METRO-I.L.A. FRINGE BENEFIT FUND
WELFARE PLAN

OPEN ACCESS PLUS MEDICAL BENEFITS
FOR ACTIVE TIER I AND TIER II PARTICIPANTS

EFFECTIVE JANUARY 1, 2008

MANAGED PHARMACY PROGRAM
FOR ACTIVE TIER I PARTICIPANTS

EFFECTIVE JANUARY 1, 2008

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IMPORTANT INFORMATION

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY METRO-I.L.A. FRINGE BENEFIT FUND WELFARE PLAN WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CONNECTICUT GENERAL (CG) PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CONNECTICUT GENERAL DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CONNECTICUT GENERAL. BECAUSE THE PLAN IS NOT INSURED BY CONNECTICUT GENERAL, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CG," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN "FUND" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."

Any statements in this Medical Booklet that disagree with the Fund's Summary Plan Description are superseded by the Fund's Summary Plan Description.

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.

SPECIAL PLAN PROVISIONS

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

SERVICES AVAILABLE IN CONJUNCTION WITH YOUR MEDICAL PLAN

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

CIGNA'S TOLL-FREE CARE LINE

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

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

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, the Fund, 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.

CASE MANAGEMENT (Continued)

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

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

ADDITIONAL PROGRAMS

Cigna 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. Cigna 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.

IMPORTANT INFORMATION ABOUT YOUR MEDICAL PLAN

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

OPPORTUNITY TO SELECT A PRIMARY CARE PHYSICIAN

Choice of Primary Care Physician

This medical plan does not require that you select a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available to you under this medical plan. Notwithstanding, a Primary Care Physician may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependents. For this reason, we encourage the use of Primary Care Physicians and provide you with the opportunity to select a Primary Care Physician from a list provided by CG for yourself and your Dependents. If you choose to select a Primary Care Physician, the Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

HOW TO FILE YOUR CLAIM

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

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

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

HOSPITAL CONFINEMENT

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

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

DOCTOR'S BILLS AND OTHER MEDICAL EXPENSES

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

CLAIM REMINDERS

- BE SURE TO USE YOUR 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.

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SECTION 1: ACCIDENT AND HEALTH PROVISIONS

CLAIMS

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

SECTION 2: ELIGIBILITY — RULES

WHO MAY BECOME ELIGIBLE

You are eligible to become covered if you are a member of a participating employer and your employement is the subject of a collective bargaining agreement between the Metropolitan Marine Maintenance Contractors' Association, Inc. and the International Longshoremen's Association Local 1814 and 1804-1, or an eligible retiree drawing pension benefits from the Metro-LA Pension Plan, and certain members of related employers that sign special agreements with the Trustees of this plan.

Your dependents, as follows, may also be eligible to become covered:

- Your lawful spouse, unless legally separated;
- Your unmarried child (including stepchild, adopted child, child placed for adoption if you are legally required to provide support until the adoption is finalized, and foster child) who
  - Depends on you for support and maintenance
  - Lives with you in a regular parent-child relationship, and
  - Is under 19, or who is 19 but less than age 23 and is a full-time student at an accredited school, college or university.

With respect to Health Benefits, a dependent child whose coverage under this plan would otherwise terminate solely due to attainment of the limiting age shall continue to be considered a dependent if:

- He is incapable of self-sustaining employement solely because of mental illness, developmental disability, mental retardation as defined in the applicable mental hygiene law, or physical handicap;
- He became so incapable prior to attainment of the limiting age;
- Written evidence of such incapacity is sent to the Plan Office within 31 days after attainment of the limiting age;

WHO MAY BECOME ELIGIBLE (Continued)

- Proof that he continues to be so incapable is sent to the Plan Office from time to time at its request; and
- Individuals eligible for coverage as members cannot be covered as dependents, and if you and your sponse are both eligible for member coverage under the plan, only one of you can cover your eligible dependent children.

WHEN DO YOU BECOME ELIGIBLE

You will become eligible for coverage under this plan on the January 1 following a calendar year during which you worked and on whose behalf the Metro-ILA Fringe Benefit Plan has received contributions for at least the minimum number of Credit Hours shown below, provided written application is made to the Welfare Plan between October 1 and December 31 in that calendar year. Applications received after December 31 will delay eligibility until the first day of the subsequent month.

FOR HEALTH CARE BENEFIT ELIGIBILITY

(Based on Prior Year's Credit Hours)

Class 1: If you are a bargaining unit employee for an employer in any Division of MMMCA other than Ship Maintenance, you must accrue at least 1,000 Credit Hours during the previous calendar year for Tier One Benefits.

Class 2: If you are a bargaining unit employee for an employer in the Ship Maintenance Division, you must accrue at least 700 Credit Hours during 2007 for Tier One Benefits in 2008, and 800 Credit hours in 2008 (and years thereafter) for Tier One Benefits the following year.

Class 3: If you are a bargaining unit employee for an employer in the Container Maintenance/Repair Division or Weighmaster Division, who has worked at least 800 hours in the prior calendar year (but fewer than 1,000), you are eligible for Tier Two Benefits (effective January 1, 2008, and years thereafter). To qualify for Tier One benefits, you (individually) may make contributions at 120% of the rate set forth in the collective bargaining agreement or otherwise established by the Plan for hourly contributions, to bring your hours up to 1,000.

FOR HEALTH CARE BENEFIT ELIGIBILITY (Continued)

[Note that for coverage in calendar year 2008, 700 was the minimum number of hours worked in 2007 to qualify for Tier II benefits or to "pay up" for Tier I.]

Class 4: If you are a non-bargaining unit employee covered by a special participation agreement between your employer and the Trustees of this Plan, you must accrue at least 1,560 Credit Hours during the prior calendar year for Tier One benefits. There is no alternative benefit plan.

Class 5: If you are a pensioner under the METRO-I.L.A. Pension Plan, you may be eligible for welfare benefits under this Plan. There is no Credit Hours requirement; however, you must apply for all benefits.

EFFECTIVE DATE OF YOUR COVERAGE

You will become covered on the date you become eligible.

CONTINUATION OF YOUR COVERAGE

Once covered, your coverage will continue, provided you have at least the minimum number of Credit Hours required for your Class each calendar year.

SECTION 3: TIER I ACTIVES OPEN ACCESS PLUS MEDICAL BENEFITS

THE SCHEDULE

For You and Your Dependents

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

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

Coinsurance

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

Copayments/Deductibles

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

SECTION 3: TIER I ACTIVES OPEN ACCESS PLUS MEDICAL BENEFITS

THE SCHEDULE

Out-of -Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for In-Network and Out-of-Network charges that are not paid by the benefit plan because of any:

- Coinsurance.

Charges will not accumulate toward the Out-of-Pocket Maximum for Covered Expenses incurred for:

- Mental Health and Substance Abuse treatment.
- non-compliance penalties.
- provider charges in excess of the Maximum Reimbursable Charge.

When the Out-of-Pocket Maximum shown in The Schedule is reached, Injury and Sickness benefits are payable at 100% except for:

- Mental Health and Substance Abuse treatment.
- non-compliance penalties.
- provider charges in excess of the Maximum Reimbursable Charge.

SECTION 3: TIER I ACTIVES OPEN ACCESS PLUS MEDICAL BENEFITS

THE SCHEDULE

Accumulation of Plan Deductibles and Out-of-Pocket Maximums

Deductibles and Out-of-Pocket Maximums will accumulate in one direction (e.g. Out-of-Network will accumulate to In-Network). All other plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted.

Multiple Surgical Reduction

Multiple surgeries performed during one operating session 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.)

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Lifetime Maximum	**Unlimited**	
Coinsurance Levels	**100%**	**70% of the Maximum Reimbursable Charge**

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Maximum Reimbursable Charge Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or A percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database we have selected. **Note:** The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles, copayments and coinsurance.	Not Applicable	50th Percentile

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Calendar Year Deductible		
Individual	Not Applicable	$200 per person
Family Maximum	Not Applicable	$500 per family
Family Maximum Calculation **Individual Calculation:** 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.		

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Out-of-Pocket Maximum		
Individual	Not Applicable	$5,000 per person
Family Maximum	Not Applicable	$10,000 per family
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.		

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Physician's Services		
Primary Care Physician's Office visit	No charge after the $15 per office visit copay	70% after plan deductible
Specialty Care Physician's Office Visits Consultant and Referral Physician's Services **Note:** OB-GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with CG.	No charge after the $30 Specialist per office visit copay	70% after plan deductible
Surgery Performed In the Physician's Office	No charge after the $15 PCP or $30 Specialist per office visit copay	70% after plan deductible

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Physician's Services		
Second Opinion Consultations (provided on a voluntary basis)	No charge after the $15 PCP or $30 Specialist per office visit copay	70% after plan deductible
Allergy Treatment/Injections	No charge after the $15 PCP or $30 Specialist per office visit copay or the actual charge, whichever is less	70% after plan deductible
Allergy Serum (dispensed by the physician in the office)	No charge	70% after plan deductible

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Preventive Care **Routine Preventive Care** Calendar Year Maximum through age 18 (including immunizations): Unlimited Calendar Year Maximum for ages 19 and above (including immunizations): $500 **Note:** Well-woman OB/GYN visits will be considered either a PCP or Specialist depending on how the provider contracts with CG. **Note:** Charges for lab and radiology services, when billed by the physician's office, will be subject to the plan's Preventive Care dollar maximum. Charges for lab and radiology services, when billed by an independent diagnostic facility or outpatient hospital do not apply to the plan's Preventive Care dollar maximum.		
Physician's Office Visit for children through age 18	No charge after the $15 PCP per office visit copay	70% after plan deductible
Immunizations for children through age 18	No charge	70% after plan deductible

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Preventive Care		
Physician's Office Visit for ages 19 and over	No charge after the $15 PCP per office visit copay	In-Network coverage only
Immunizations for ages 19 and over	No charge after the $15 PCP per office visit copay	In-Network coverage only
Well-Woman Exam	No charge after the $15 PCP or $30 Specialist per office visit copay	70% after plan deductible

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Inpatient Hospital - Facility Services	No charge if billed by an independent diagnostic facility or outpatient hospital. **Note:** The associated wellness exam will be covered at no charge after the $15 PCP or $30 Specialist per visit copay.	70% after plan deductible
Semi-Private Room and Board	No charge	70% after plan deductible
Private Room	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
PSA and Pap Smear	No charge after the $15 PCP or $30 Specialist per office visit copay	70% after plan deductible
Inpatient Hospital - Facility Services	No charge	70% after plan deductible
Semi-Private Room and Board	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Private Room	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate
Outpatient Facility Services		
Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room.	No charge	70% after plan deductible

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Inpatient Hospital Physician's Visits/Consultations	No charge	70% after plan deductible
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	No charge	70% after plan deductible
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	No charge	70% after plan deductible

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Emergency and Urgent Care Services		
Physician's Office Visit	No charge after the $15 PCP or $30 Specialist per office visit copay	No charge after the $15 PCP or $30 Specialist per office visit copay (except if not a true emergency, then 70% after plan deductible)
Hospital Emergency Room	No charge after $50 per visit copay* *waived if admitted	No charge after $50 per visit copay* (except if not a true emergency, then 70% after plan deductible) *waived if admitted
Outpatient Professional services (radiology, pathology and ER Physician)	No charge	No charge (except if not a true emergency, then 70% after plan deductible)
Urgent Care Facility or Outpatient Facility	No charge after $25 per visit copay* *waived if admitted	No charge after $25 per visit copay* (except if not a true emergency, then 70% after plan deductible) *waived if admitted

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Emergency and Urgent Care Services		
X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	No charge	No charge (except if not a true emergency, then 70% after plan deductible)
Independent x-ray and/or Lab Facility in conjunction with an ER visit	No charge	No charge (except if not a true emergency, then 70% after plan deductible)
Ambulance	No charge	No charge (except if not a true emergency, then 70% after plan deductible)

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub- Acute Facilities Calendar Year Maximum: 70 days combined	No charge	70% after plan deductible

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Laboratory and Radiology Services (includes pre-admission testing)		
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans) **Note:** The copay/deductible applies on a per procedure basis, for any place of service (including inpatient facility, etc.)	No charge after $50 per procedure copay	70% after plan deductible
Other Laboratory and Radiology Services:		
Physician's Office Visit	No charge after the $15 PCP or $30 Specialist per visit copay	70% after plan deductible

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Other Laboratory and Radiology Services:		
Outpatient Hospital Facility	No charge	70% after plan deductible
Independent X-ray and/or Lab facility	No charge	70% after plan deductible
Note: All charges for lab and radiology if coded as preventive will apply to the Preventive Care dollar maximum.		

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Outpatient Short-Term Rehabilitative Therapy Calendar Year Maximum: 60 days for all therapies combined Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy	No charge after the $15 PCP per visit copay **Note:** Outpatient Short Term Rehab copay applies, regardless of place of service, including the home.	70% after plan deductible
Chiropractic Services Calendar Year Maximum: 15 visits	No charge after the $15 per visit copay	70% after plan deductible

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Home Health Care Calendar Year Maximum: 200 days (includes outpatient private nursing when approved as medically necessary)	No charge	70% after plan deductible
Hospice		
Inpatient Services	No charge	70% after plan deductible
Outpatient Services (same coinsurance level as Home Health Care)	No charge	70% after plan deductible

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Bereavement Counseling		
Services provided as part of Hospice Care		
Inpatient	No charge	70% after plan deductible
Outpatient	No charge	70% after plan deductible
Services provided by Mental Health Professional	Covered under Mental Health Benefit	Covered under Mental Health Benefit

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Maternity Care Services		
Initial Visit to Confirm Pregnancy **Note:** OB/GYN providers will be considered either a PCP or Specialist depending on how the provider contracts with CG.	No charge after the $15 PCP or $30 Specialist per visit copay	70% after plan deductible
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	No charge	70% after plan deductible
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	No charge after the $15 PCP or $30 Specialist per visit copay	70% after plan deductible

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Maternity Care Services		
Delivery – Facility (Inpatient Hospital, Birthing Center)	No charge	70% after plan deductible
Abortion Includes elective and non-elective procedures		
Physician's Office Visit	No charge after the $15 PCP or $30 Specialist per visit copay	70% after plan deductible
Inpatient Facility	No charge	70% after plan deductible
Outpatient Facility	No charge	70% after plan deductible
Physician's Services	No charge	70% after plan deductible

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Family Planning Services		
Office Visits, Lab and Radiology Tests and Counseling	No charge after the $15 PCP or $30 Specialist per office visit copay	In-Network coverage only
Maximum: subject to plan's Preventive Care dollar maximum		
Surgical Sterilization Procedures for Vasectomy/Tubal Ligation (excludes reversals)		
Inpatient Facility	No charge	70% after plan deductible
Outpatient Facility	No charge	70% after plan deductible
Physician's Services	No charge	70% after plan deductible
Physician's Office Visit	No charge after the $15 PCP or $30 Specialist per visit copay	70% after plan deductible

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Infertility Treatment Services Not Covered include: • 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 means of becoming pregnant (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc). **Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.	Not Covered	Not Covered

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Organ Transplants Includes all medically appropriate, non-experimental transplants		
Physician's Office Visit	No charge after the $15 PCP or $30 Specialist per office visit copay	In-Network coverage only
Inpatient Facility	No charge at Lifesource center, otherwise No charge	In-Network coverage only
Physician's Services	No charge at Lifesource center, otherwise No charge	In-Network coverage only
Lifetime Travel Maximum: $10,000 per transplant	No charge (only available when using Lifesource facility)	In-Network coverage only

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Durable Medical Equipment Calendar Year Maximum: Unlimited	No charge	70% after plan deductible
External Prosthetic Appliances Calendar Year Maximum: Unlimited	$200 EPA deductible per Calendar Year, then No charge	$200 EPA deductible per Calendar Year, then 70% after plan deductible
Nutritional Evaluation Calendar Year Maximum: 3 visits per person		
Physician's Office Visit	No charge after the $15 PCP or $30 Specialist per office visit copay	70% after plan deductible
Inpatient Facility	No charge	70% after plan deductible
Outpatient Facility	No charge	70% after plan deductible
Physician's Services	No charge	70% after plan deductible

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Additional Prescription Drug Benefit Covered Under the Medical Plan for the Balance of the Calendar Year after the $5,000 Individual Annual Maximum is Reached under Prescription Drug Plan	Not Covered	70% after plan deductible
Dental Care Limited only to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth. Standard dental benefits are provided under the Cigna PPO or DHMO Plan.		
Physician's Office Visit	No charge after the $15 PCP or $30 Specialist per visit copay	70% after plan deductible
Inpatient Facility	No charge	70% after plan deductible
Outpatient Facility	No charge	70% after plan deductible

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Dental Care		
Physician's Services	No charge	70% after plan deductible
TMJ Surgical and Non-Surgical Always excludes appliances and orthodontic treatment. Subject to medical necessity.		
Physician's Office Visit	No charge after the $15 PCP or $30 Specialist per visit copay	70% after plan deductible
Inpatient Facility	No charge	70% after plan deductible
Outpatient Facility	No charge	70% after plan deductible
Physician's Services	No charge	70% after plan deductible

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes and peripheral vascular disease.	Not covered except for services associated with foot care for diabetes and peripheral vascular disease.
Mental Health and Substance Abuse All Requests for Mental Health and Substance Abuse Benefits must be presented to and approved by the Director of the Metro-ILA Member Assistance Program. Participants may contact the Plan Office for more information.		

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Mental Health and Substance Abuse		
Inpatient Calendar Year Maximum: 35 days Lifetime Maximum: 2 Inpatient Admissions Acute: based on a ratio of 1:1 Acute detox (for Substance Abuse): requires 24 hour nursing; based on a ratio of 1:1 Acute Inpatient Rehab (for Substance Abuse): requires 24 hour nursing; based on a ratio of 1:1 Partial: based on a ratio of 2:1 Residential: based on a ratio of 2:1	No charge	Not Covered

TIER I BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK This Plan Will Pay:
Mental Health and Substance Abuse	No charge after the $15 per visit copay	Not Covered
Outpatient		
Calendar Year Maximum: 30 visits		
Outpatient Group Therapy (One group therapy session equals one individual therapy session. Visits used reduce the number of Mental Health and Substance Abuse Outpatient visits available.)	No charge	Not Covered

SECTION 4: TIER I ACTIVES PRESCRIPTION DRUG BENEFITS

THE SCHEDULE

For You and Your Dependents

This plan provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for Prescription Drugs and Related Supplies for each 30-day supply at a retail pharmacy or each 60-day supply at a mail order pharmacy. That portion is the Copayment, Deductible or Coinsurance.

Copayments/Deductibles

Copayments are expenses to be paid by you or your Dependent for covered Prescription Drugs and Related Supplies. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance.

Annual Maximum

The total amount of Prescription Drug benefits payable for all expenses incurred at a Pharmacy in a calendar year will not exceed the Annual Maximums shown in The Schedule.

Calendar Year Deductible

Deductibles are expenses to be paid by you or your Dependent for Covered Prescription Drugs. These Deductibles are in addition to any copayments or coinsurance. Once the Deductible maximum shown in The Schedule has been reached you and your family need not satisfy any further Prescription Drug Deductible for the rest of that year.

TIER I PHARMACY BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	NON-PARTICIPAT-ING PHARMACY
Annual Maximum		
Individual Annual Maximum	$5,000 per person	In Network Only
Family Annual Maximum	Not Applicable	In Network Only
Calendar Year Deductible for Brand-Name Drugs		
Individual	$150 per person	In Network Only
Family	$300 per family	In Network Only

TIER I PHARMACY BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	NON-PARTICIPAT-ING PHARMACY
Prescription Drugs Retail/Over the Counter: 30-day supply**		
Generic* drugs on the Prescription Drug List	No charge per prescription order or refill ($0 copay and No Plan Deductible)	In-network coverage only
Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	$20 copay per prescription order or refill, after Plan Deductible	In-network coverage only
Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	$40 copay per prescription order or refill , after Plan Deductible	In-network coverage only

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

** **Supply Limitations:** An original prescription plus two refills may be filled via a network retail pharmacy ("over the counter"); after that, the CIGNA Tel-Drug mail order program MUST be used in order for that specific prescription to be covered under the Plan.

TIER I PHARMACY BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	NON-PARTICIPAT-ING PHARMACY
Mail-Order Drugs 60-day supply		
Generic* drugs on the Prescription Drug List	No charge per prescription order or refill ($0 copay and No Plan Deductible)	In-network coverage only
Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	$40 copay per prescription order or refill, after Plan Deductible	In-network coverage only
Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	$80 copay per prescription order or refill, after Plan Deductible	In-network coverage only

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

SECTION 5: TIER II BENEFITS

THE SCHEDULE

TIER II BENEFIT HIGHLIGHTS	IN-NETWORK This Plan Will Pay:	OUT-OF-NETWORK This Plan Will Pay:
Lifetime Maximum	Unlimited	
Calendar Year Maximum	$50,000	
Coinsurance Levels	80%	60% of the Maximum Reimbursable Charge

TIER II BENEFIT HIGHLIGHTS	IN-NETWORK This Plan Will Pay:	OUT-OF-NETWORK This Plan Will Pay:
Maximum Reimbursable Charge		
Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or		
A percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database we have selected.	Not Applicable	50th Percentile

TIER II BENEFIT HIGHLIGHTS	IN-NETWORK This Plan Will Pay:	OUT-OF-NETWORK This Plan Will Pay:
Maximum Reimbursable Charge **Note:** The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles, copayments and coinsurance.		
Calendar Year Deductible		
Individual	Not Applicable	$500 per person
Family Maximum	Not Applicable	$1,250 per family

TIER II BENEFIT HIGHLIGHTS	IN-NETWORK This Plan Will Pay:	OUT-OF-NETWORK This Plan Will Pay:
Family Maximum Calculation **Individual Calculation:** 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.		

TIER II BENEFIT HIGHLIGHTS	IN-NETWORK This Plan Will Pay:	OUT-OF-NETWORK This Plan Will Pay:
Out-of-Pocket Maximum		
Individual	$5,000 per person	$5,000 per person
Family Maximum	$10,000 per family	$10,000 per family
Family Maximum Calculation **Individual Calculation:** Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.		

TIER II BENEFIT HIGHLIGHTS	IN-NETWORK This Plan Will Pay:	OUT-OF-NETWORK This Plan Will Pay:
Physician's Services		
Primary Care Physician's Office visit	80%	60% after plan deductible
Specialty Care Physician's Office Visits Consultant and Referral Physician's Services **Note:** OB-GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with CG.	80%	60% after plan deductible
Surgery Performed In the Physician's Office	80%	60% after plan deductible

TIER II BENEFIT HIGHLIGHTS	IN-NETWORK This Plan Will Pay:	OUT-OF-NETWORK This Plan Will Pay:
Physician's Services Second Opinion Consultations (provided on a voluntary basis)	80%	60% after plan deductible
Allergy Treatment/Injec-tions	80%	60% after plan deductible
Allergy Serum (dispensed by the physician in the office)	80%	60% after plan deductible

Preventive Care

Routine Preventive Care

Calendar Year Maximum through age 18 (including immunizations): Unlimited. Calendar Year Maximum for ages 19 and above (including immunizations): $500.

Note:

Well-woman OB/GYN visits will be considered either a PCP or Specialist depending on how the provider contracts with CG.

Note:

Charges for lab and radiology services, when billed by the physician's office, will be subject to the plan's Preventive Care dollar maximum. Charges for lab and radiology services, when billed by an independent diagnostic facility or outpatient hospital do not apply to the plan's Preventive Care dollar maximum.

TIER II BENEFIT HIGHLIGHTS	IN-NETWORK This Plan Will Pay:	OUT-OF-NETWORK This Plan Will Pay:
Preventive Care		
Physician's Office Visit for children through age 18	80%	In-Network coverage only
Immunizations for children through age 18	No charge	In-Network coverage only
Physician's Office Visit for ages 19 and over	80%	In-Network coverage only
Immunizations for ages 19 and over	80%	In-Network coverage only
Well Woman Exam	80%	60% after plan deductible
Mammograms, PSA, Pap Smear	80% if billed by an independent diagnostic facility or outpatient hospital.	60% after plan deductible

TIER II BENEFIT HIGHLIGHTS	IN-NETWORK This Plan Will Pay:	OUT-OF-NETWORK This Plan Will Pay:
Inpatient Hospital Facility Services	80%	60% after plan deductible
Semi-Private Room and Board	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Private Room	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate
Outpatient Facility Services		
Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room.	80%	60% after plan deductible
Inpatient Hospital Physician's Visits/Consultations	80%	60% after plan deductible

TIER II BENEFIT HIGHLIGHTS	IN-NETWORK This Plan Will Pay:	OUT-OF-NETWORK This Plan Will Pay:
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	80%	60% after plan deductible
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	80%	60% after plan deductible

TIER II BENEFIT HIGHLIGHTS	IN-NETWORK This Plan Will Pay:	OUT-OF-NETWORK This Plan Will Pay:
Emergency and Urgent Care Services		
Physician's Office Visit	80%	80% (except if not a true emergency, then 60% after plan deductible)
Hospital Emergency Room	80%	80% (except if not a true emergency, then 60% after plan deductible)
Outpatient Professional services (radiology, pathology and ER Physician)	80%	80% (except if not a true emergency, then 60% after plan deductible)
Urgent Care Facility or Outpatient Facility	80%	80% (except if not a true emergency, then 60% after plan deductible)
X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	80%	80% (except if not a true emergency, then 60% after plan deductible)
Independent x-ray and/or Lab Facility in conjunction with an ER visit	80%	80% (except if not a true emergency, then 60% after plan deductible)

TIER II BENEFIT HIGHLIGHTS	IN-NETWORK This Plan Will Pay:	OUT-OF-NETWORK This Plan Will Pay:
Ambulance	80%	80% (except if not a true emergency, then 60% after plan deductible)
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: 70 days combined	80%	60% after plan deductible

TIER II BENEFIT HIGHLIGHTS	IN-NETWORK This Plan Will Pay:	OUT-OF-NETWORK This Plan Will Pay:
Laboratory and Radiology Services (includes pre-admission testing)		
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)	$50 per procedure copay, then 80%	60% after plan deductible
Note: The copay/deductible applies on a per procedure basis, for any place of service (including inpatient facility, etc.)		
Other Laboratory and Radiology Services:		
Physician's Office Visit	80%	60% after plan deductible
Outpatient Hospital Facility	80%	60% after plan deductible
Independent X-ray and/or Lab facility	80%	60% after plan deductible

TIER II BENEFIT HIGHLIGHTS	IN-NETWORK This Plan Will Pay:	OUT-OF-NETWORK This Plan Will Pay:
Outpatient Short-Term Rehabilitative Therapy Calendar Year Maximum: 60 days for all therapies combined Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy	80%	60% after plan deductible
Chiropractic Care Calendar Year Maximum: 15 visits	80%	60% after plan deductible
Home Health Care Calendar Year Maximum: 200 days (includes outpatient private nursing when approved as medically necessary)	80%	60% after plan deductible

TIER II BENEFIT HIGHLIGHTS	IN-NETWORK This Plan Will Pay:	OUT-OF-NETWORK This Plan Will Pay:
Hospice		
Inpatient Services	80%	60% after plan deductible
Outpatient Services (same coinsurance level as Home Health Care)	80%	60% after plan deductible
Bereavement Counseling Services provided as part of Hospice Care		
Inpatient	80%	60% after plan deductible
Outpatient	80%	60% after plan deductible
Services provided by Mental Health Professional	Covered under Mental Health Benefit	Covered under Mental Health Benefit

TIER II BENEFIT HIGHLIGHTS	IN-NETWORK This Plan Will Pay:	OUT-OF-NETWORK This Plan Will Pay:
Maternity Care Services		
Initial Visit to Confirm Pregnancy **Note:** OB/GYN providers will be considered either a PCP or Specialist depending on how the provider contracts with CG.	80%	60% after plan deductible
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	80%	60% after plan deductible
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	80%	60% after plan deductible
Delivery - Facility (Inpatient Hospital, Birthing Center)	80%	60% after plan deductible

TIER II BENEFIT HIGHLIGHTS	IN-NETWORK This Plan Will Pay:	OUT-OF-NETWORK This Plan Will Pay:
Abortion		
Includes elective and non-elective procedures		
Physician's Office Visit	80%	60% after plan deductible
Inpatient Facility	80%	60% after plan deductible
Outpatient Facility	80%	60% after plan deductible
Physician's Services	80%	60% after plan deductible

TIER II BENEFIT HIGHLIGHTS	IN-NETWORK This Plan Will Pay:	OUT-OF-NETWORK This Plan Will Pay:
Family Planning Services		
Office Visits, Lab and Radiology Tests and Counseling	80%	In-Network coverage only
Maximum: subject to plan's Preventive Care dollar maximum		
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 Procedures for Vasectomy/Tubal Ligation (excludes reversals)		
Inpatient Facility	80%	60% after plan deductible

TIER II BENEFIT HIGHLIGHTS	IN-NETWORK This Plan Will Pay:	OUT-OF-NETWORK This Plan Will Pay:
Family Planning Services		
Outpatient Facility	80%	60% after plan deductible
Physician's Services	80%	60% after plan deductible
Physician's Office Visit	80%	60% after plan deductible

TIER II BENEFIT HIGHLIGHTS	IN-NETWORK This Plan Will Pay:	OUT-OF-NETWORK This Plan Will Pay:
Infertility Treatment Services Not Covered Include: • 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 means of becoming pregnant (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc). **Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.	Not Covered	Not Covered

TIER II BENEFIT HIGHLIGHTS	IN-NETWORK This Plan Will Pay:	OUT-OF-NETWORK This Plan Will Pay:
Organ Transplants Includes all medically appropriate, non-experimental transplants		
Physician's Office Visit	80%	In-Network coverage only
Inpatient Facility	No charge at Lifesource center, otherwise 80%	In-Network coverage only
Physician's Services	No charge at Lifesource center, otherwise 80%	In-Network coverage only
Lifetime Travel Maximum: $10,000 per transplant	No charge (only available when using Lifesource facility)	In-Network coverage only

TIER II BENEFIT HIGHLIGHTS	IN-NETWORK This Plan Will Pay:	OUT-OF-NETWORK This Plan Will Pay:
Durable Medical Equipment	80%	60% after plan deductible
Calendar Year Maximum: $700		
External Prosthetic Appliances	$200 EPA deductible per Calendar Year, then 80%	$200 EPA deductible per Calendar Year, then 60% after plan deductible
Calendar Year Maximum: $1,000		
Nutritional Evaluation		
Calendar Year Maximum: 3 visits per person		
Physician's Office Visit	80%	60% after plan deductible
Inpatient Facility	80%	60% after plan deductible
Outpatient Facility	80%	60% after plan deductible
Physician's Services	80%	60% after plan deductible

TIER II BENEFIT HIGHLIGHTS	IN-NETWORK This Plan Will Pay:	OUT-OF-NETWORK This Plan Will Pay:
Dental Care Limited only to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth. (Standard dental benefits are not available under the Tier II Plan.)		
Physician's Office Visit	80%	60% after plan deductible
Inpatient Facility	80%	60% after plan deductible
Outpatient Facility	80%	60% after plan deductible

TIER II BENEFIT HIGHLIGHTS	IN-NETWORK This Plan Will Pay:	OUT-OF-NETWORK This Plan Will Pay:
TMJ Surgical and Non-Surgical Always excludes appliances and orthodontic treatment. Subject to medical necessity.		
Physician's Office Visit	80%	60% after plan deductible
Inpatient Facility	80%	60% after plan deductible
Outpatient Facility	80%	60% after plan deductible
Physician's Services	80%	60% after plan deductible
Physician's Services	80%	60% after plan deductible

TIER II BENEFIT HIGHLIGHTS	IN-NETWORK This Plan Will Pay:	OUT-OF-NETWORK This Plan Will Pay:
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes and peripheral vascular disease.	Not covered except for services associated with foot care for diabetes and peripheral vascular disease.
Mental Health and Substance Abuse All Requests for Mental Health and Substance Abuse Benefits must be presented to and approved by the Director of the Metro-ILA Member Assistance Program. Participants may contact the Plan Office for more information.	No charge	60% after plan deductible

TIER II BENEFIT HIGHLIGHTS	IN-NETWORK This Plan Will Pay:	OUT-OF-NETWORK This Plan Will Pay:
Mental Health and Substance Abuse **Inpatient** Calendar Year Maximum: 35 days Lifetime Maximum: 2 Inpatient Admissions Acute: based on a ratio of 1:1 Acute detox (for Substance Abuse): requires 24 hour nursing; based on a ratio of 1:1 Acute Inpatient Rehab (for Substance Abuse): requires 24 hour nursing; based on a ratio of 1:1 Partial: based on a ratio of 2:1 Residential: based on a ratio of 2:1		

TIER II BENEFIT HIGHLIGHTS	IN-NETWORK This Plan Will Pay:	OUT-OF-NETWORK This Plan Will Pay:
Mental Health and Substance Abuse		
Outpatient	80%	60% after plan deductible
Calendar Year Maximum:		
30 visits		
Outpatient Group Therapy (One group therapy session equals one individual therapy session. Visits used reduce the number of Mental Health and Substance Abuse Outpatient visits available.)	80%	60% after plan deductible

SECTION 6: CERTIFICATION REQUIREMENTS FOR ACTIVE TIER I AND TIER II PARTICIPANTS

CERTIFICATION REQUIREMENTS - OUT-OF-NETWORK

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 the treatment of Mental Health or Substance Abuse in an Intensive Outpatient Therapy Program.
- for Mental Health or Substance Abuse Residential Treatment Services.

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

Covered Expenses incurred will be reduced by 50% for 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.

For You and Your Dependents (Continued)

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

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 be reduced by 50% 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

OUTPATIENT CERTIFICATION REQUIREMENTS OUT-OF-NETWORK (Continued)

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

PRIOR AUTHORIZATION/PRE-AUTHORIZED

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

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

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

SECTION 7: COVERED EXPENSES

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and 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 EXPENSES

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board 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.

COVERED EXPENSES (Continued)

- 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, and other medical services, information and counseling on contraception, implanted/injected contraceptives.
- office visits, tests and counseling for Family Planning services are subject to the Preventive Care Maximum shown in the Schedule.
- charges made for Routine Preventive Care from age 19 including immunizations, not to exceed the maximum shown in the Schedule. Routine Preventive Care means health care assessments, wellness visits and any related services.
- charges made for visits for routine preventive care of a Dependent child during the first 18 years of that Dependent child’s life, including immunizations.

COVERED EXPENSES (Continued)

charges made for medical diagnostic services to determine the cause of erectile dysfunction. Penile implants are covered for an established medical condition that clearly is the cause of erectile dysfunction, such as postoperative prostatectomy and diabetes. Penile implants are not covered as treatment of psychogenic erectile dysfunction.

- surgical or nonsurgical treatment of TMJ Dysfunction.
- charges made for Prescription Drugs after the Prescription Drug maximum is met.

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;

CLINICAL TRIALS (Continued)

- 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
- 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.

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.

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. 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.

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;
    - 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;

HOSPICE CARE SERVICES (Continued)

- 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;

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, Mental Health Intensive Outpatient Therapy Program and Mental Health Residential Treatment Services.

Inpatient Mental Health services are exchangeable with **Partial Hospitalization** sessions when services are provided for not less than 4 hours and not more than 12 hours in any 24-hour period. The exchange for services will be two Partial Hospitalization sessions are equal to one day of inpatient care.

INPATIENT MENTAL HEALTH SERVICES (Continued)

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.

Mental Health Residential Treatment services are exchanged with Inpatient Mental Health services at a rate of two days of Mental Health Residential Treatment being equal to one day of Inpatient Mental Health Treatment.

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 Inpatient Mental Health services at a rate of three days of Mental Health Intensive Outpatient Therapy being equal to one day of Inpatient Mental Health Services.

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 or group program. Covered services include, but are not limited to, outpatient treatment of

OUTPATIENT MENTAL HEALTH SERVICES (Continued)

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.

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 and Substance Abuse Intensive Outpatient Therapy Program sessions and Residential Treatment services.

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

Substance Abuse Residential Treatment Services are services provided by a Hospital 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 services are exchanged with Inpatient Substance Abuse services at a rate of two days of Substance Abuse Residential Treatment being equal to one day of Inpatient Substance Abuse Treatment.

Substance Abuse Residential Treatment Center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of Substance Abuse; (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)

INPATIENT SUBSTANCE ABUSE REHABILITATION SERVICE (Continued)

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.

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 Inpatient Substance Abuse services at a rate of three days of Substance Abuse Intensive Outpatient Therapy being equal to one day of Inpatient Substance Abuse Services.

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 or group program.

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. The Director of the Metro-ILA Member Assistance Program, together with Cigna, will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

EXCLUSIONS

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

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

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 (Continued)

- 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.

DURABLE MEDICAL EQUIPMENT (Continued)

- charges made or ordered by a Physician for the initial purchase and

EXTERNAL PROSTHETIC APPLIANCES AND DEVICES

- 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.

ORTHOSES AND ORTHOTIC DEVICES (Continued)

- 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.
- 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.

SHORT-TERM REHABILITATIVE THERAPY AND CHIROPRACTIC CARE SERVICES

- charges made for Short-term Rehabilitative Therapy that is part of a rehabilitative program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting. Also included are services that are provided by a chiropractic Physician when provided in an outpatient setting. Services of a chiropractic Physician include the conservative

- management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment that is rendered to restore motion, reduce pain and improve function.

The following limitations apply to Short-term Rehabilitative Therapy and Chiropractic Care 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 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 Injury or Sickness.

Short-term Rehabilitative Therapy and Chiropractic Care 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;

SHORT-TERM REHABILITATIVE THERAPY AND CHIROPRACTIC CARE SERVICES (Continued)

- 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;
- Maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrences or to maintain the patient's current status;

The following are specifically excluded from Chiropractic Care Services:

- 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;
- Vitamin therapy.

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.

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 or its territories. 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.

TRANSPLANT SERVICES (Continued)

All Transplant services, other than cornea, are payable at 100% when received at CIGNA LIFESOURCE Transplant Network® Facilities. Cornea transplants are not covered at CIGNA LIFESOURCE Transplant Network® facilities. Transplant services, including cornea, when received from Participating Provider facilities other than CIGNA LIFESOURCE Transplant Network® facilities are payable at the In-Network level. Transplant services received at any other facilities are not covered.

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:

TRANSPLANT TRAVEL SERVICES (Continued)

- 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.

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.

SECTION 8: TIER I AND TIER II OPEN ACCESS PLUS PLAN: 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:

Exclusions, Expenses Not Covered and General Limitations (Continued)

- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
- the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section of this plan; or
- the subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of this plan.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- regardless of clinical indication for rhinoplasty; blepharoplasty; orthognathic surgeries; acupressure; dance therapy, movement therapy; applied kinesiology; rolfing; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an Injury to sound natural teeth; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; (c) charges made by a Free-Standing Surgical Facility or the outpatient department of a Hospital in connection with surgery.
- 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.

Exclusions, Expenses Not Covered and General Limitations (Continued)

- 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.
- infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- reversal of male and female voluntary sterilization procedures.
- 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.
- 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.

Exclusions, Expenses Not Covered and General Limitations (Continued)

- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the “Home Health Services” or “Breast Reconstruction and Breast Prostheses” sections of this plan.
- private Hospital rooms and/or private duty nursing unless determined by the utilization review Physician to be Medically Necessary.
- 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 routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.
- treatment by acupuncture.
- all noninjectable prescription drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.

Exclusions, Expenses Not Covered and General Limitations (Continued)

- 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.

Exclusions, Expenses Not Covered and General Limitations (Continued)

- 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.

Pre-existing Condition Limitations

No payment will be made for Covered Expenses for or in connection with an Injury or a Sickness which is a Pre-existing Condition, unless those expenses are incurred after a continuous one-year period during which a person is satisfying a waiting period and/or is insured for these benefits.

Pre-existing Condition

A Pre-existing Condition is an Injury or a Sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a Physician during the 90 days before the earlier of the date a person begins an eligibility waiting period, or becomes insured for these benefits.

Exceptions to Pre-existing Condition Limitation

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

Exceptions to Pre-existing Condition Limitation (Continued)

A newborn child, an adopted child, or a child placed for adoption before age 18 will not be subject to any Pre-existing Condition limitation if such child was covered within 31 days of birth, adoption or placement for adoption. Such waiver will not apply if 63 days elapse between coverage during a prior period of Creditable Coverage and coverage under this plan.

Credit for Coverage Under Prior Plan

If a person was previously covered under a plan which qualifies as Creditable Coverage, the following will apply, provided he notifies the Fund of such prior coverage, and fewer than 63 days elapse between coverage under the prior plan and coverage under this plan, exclusive of any waiting period. CG will reduce any Pre-existing Condition limitation period under this policy by the number of days of prior Creditable Coverage you had under a creditable health plan or policy.

SECTION 9: TIER I PHARMACY BENEFITS: COVERED EXPENSES, EXCLUSIONS AND LIMITATIONS

COVERED EXPENSES

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, CG will provide coverage for those expenses as shown in the Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a Dependent is issued a prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by CG, as if filled by a Participating Pharmacy.

LIMITATIONS

Each Prescription Order or refill shall be limited as follows:

- up to a consecutive 30-day supply, at a retail Pharmacy, unless limited by the drug manufacturer's packaging: or
- up to a consecutive 60-day supply at a mail-order Participating Pharmacy, unless limited by the drug manufacturer's packaging; or
- to a dosage and/or dispensing limit as determined by the P&T Committee.

Coverage for certain Prescription Drugs and Related Supplies requires your Physician to obtain authorization prior to prescribing. Prior authorization may include, for example, a step therapy determination. Step therapy determines

LIMITATIONS (Continued)

the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If your Physician wishes to request coverage for Prescription Drugs or Related Supplies for which prior authorization is required, your Physician may call or complete the appropriate prior authorization form and fax it to CG to request prior authorization for coverage of the Prescription Drugs or Related Supplies. Your Physician should make this request before writing the prescription.

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

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

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

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

All drugs newly approved by the Food and Drug Administration (FDA) are designated as either non-Preferred or non-Formulary drugs until the P & T Committee clinically evaluates the prescription drug for a different designation.

Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad

LIMITATIONS (Continued)

hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

YOUR PAYMENTS

Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy is subject to the Copayment or Coinsurance shown in the Schedule, after you have satisfied your Prescription Drug Deductible, if applicable. Please refer to the Schedule for any required Copayments, Coinsurance, Deductibles or Maximums if applicable.

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

EXCLUSIONS

No payment will be made for the following expenses:

- drugs available over the counter that do not require a prescription by federal or state law;
- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- injectable drugs, including injectable infertility drugs. However, self-administered injectables on the Formulary, which are used to treat diabetes, acute migraine headaches, anaphylactic reactions, vitamin deficiencies and injectables used for anticoagulation are covered. However, upon prior authorization by CG, injectable drugs may be covered subject to the required Copayment or Coinsurance.
- any drugs that are experimental or investigational as described under the Medical "Exclusions" section of your certificate;

EXCLUSIONS (Continued)

- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, The American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
- prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- implantable contraceptive products;
- contraceptive drugs, and prescription appliances for contraception;
- any fertility drug;
- drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, and decreased libido;
- dietary supplements, and fluoride products;
- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
- diet pills or appetite suppressants (anorectics);
- prescription smoking cessation products;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance;
- drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;

EXCLUSIONS (Continued)

- prescriptions more than one year from the original date of issue.
- Other limitations are shown in the Medical "Exclusions" section.

REIMBURSEMENT/FILING A CLAIM

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

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

SECTION 10: COORDINATION OF BENEFITS

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

DEFINITIONS

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

PLAN

Any of the following that provides benefits or services for medical 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) Governmental benefits as permitted by law, excepting Medicaid, Medicare and Medicare supplement policies.

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

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

CLOSED PANEL PLAN

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

PRIMARY PLAN

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

SECONDARY PLAN

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

ALLOWABLE EXPENSE

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

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

(1) An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.

(2) If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.

(3) If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.

(4) If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.

(5) If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply

ALLOWABLE EXPENSE (Continued)

(6) with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

CLAIM DETERMINATION PERIOD

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

REASONABLE CASH VALUE

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

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

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

(a) first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that

ORDER OF BENEFIT DETERMINATION RULES (Continued)

(b) parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;

(c) then, the Plan of the parent with custody of the child;

(d) then, the Plan of the spouse of the parent with custody of the child;

(e) then, the Plan of the parent not having custody of the child, and

(f) finally, the Plan of the spouse of the parent not having custody of the child.

(4) The Plan that covers you as an active member (or as that member's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired member (or as that member'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 member or retiree (or as that member'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.

EFFECT ON THE BENEFITS OF THIS PLAN

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

EFFECT ON THE BENEFITS OF THIS PLAN (Continued)

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

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

(1) CG's obligation to provide services and supplies under this policy;

(2) whether a benefit reserve has been recorded for you; and

(3) whether there are any unpaid Allowable Expenses during the Claims Determination Period.

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

RECOVERY OF EXCESS BENEFITS

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

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

RIGHT TO RECEIVE AND RELEASE INFORMATION

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.

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.

SUBROGATION/RIGHT OF REIMBURSEMENT (Continued)

(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.

ADDITIONAL TERMS (Continued)

- 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.

SECTION 11: 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.

DEPENDENTS

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

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

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

SECTION 12: FEDERAL REQUIREMENTS

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

NOTICE OF PROVIDER DIRECTORY/NETWORKS

Notice Regarding Provider/Pharmacy Directories and Provider/Pharmacy Networks

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

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

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

Eligibility for Coverage Under a QMCSO

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

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) [Continued]

You must notify the Fund 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:

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

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

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

(4) the order states the period to which it applies; and

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

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

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.

CHANGES IN COVERAGE OF SPOUSE OR DEPENDENT UNDER THE FUND'S PLAN

You may make a coverage election change if the plan of your spouse or Dependent: (a) incurs a change such as adding or deleting a benefit option; (b) allows election changes due to Special Enrollment, Change in Status,

Court Order or Medicare or Medicaid Eligibility/Entitlement; or (c) this Plan and the other plan have different periods of coverage or open enrollment periods.

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) (Continued)

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.

PRE-EXISTING CONDITIONS UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA)

A federal law known as the Health Insurance Portability & Accountability Act (HIPAA) establishes requirements for Pre-existing Condition limitation provisions in health plans. Following is an explanation of the requirements and limitations under this law.

Pre-Existing Condition Limitation

Under HIPAA, a Pre-existing Condition limitation is a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage under the plan, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. A Pre-existing Condition limitation is permitted under group health plans, provided it is applied only to a physical or mental condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period (or a shorter period as applies under the plan) ending on the enrollment date. Plan provisions may vary. Please refer to the section entitled "Exclusions, Expenses Not Covered and General Limitations" for the specific Pre-existing Condition limitation provision which applies under this Plan, if any.

Exceptions to Pre-existing Condition Limitation

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

A newborn child, an adopted child, or a child placed for adoption before age 18 will not be subject to any Pre-existing Condition limitation if such child was covered under any creditable coverage within 30 days of birth, adoption or placement for adoption. Such waiver will not apply if 63 days or more elapse between coverage under the prior creditable coverage and coverage under this Plan.

Credit for Coverage Under Prior Plan

If you and/or your Dependent(s) were previously covered under a plan which qualifies as Creditable Coverage, CG will reduce any Pre-existing Condition limitation period under this policy by the number of days of prior Creditable Coverage you had under the prior plan(s). However, credit is available only if you notify the Fund of such prior coverage, and fewer than 63 days elapse between coverage under the prior plan and coverage under this Plan, exclusive of any waiting period. Credit will be given for coverage under all prior Creditable Coverage, provided fewer than 63 days elapsed between coverage under any two plans.

Certificate of Prior Creditable Coverage

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

Creditable Coverage

Creditable Coverage will include coverage under any of the following: A self-insured employer group health plan; Individual or group health insurance indemnity or HMO plans; Part A or Part B of Medicare; Medicaid, except coverage solely for pediatric vaccines; A health plan for certain members of the uniformed armed services and their dependents, including the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service; A medical care program of the Indian Health Service or of a tribal organization; A state health benefits risk pool; The Federal Employees Health Benefits Program; A public health plan established by a State, the U.S. government, or a foreign country; the Peace Corps Act; Or a State Children's Health Insurance Program.

Obtaining a Certificate of Creditable Coverage Under This Plan

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

REQUIREMENTS OF MEDICAL LEAVE ACT OF 1993 (FMLA)

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

Continuation of Health Insurance During Leave

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

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

Continuation of Health Insurance During Leave (Continued)

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

Reinstatement of Canceled Insurance Following Leave

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

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

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

UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Member's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

Continuation of Coverage

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

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

Continuation of Coverage (Continued)

You may continue benefits by paying the required premium to the Fund, until the earliest of the following:

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

The Fund may charge you and your Dependents up to 102% of the total premium.

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

Reinstatement of Benefits (Applicable to All Coverages)

If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by the Fund, coverage for you and your Dependents may be reinstated if (a) you gave the Fund advance written or verbal notice of your military service leave, and (b) the duration of all military leaves while you are employed with the Fund does not exceed 5 years.

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

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

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

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.

Preservice Medical Necessity Determinations (Continued)

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.

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

Postservice Medical Necessity Determinations (Continued)

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

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

Postservice Claim Determinations

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

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the plan's review

Notice of Adverse Determination (Continued)

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.

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.

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.

Level-Two Appeal (Continued)

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.

Independent Review Procedure (Continued)

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.

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.

Notice of Benefit Determination on Appeal (Continued)

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.

Interaction With Other Continuation Benefits

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

ERISA REQUIRED INFORMATION

The name of the Plan is: Metro-I.L.A. Fringe Benefit Fund

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

Metro-I.L.A. Fringe Benefit Fund
301 Route 17 North
Rutherford, NJ 07070
(201) 842-0202

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

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

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

The cost of the plan is paid by the Fund.

The Plan's fiscal year ends on 12/31.

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

Plan Trustees

A list of any Trustees of the Plan, which includes name, title and address, is available upon request 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 and if the Fund is a sponsor. A copy is available for examination from the Plan Administrator upon written request.

Discretionary Authority

The Plan Administrator delegates to CG the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, 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 CG the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

Plan Modification, Amendment and Termination

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

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

Plan Modification, Amendment and Termination (Continued)

A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

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

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

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

Statement of Rights

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

Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure room of the 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.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report

Enforce Your Rights (Continued)

from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

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

Assistance with Your Questions

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

SECTION 13: DEFINITIONS

Bed and Board

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

Charges

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

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.

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.

Expense Incurred

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

Formulary

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

Free-Standing Surgical Facility

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

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;

Free-Standing Surgical Facility (Continued)

- 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.

Fund

The term Fund means an employer participating in the fund which is established under the agreement of Trust for the purpose of providing insurance. It also means the plan sponsor self-insuring the benefits described in this booklet, on whose behalf CG is providing claim administration services.

Hospice Care Program

The term Hospice Care Program means:

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

Hospice Care Services

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

Hospice Facility

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

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by CG; and

Hospice Facility

- fulfills any licensing requirements of the state or locality in which it operates.

Hospital

The term Hospital means:

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

Hospital (Continued)

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

Hospital Confinement or Confined in a Hospital

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

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

Injury

The term Injury means an accidental bodily injury.

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.

Maximum Reimbursable Charge – Medical (Continued)

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.

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.

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.

Medicare

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

Medicare (Continued)

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

Member

The term Member means a full-time member of the Fund who is currently in Active Service and qualifies as a member of an eligible class as defined on pages 15 and 16.

Necessary Services and Supplies

The term Necessary Services and Supplies includes:

- any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement;
- any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and
- any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

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

Nurse

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

Other Health Care Facility

The term Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities. The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

Other Health Care Facility

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

Other Health 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.

Participating Pharmacy

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

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.

Participation Date

The term Participation Date means the later of:

- The Effective Date of the policy; or
- The date on which the Fund becomes a participant in the plan of insurance authorized by the agreement of Trust.

Pharmacy

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

Pharmacy & Therapeutics (P & T) Committee

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

Physician

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

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

Prescription Drug

Prescription Drug means; (a) a drug which has been approved by the Food and Drug Administration for safety and efficacy; (b) certain drugs approved under the Drug Efficacy Study Implementation review; or (c) drugs marketed

Prescription Drug (Continued)

prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

Prescription Order

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

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.

Psychologist

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

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

Related Supplies

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

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.

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.

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.

Specialist

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

Terminal Illness

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

Urgent Care

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