years, coverage will continue under the Columbia University program. Medicare health insurance coverage generally becomes available if you have been entitled to Social Security benefits for two years. You must enroll for Medicare when available. For additional information about the need to apply for Medicare, please contact the Columbia University Retiree Service Center at 212-851-7000 For Medicare information, please contact 1-800-Medicare (1-800-633-4227).

If You Take a Leave of Absence

In general, during an approved leave of absence, the coverage in effect before the leave will continue provided that you make the necessary monthly premium payments. However, additional rules apply to military leaves or you may qualify for a protected leave under the Family and Medical Leave Act (see the next page). Please contact the HR Benefits Service Center to discuss these rules.

Please note that for certain coverages to remain in effect during your leave of absence, you must pay the monthly premium costs associated with them. You will be billed separately for these coverages by Employee Benefit Plan Administrators (EBPA), an outside vendor. The HR Benefits Service Center will notify EBPA of your leave of absence status and calculate the monthly costs for those coverages that will require payment during your leave.

EBPA will bill you for these monthly costs using a payment coupon. Payment must be remitted to EBPA at the address shown on the payment coupon. Failure to make the required premium payments will result in termination of coverage retroactive to the date for which the last contribution was received.

Coverage While on a Leave Under the Family and Medical Leave Act of 1993 (FMLA)

You're entitled by Federal law to up to 12 weeks of unpaid leave under the FMLA for specified family medical purposes, such as the birth or adoption of a child, or to care for a spouse, child, or parent who is seriously ill or for your own illness. You are entitled to continue your group health coverage under Columbia University Medical Plans during your FMLA leave period at the same rate as if you were still at work, as long as you continue to make

payments. If you don't timely return to covered employment after your leave ends, you are entitled to COBRA continuation coverage.

Coverage While on Military Duty in the United States Armed Forces

If you enter the United States armed forces, you'll be offered the opportunity to continue medical coverage for yourself and your covered dependents based on the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). You may elect to either stop or continue your medical coverage during the period of your military absence. If you elect to continue your medical coverage:

- During the first six months of your military absence, you will continue to pay your portion of the cost for the medical coverage you have in effect at the time your military absence began.
- During the seventh through the 24th month of your military absence, you will be directly billed for the cost of the medical coverage you have in effect at the time your military absence began, or, in the following calendar year, based on the coverage and cost in effect under COBRA rules. No further medical coverage will be provided beyond the twenty-fourth month of a military absence.

If you choose not to continue coverage during the period of military service, you're entitled to have your coverage reinstated provided you timely return to employment with the Company. No additional exclusion or waiting period will be imposed, except in the case of certain service-connected disabilities. These rights granted by USERRA are dependent on uniformed service that ends honorably.

If You Die

If you die, your surviving dependents who are covered under the Columbia University Medical Plan at the time of your death will receive:

- Medical and prescription coverage for 1 year following the date of your death, free of charge.
- COBRA benefits will then be offered following the one year period of free coverage.

If you were eligible for Retiree Medical benefits at the time of your death, your surviving dependents will be given the choice between COBRA or Retiree Medical coverage.

If Your Eligible Dependent Dies

If an eligible dependent dies, you can change your medical plan and coverage tier. Any change must be made within 31 days of your dependent's death; otherwise, you'll have to wait until the next fall annual Benefits Open Enrollment period.

Other Events Ending Your Coverage

Your coverage may also end when any of the following happen. If your coverage is terminated for any of the reasons below, you will be provided written notice that coverage has ended on the date the Plan Administrator identifies in the notice.

- **Fraud, Misrepresentation or False Information** - occurs when there has been fraud or misrepresentation, or the Employee knowingly gave their selected health plan or Columbia University false material information. Examples include false information relating to another person's eligibility or status as a Dependent. Columbia University reserves the right to demand that you pay back any reimbursement paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.
- **Material Violation** – occurs when there was a material violation of the terms of the Plan.
- **Threatening Behavior** – occurs when you have committed acts of physical or verbal abuse that pose a threat to Columbia University's staff or the staff of your selected health plan staff.

Uniformed Services Employment and Reemployment Rights Act

An Employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Employee and the Employee's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on an Employee's behalf. If an Employee's Military Service is for a period of time less than 31 days, the Employee may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

An Employee may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Employee's absence from work; or
- the day after the date on which the Employee fails to apply for, or return to, a position of employment.

Regardless of whether an Employee continues health coverage, if the Employee returns to a position of employment, the Employee's health coverage and that of the Employee's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Employee or the Employee's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

When Coverage Ends for Your Dependents

When you drop coverage for one or more of your covered dependents either during Benefits Open Enrollment or through a Qualified Change in Status, coverage will end as follows:

Spouse

End of the month or 21 days (whichever is greater) following the date of your divorce, or commencement of other medical coverage (through spouse's employer, etc.).

Same-Sex Domestic Partner

End of the month or 21 days (whichever is greater) following the dissolution of the partnership or commencement of other medical coverage (through partner's employer).

Child

The coverage end date varies based upon the following situations:

Reaches Age 19: Coverage ends December 31st of the calendar year in which your child turned 19.

Full-time student over age 19 graduates: End of the month or 21 days whichever is greater following the date of graduation or the date your child is no longer a student.

Full-time student reaches age 26 (and has not yet graduated): Coverage stops the end of the month in which the child reached age 26

Coverage of Students on Medically Necessary Leave of Absence

If your Dependent child is covered by this plan as a student, as defined in the Definition of Dependent, coverage will remain active for that child if the child is on a medically necessary leave of absence from a postsecondary educational institution (such as a college, university or trade school.)

Coverage will terminate on the earlier of:

- a) The date that is one year after the first day of the medically necessary leave of absence; or
- b) The date on which coverage would otherwise terminate under the terms of the plan.

The child must be a Dependent under the terms of the plan and must have been enrolled in the plan on the basis of being a student at a postsecondary educational institution immediately before the first day of the medically necessary leave of absence.

The plan must receive written certification from the treating physician that the child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

A “medically necessary leave of absence” is a leave of absence from a postsecondary educational institution, or any other change in enrollment of the child at the institution that: (1) starts while the child is suffering from a serious illness or condition; (2) is medically necessary; and (3) causes the child to lose student status under the terms of the plan.

Obtaining a Certificate of Creditable Coverage

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

COBRA Continuation Rights

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, *Glossary*.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if Columbia University is subject to the provisions of COBRA.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- an Employee;
 - an Employee's enrolled Dependent, including with respect to the Employee's children, a child born to or placed for adoption with the Employee during a period of continuation coverage under federal law; or
 - an Employee's former Spouse.
- Qualifying Events for Continuation Coverage under COBRA The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage ¹	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Columbia University files for bankruptcy under Title 11, United States Code. ²	36 months	36 months ³	36 months ³

¹Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

²This is a qualifying event for any Retired Employee and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

³From the date of the Employee's death if the Employee dies during the continuation coverage.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, you Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Employee and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a Provider, inform that Provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during Open Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2, *Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide the Benefits Service Center with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 15, *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Employees who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA

coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If an Employee qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Employee must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Employee will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

When COBRA Ends

COBRA coverage will end before the maximum continuation period shown above if:

- you or your covered Dependent becomes covered under another group medical plan, as long as the other plan doesn't limit your coverage due to a preexisting condition; or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends;
- you or your covered Dependent becomes eligible for, and enrolls in, Medicare after electing COBRA;
- the first required premium is not paid within 45 days;
- any other monthly premium is not paid within 30 days of its due date;
- the entire Plan ends; or
- coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Special Plan Provisions

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 which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

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

1 You, your dependent or an attending Physician can request Case Management services by calling the toll-free 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.

FPCM6

1 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.

2 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).

3 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).

4 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.

FPCM2

Additional Programs

We may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to our members for the purpose of promoting the general health and well being of our members. We may also

arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Policyholder. Contact us for details regarding any such arrangements.

Notice Regarding Emergency Services and Urgent Care

In the event of an Emergency, get help immediately. Go to the nearest emergency room, the nearest Hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help. You do not need a referral from your PCP for Emergency Services, but you do need to call your PCP as soon as possible for further assistance and advice on follow-up care. If you require specialty care or a Hospital admission, your PCP will coordinate it and handle the necessary authorizations for care or hospitalization. Participating Providers are on call 24 hours a day, seven days a week to assist you when you need Emergency Services.

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

Urgent Care Inside the Service Area

For Urgent Care inside the service area, you must take all reasonable steps to contact your PCP for direction and you must receive care from a Participating Provider, unless otherwise authorized by your PCP or the Review Organization.

Urgent Care Outside the Service Area

In the event you need Urgent Care while outside the service area, you should, whenever possible, contact your PCP or the CIGNA HealthCare 24-Hour Health Information Line for direction and authorization prior to receiving services.

Continuing or Follow-up Treatment

Continuing or follow-up treatment, whether in or out of the service area is not covered unless it is provided or arranged for by your PCP or upon prior authorization by the Review Organization.

How To File Your Claim

When you or your Dependents seek care through a Participating Provider, you are only responsible for the applicable coinsurance or deductible amount shown in the Schedule. You do not need to file a claim form.

If you or your Dependents seek care through a Non-Participating Provider, you must submit a claim form to be reimbursed.

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

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

Hospital Confinement

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

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

Doctor's Bills and Other Medical Expenses

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

periodically.

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT NUMBER WHEN YOU FILE CG'S CLAIM FORMS, OR WHEN YOU CALL YOUR CG CLAIM OFFICE.

YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

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

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

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

Accident and Health Provisions

Notice of Claim

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

Claim Forms

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

Proof of Loss

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

Physical Examination

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

Explanation of Terms

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

The Schedule

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

Important Information About Your Medical Plan

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

COMPREHENSIVE MEDICAL BENEFITS

The Schedule

For You and Your Dependents

To receive Comprehensive Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Deductible and Coinsurance.

Coinsurance

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

Deductibles

Deductibles are expenses to be paid by you or your Dependent. Deductible amounts are separate from and are in addition to any Coinsurance. Once the Deductible maximum shown in The Schedule has been reached, you and your family need not satisfy any further medical deductible for the rest of that year.

Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed 20 percent of the surgeon's allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

Co-Surgeon

The maximum amount payable will be limited to charges made by co-surgeons that do not exceed 20 percent of the surgeon's allowable charge plus 20 percent. (For purposes of this limitation, allowable charge means the amount payable to the surgeons prior to any reductions due to coinsurance or deductible amounts.)

BENEFIT HIGHLIGHTS

<p>Lifetime Maximum</p>	<p>Unlimited</p>
<p>Coinsurance Level</p>	<p>100% of the Maximum Reimbursable Charge</p>
<p>Maximum Reimbursable Charge</p> <p>Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or</p> <p>A percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database we have selected.</p> <p>Note:</p> <p>The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles, copayments and coinsurance.</p>	<p>90th Percentile</p>
<p>Calendar Year Deductible</p> <p>Individual</p> <p>Family Maximum</p> <p>Family Maximum Calculation</p> <p>Individual Calculation:</p> <p>Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.</p>	<p>\$3,500 per person</p> <p>\$7,000 per family</p>

BENEFIT HIGHLIGHTS

<p>Physician's Services</p> <p>Primary Care Physician's Office visit</p> <p>Specialty Care Physician's Office Visits Consultant and Referral Physician's Services</p> <p>Surgery Performed In the Physician's Office</p>	<p>100% after plan deductible</p> <p>100% after plan deductible</p> <p>100% after plan deductible</p>
<p>Second Opinion Consultations (provided on a voluntary basis)</p> <p>Allergy Treatment/Injections</p> <p>Allergy Serum (dispensed by the physician in the office)</p>	<p>100% after plan deductible</p> <p>100% after plan deductible</p> <p>100% after plan deductible</p>
<p>Preventive Care</p> <p>Routine Preventive Care for children through age 19 (including immunizations)</p> <p>Immunizations</p>	<p>100% after plan deductible</p> <p>100% after plan deductible</p>
<p>Well Woman Exam, Mammograms, PSA, Pap Smear</p>	<p>Not Covered</p>
<p>Inpatient Hospital - Facility Services</p> <p>Semi-Private Room and Board</p> <p>Private Room</p> <p>Special Care Units (ICU/CCU)</p>	<p>100% after plan deductible</p> <p>Limited to the semi-private room rate</p> <p>Limited to the semi-private room rate</p> <p>Limited to the ICU/CCU daily room rate</p>

BENEFIT HIGHLIGHTS

<p>Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</p> <p>Calendar Year Maximum: 60 days combined</p>	<p>100% after plan deductible</p>
<p>Laboratory and Radiology Services (includes pre-admission testing)</p> <p>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)</p> <p>Other Laboratory and Radiology Services:</p> <p>Physician's Office Visit</p> <p>Outpatient Hospital Facility</p> <p>Independent X-ray and/or Lab facility</p>	<p>100% after plan deductible</p> <p>100% after plan deductible</p> <p>100% after plan deductible</p> <p>100% after plan deductible</p>
<p>Outpatient Short-Term Rehabilitative Therapy</p> <p>Includes:</p> <p>Cardiac Rehab – 60 Visits Pulmonary Rehab – 60 Visits Cognitive Therapy – 60 Visits Physical Therapy – 60 Visits combined Speech Therapy – 60 Visits combined Occupational Therapy – 60 Visits combined</p>	<p>100% after plan deductible</p>
<p>Chiropractic Care</p> <p>Physician's Office Visit</p> <p>Calendar Year Maximum: 60 Visits</p>	<p>100% after plan deductible</p>

BENEFIT HIGHLIGHTS

Home Health Care Calendar Year Maximum: 200 days (includes outpatient private nursing when approved as medically necessary)	100% after plan deductible
Hospice Inpatient Services - Outpatient Services (same coinsurance level as Home Health Care) 220 days inpatient and outpatient service combined	100% after plan deductible 100% after plan deductible
Bereavement Counseling Services Provided as part of Hospice Care Inpatient Outpatient Calendar Year Maximum: 3 visits Services Provided by Mental Health Professional	100% after plan deductible 100% after plan deductible Covered under Mental Health benefit

BENEFIT HIGHLIGHTS

<p>Maternity Care Services</p> <p>Initial Visit to Confirm Pregnancy</p> <p>All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)</p> <p>Physician's Office Visits in addition to the global maternity fee when performed by an OB or Specialist</p> <p>Delivery - Facility (Inpatient Hospital, Birthing Center)</p>	<p>100% after plan deductible</p> <p>100% after plan deductible</p> <p>100% after plan deductible</p> <p>100% after plan deductible</p>
<p>Abortion</p> <p>Includes elective and non-elective procedures</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p>	<p>100% after plan deductible</p> <p>100% after plan deductible</p> <p>100% after plan deductible</p> <p>100% after plan deductible</p>

BENEFIT HIGHLIGHTS

Family Planning Services

Office Visits, Lab and Radiology Tests and Counseling

100% after plan deductible

Note:

The standard benefit will include coverage for contraceptive devices (e.g. Depo-Provera and Intrauterine Devices (IUDs). Diaphragms will also be covered when services are provided in the physician's office.

Surgical Sterilization Procedure for Vasectomy/
Tubal Ligation (excludes reversals)

Inpatient Facility

100% after plan deductible

Outpatient Facility

100% after plan deductible

Physician's Services

100% after plan deductible

Physician's Office Visit

100% after plan deductible

BENEFIT HIGHLIGHTS

Infertility Treatment

Coverage will be provided for the following services:

- Testing and treatment services performed in connection with an underlying medical condition.
- Testing performed specifically to determine the cause of infertility.
- Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).
- Artificial Insemination, In-vitro, GIFT, ZIFT, etc.

<p>Physician's Office Visit (Lab and Radiology Tests, Counseling)</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p> <p>Calendar Year Maximum: \$5,000 per member (maximum applies to GIFT, ZIFT, Artificial Insemination and In-vitro procedures)</p> <p>Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility).</p>	<p>100% after plan deductible</p> <p>100% after plan deductible</p> <p>100% after plan deductible</p> <p>100% after plan deductible</p>
<p>Organ Transplant</p> <p>Includes all medically appropriate, non-experimental transplants</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Physician's Services</p> <p>Lifetime Travel Maximum: \$10,000 per transplant</p>	<p>100% after plan deductible</p> <p>100% after plan deductible</p> <p>100% after plan deductible</p> <p>No charge (only available when using Lifesource facility)</p>

BENEFIT HIGHLIGHTS

<p>Durable Medical Equipment</p> <p>Calendar Year Maximum: 1 every two years</p>	<p>100% after plan deductible</p>
<p>External Prosthetic Appliances</p> <p>Calendar Year Maximum: Unlimited</p>	<p>100% after plan deductible</p>
<p>Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p>	<p>100% after plan deductible</p> <p>100% after plan deductible</p> <p>100% after plan deductible</p> <p>100% after plan deductible</p>
<p>Retail Medical Prescriptions – coverage includes oral contraceptives, contraceptive devices, Insulin, Insulin needles and syringes, glucose test strips and lancets, Pre-natal prescription vitamins and self-administered injectable drugs</p>	<p>100% after plan deductible</p>
<p>Routine Foot Disorders</p>	<p>Not covered except for services associated with foot care for diabetes and peripheral vascular disease.</p>
<p>Treatment Resulting From Life Threatening Emergencies Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.</p>	

BENEFIT HIGHLIGHTS

<p>Mental Health</p> <p>Inpatient</p> <p>Outpatient</p> <p>Calendar Year Maximum: 60 visits Pre Certification Required</p> <p>Outpatient Group Therapy</p>	<p>100% after plan deductible</p> <p>100% after plan deductible</p> <p>100% after plan deductible</p>
<p>Substance Abuse</p> <p>Inpatient</p> <p>Outpatient</p> <p>Calendar Year Maximum: 60 visits Pre Certification Required</p> <p>Outpatient Group Therapy</p>	<p>100% after plan deductible</p> <p>100% after plan deductible</p> <p>100% after plan deductible</p>

Prior Authorization

Prior Authorization/Pre-Authorized – In Network – Call toll-free number on back of your ID card.

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

Services that require Prior Authorization include, but are not limited to:

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

Pre Certification Requirements – Out of Network – Call toll-free number on back of your ID card.

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

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

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

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

Covered Expenses incurred will not include the first \$500 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 not include:

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

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

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.

Outpatient Certification Requirements Out-of-Network – Call toll-free number on back of your ID card.

Outpatient Certification refers to the process used to certify the Medical Necessity of outpatient diagnostic testing and outpatient procedures, including, but not limited to, those listed in this section when performed as an outpatient in a Free-standing Surgical Facility, Other Health Care Facility or a Physician's office. You or your Dependent should call the toll-free number on the back of your I.D. card to determine if Outpatient Certification is required prior to any outpatient diagnostic testing or procedures. Outpatient Certification is performed through a utilization review program by a Review Organization with which CG has contracted. Outpatient Certification should only be requested for nonemergency procedures or services, and should be requested by you or your Dependent at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

Covered Expenses incurred will not include the first \$500 for charges made for any outpatient diagnostic testing or procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

Covered Expenses incurred will not include expenses incurred for charges made for outpatient diagnostic testing or procedures for which Outpatient Certification was performed, but, which was not certified as Medically Necessary.

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

Diagnostic Testing and Outpatient Procedures

Including, but not limited to:

Advanced radiological imaging – CT Scans, MRI, MRA or PET scans.

Hysterectomy

Covered Services

The term Covered Services (or Covered Expenses) means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Services 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 CG. **Any applicable**

Copayments, Deductibles or limits are shown in The Schedule.

Covered Services

- 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 Health Care 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 Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.

- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.
- 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.
- charges made for a mammogram for women ages 35 to 69, every one to two years, or at any age for women at risk, when recommended by a Physician.
- charges made for an annual Papanicolaou laboratory screening test.
- charges made for an annual prostate-specific antigen test (PSA).
- 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 Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives.
- charges made in-Network for Routine Preventive Care, including immunizations. Routine Preventive Care means health care assessments, wellness visits and any related services.
- charges made for medical diagnostic services to determine the cause of erectile dysfunction. Penile implants are covered for an established medical condition that clearly is the cause of erectile dysfunction, such as postoperative prostatectomy and diabetes. Penile implants are not covered as treatment of psychogenic erectile dysfunction.

Clinical Trials

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

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

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

Genetic Testing

- charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:
 - a person has symptoms or signs of a genetically-linked inheritable disease;

- it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or

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

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

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

Nutritional Evaluation

- charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease or covered up to 3 visits per calendar year.

Internal Prosthetic/Medical Appliances

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

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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 Health Care Facility.

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

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

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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 Health Care Facility for:
 - part-time or intermittent nursing care by or under the supervision of a Nurse;
 - part-time or intermittent services of an Other Health Care Professional;

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

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

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- for any period when you or your Dependent is not under the care of a Physician;
- for services 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 policy;
- 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

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 4 hours and not more than 12 hours in any 24-hour period.

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

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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 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. Mental Health Intensive Outpatient Therapy Program services are exchanged with Outpatient Mental Health services at a rate of one visit of Mental Health Intensive Outpatient Therapy being equal to one visit of Outpatient Mental Health Services.

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Inpatient Substance Abuse Rehabilitation Services

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

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

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

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 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. Substance Abuse Intensive Outpatient Therapy Program services are exchanged with Outpatient Substance Abuse services at a rate of one visit of Substance Abuse Intensive Outpatient Therapy being equal to one visit of Outpatient Substance Abuse Rehabilitation Services.

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Substance Abuse Detoxification Services

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

Exclusions from Mental Health and Substance Abuse

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

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.
- Treatment of 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.

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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 CG for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a 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, wheel chairs, and dialysis machines.

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

- **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses.
- **Bath Related Items:** bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-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 and necessary for the alleviation or correction of Injury, Sickness or congenital defect.

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:

- Nonfoot orthoses – only the following nonfoot 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 it 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. amputation) 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.

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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.
 - 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

Infertility Services

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

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

However, the following are specifically excluded infertility services:

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

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Short-Term Rehabilitative Therapy

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

The following 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, training, educational or developmental in nature.
- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Illness or Injury or Sickness.

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

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

If multiple outpatient services are provided on the same day, they constitute one visit.

A separate Copayment will apply to the services provided by each provider.

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

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. For these services you have direct access to qualified chiropractic Physicians.

You do not need a referral from your Primary Care Physician.

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The following limitations apply to 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 had not been previously achieved prior to the Injury or Sickness.
- Services are not covered if they are considered custodial, training, 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;
- Vitamin therapy;
- Massage therapy in the absence of other modalities.

GM6000 05BPT10

Transplant Services

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

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

All Transplant services received from non-Participating Providers are payable at the Out-of-Network level.

All Transplant services, other than cornea, must be received at a CIGNA LIFESOURCE Transplant Network® facility. Cornea transplants are payable when received from Participating Provider facilities other than CIGNA LIFESOURCE Transplant Network® facilities.

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

Transplant Travel Services

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

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family,

your legal guardian, or any person not related to you, but actively involved as your caregiver. The following are specifically excluded travel expenses:

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

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

GM6000 05BPT7

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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 nondiseased 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, noncosmetic 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.

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Vision Benefits The Schedule		
BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
<p>Vision Benefits</p> <p>For You and Your Dependents Examinations</p> <p>One Eye Exam every 24 months.</p>	<p>You or Your Dependents Will Pay:</p> <p>\$10 per office visit copay</p>	<p>In-Network coverage only</p>
<p>Maximum Benefit for:</p> <p>Reimbursement toward purchase of a pair of glasses or contact lenses every 24 months</p>		
<p>Lenses</p> <p>Per pair, one pair per 24 month period:</p> <p>Single Vision</p> <p>Bifocal</p> <p>Trifocal</p> <p>Lenticular</p> <p>Contact Lenses (excludes cosmetic lenses)</p> <p>Medically Necessary Contacts</p> <p>Elective Contacts</p> <p>Frames</p> <p>Per pair, one pair per 24 month period</p>	<p>This Plan Will Pay</p> <p>\$20</p> <p>\$30</p> <p>\$40</p> <p>\$75</p> <p>\$75</p> <p>\$75</p> <p>\$30</p>	<p>In-Network coverage only</p>

Vision Benefits

For You and Your Dependents

Covered Expenses

If you or any one of your Dependents, while insured for Vision Benefits, incurs expenses for charges made In-Network for one complete eye exam, including basic vision screening, refraction and tonometric testing, CG will pay that portion of the expense remaining after you or your Dependent has paid the required Copayment shown in The Schedule. You do not need a referral from your PCP to access these services.

Expenses incurred for charges made In-Network for the purchase of eyeglasses and contact lenses will be subject to the maximum benefit shown in The Schedule.

Exclusions

The following are specifically excluded from coverage:

- any services or items related to orthoptics or vision training;
- magnification vision aids;
- any nonprescription eyeglasses, lenses or contact lenses;
- any charges for tinting, antireflective coatings, prescription sunglasses or light-sensitive lenses;
- any eye examination required by an Employer as a condition of employment or which an Employer is required to provide under a collective bargaining agreement;
- any eye examination required by law;
- safety glasses or lenses required for employment;
- any eye examination or materials that exceed the frequency limits shown in The Schedule. Other limitations are shown in the "General Limitations" section.

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.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.

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

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

- the subject of an ongoing phase I, II or III clinical trial, except as provided in the “Clinical Trials” section of this plan.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one’s appearance.
- regardless of clinical indication for acupuncture; dance therapy; movement therapy; applied kinesiology; rolfing; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an Injury to sound natural teeth; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; (c) charges made by a Free-Standing Surgical Facility or the outpatient department of a Hospital in connection with surgery.
- for medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute guideline is covered if the services are demonstrated, through peer-reviewed medical literature and scientifically based guidelines, to be safe and effective for treatment of the condition.
- 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.
- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- for treatment of erectile dysfunction. However, penile implants are covered when an established medical condition is the cause of erectile dysfunction.
- surgical or nonsurgical treatment of TMJ Dysfunction.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.

- nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical 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.
- treatment for acupuncture.
- private Hospital rooms and/or private duty nursing except as provided under the **Home Health Services** provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- medical benefits for eyeglasses, contact lenses or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery.
- 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 noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician’s opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.
- nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.

- medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- telephone, e-mail, and Internet consultations, and telemedicine.
- massage therapy.
- for charges which would not have been made if the person had no insurance.
- to the extent that they are more than Maximum Reimbursable Charges.
- expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure.
- charges made by any covered provider who is a member of your family or your Dependent's family.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.

Coordination of Benefits

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

Coverage under this Plan plus another Plan will not guarantee 100% total reimbursement.

Definitions

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

Plan

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

- (1) Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public nor is individually underwritten including closed panel coverage.
- (2) Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.
- (3) Medical benefits coverage of group, group-type, and individual automobile contracts.

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

Closed Panel Plan

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and which 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.

Reasonable Cash Value

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

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 a person as an enrollee or an employee shall be the Primary Plan and the Plan that covers that person as a Dependent shall be the Secondary Plan;
- (2) For 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;
- (3) For 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 noncustodial parent of the child, and
 - (e) finally, the Plan of the spouse of the parent not having custody of the child.
- (4) The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- (5) The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- (6) If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

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

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

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, the benefits that would be payable under this Plan in the absence of Coordination will be reduced by the benefits payable under all other Plans for the expense covered under this Plan.

When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service rendered will be considered both an expense incurred and a benefit payable.

GM6000 MOB3

Recovery of Excess Benefits

If CG pays charges for services and supplies that should have been paid by the Primary Plan, CG will have the right to recover such payments.

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

Right to Receive and Release Information

CG, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. 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 MOB4

Medicare Eligibles

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

- (a) a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;
- (b) a former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;
- (c) an Employee whose Employer and each other Employer participating in the Employer's plan have

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

- (d) the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;
- (e) an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;
- (f) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

GM6000 MEL23

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CG will assume the amount payable under:

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

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

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

Domestic Partners

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

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

1. Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be

responsible as a result of having caused or contributed to an Injury or Sickness.

2. Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

Subrogation/Right of Reimbursement

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

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

Lien of the Plan

By accepting benefits under this plan, a Participant:

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

Additional Terms

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

including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

Payment of Benefits

To Whom Payable

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

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

If you die while any of these benefits remain unpaid, CG may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

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

Time of Payment

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

Recovery of Overpayment

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

Calculation of Covered Expenses

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

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

Claim Determination Procedures Under ERISA

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

Procedures Regarding Medical Necessity Determinations

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

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

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

Preservice Medical Necessity Determinations

When you or your representative request a required Medical Necessity determination prior to care, CG will notify you or your representative of the determination within 15 days after receiving the request. However, if

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

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

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

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

Concurrent Medical Necessity Determinations

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

Postservice Medical Necessity Determinations

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

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

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Postservice Claim Determinations

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

resume on the date you or your representative responds to the notice.

Notice of Adverse Determination

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

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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.

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

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

Start With Member Services

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

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

Appeals Procedure

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

Level-One Appeal

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

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

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

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Level-Two Appeal

If you are dissatisfied with our level-one appeal decision, you may request a second review. To initiate a level-two

appeal, follow the same process required for a level-one appeal.

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

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

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

Independent Review Procedure

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

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

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

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

Notice of Benefit Determination on Appeal

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

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

Relevant Information

Relevant information is any document, record or other information which: (a) was relied upon in making the benefit determination; (b) was submitted, considered or

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

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against CG until you have completed the Level-One and Level-Two appeal processes. If your appeal is expedited, there is no need to complete the Level-Two process prior to bringing legal action.

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Receive Information About Your Plan and Benefits

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

Continue Group Health Plan Coverage

- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your federal continuation coverage rights.

- reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect federal continuation coverage, when your federal continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Definitions

Active Service

You will be considered in Active Service:

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

DFS1

Bed and Board

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

DFS14

Charges

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

DFS940

Chiropractic Care

The term Chiropractic Care means the conservative management of neuromusculoskeletal conditions through

manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

DFS1689

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

DFS1222

DFS2051

Emergency Services

Emergency services are medical, psychiatric, surgical, Hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily Injury or serious Sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones. The symptoms that led you to believe you needed

emergency care, as coded by the provider and recorded by the Hospital on the UB92 claim form, or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.

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 the minimum required number of hours a week for the Employer.

DFS1427 M

Employer

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

DFS1595

Expense Incurred

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

DFS60

Free-Standing Surgical Facility

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

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement 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 Health Care Agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program.

DFS599

Hospice Facility

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

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

DFS72

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision

of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses;

- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and 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;

DFS1815M

In-Network/Out-of-Network

The term In-Network refers to healthcare services or items provided by your Primary Care Physician or services/items provided by another Participating Provider and authorized by your Primary Care Physician or the Review Organization. Authorization by your Primary Care Physician or the Review Organization is not required in the case of Mental Health and Substance Abuse treatment, other than Hospital Confinement solely for detoxification.

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

Emergency Care which meets the definition of Emergency Services and is authorized as such by either the Primary Care Physician or the Review Organization is considered In-Network. (For details, refer to the Emergency Services and Urgent Care coverage section.)

DFS1694

Injury

The term Injury means an accidental bodily injury.

DFS147

Maintenance Treatment

The term Maintenance Treatment means:

- treatment rendered to keep or maintain the patient's current status.

DFS1650

Maximum Reimbursable Charge - Medical

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

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

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

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

GM6000 DFS1997

V5

Medicaid

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

DFS192

Medically Necessary/Medical Necessity

Medically Necessary 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 health care 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 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.

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

DFS285

Nurse

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

DFS155

Other Health Care Facility

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

DFS1686

Other Health 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 Provider

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

DFS1910

Physician

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

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

DFS164

Preventive Treatment

The term Preventive Treatment means:

- treatment rendered to prevent disease or its recurrence.

DFS1652

Primary Care Physician

The term Primary Care Physician means a Physician: (a) who qualifies as a Participating Provider in general practice, internal medicine, family practice or pediatrics; and (b) who has been selected by you, as authorized by the Provider Organization, to provide or arrange for medical care for you or any of your insured Dependents.

DFS622

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: (1) any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is: (a) operating within the scope of his license; and (b) performing a service for which benefits are provided under this plan when performed by a Psychologist; and (2) any psychotherapist while he is providing care authorized by the Provider Organization if he is: (a) state licensed or nationally certified by his professional discipline; and (b) performing a service for which benefits are provided under this plan when performed by a Psychologist.

DFS585

Review Organization

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

DFS1688

Sickness – For Medical Insurance

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

DFS531

Skilled Nursing Facility

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

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis; but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

DFS193

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

DFS1534