IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF CONNECTICUT

CONNECTICUT GENERAL LIFE INSURANCE COMPANY; CIGNA HEALTH AND LIFE INSURANCE COMPANY **PLAINTIFFS,** **V.** **HEALTH DIAGNOSTIC LABORATORY, INC.** **DEFENDANT**	CIVIL NO. 3:14-cv-01519-SRU JANUARY 16, 2015

PLAINTIFFS' AMENDED COMPLAINT

Plaintiffs Connecticut General Life Insurance Company and Cigna Health and Life Insurance Company (collectively, "Cigna") file this Amended Complaint against Defendant Health Diagnostic Laboratory, Inc. ("HDL") and allege as follows:

INTRODUCTION

1. This case arises out of a scheme by HDL to submit fictional, excessive charges for routine healthcare services to Cigna which bear no relation to HDL's actual charges to patients. By means of that scheme, HDL has unlawfully obtained approximately $84 million from Cigna and the benefit plans it serves.

2. Cigna is a Connecticut managed care company that administers employee health and welfare benefit plans (including, but not limited to, plans insured by Cigna). It is part of Cigna's responsibilities to those plans to control overall healthcare costs. One way Cigna discharges that responsibility is by entering into agreements with networks of healthcare providers, under which the providers agree to accept fixed rates for services in consideration of

other benefits, including access to plan members. In the plans at issue here, plan members remain free to use providers outside these networks, but they are given incentives to remain in the network, and thereby to lower costs for the plan as a whole.

3. One such incentive involves requiring plan members to bear a portion of the cost (either through co-payment, co-insurance or deductible obligations) of treatment by out-of-network providers, who generally charge higher rates than doctors in the network. Without this obligation, out-of-network providers could submit charges to healthcare plans which have no relation either to the provider's actual costs or to the actual market for medical services, and members would have no incentive to avoid those providers.

4. HDL, a provider of routine laboratory services that does not participate in Cigna's provider networks, undermines these safeguards by means of a fraudulent "fee forgiving" scheme. HDL lures patients from health plans that are administered and/or insured by Cigna by misrepresenting those patients' responsibilities under the plans, by promising not to collect any co-payment, co-insurance or deductible obligation, and by further promising not to seek reimbursement from the patient for any other portion of its bill that the plan does not cover. HDL then misleadingly bills Cigna and the plans themselves at exorbitant and unjustified rates. The rates HDL submits to Cigna are fictional rates that misrepresent what HDL actually intended to collect.

5. Indeed, courts have referred to the charges submitted by fee-forgiving providers like HDL as "phantom" charges.

6. As an example, for one of the patients described below, HDL submitted "charges" of $2,979.00 to Cigna. Based on these charges, the patient's cost-sharing responsibilities under his or her plan were $649.40. However, HDL charged the patient ***nothing*.**

7. "Fee forgiving" of this kind has long been recognized as a variety of medical billing fraud. More than two decades ago, the American Medical Association advised its members: "[P]hysicians should be aware that … [r]outine forgiveness of waiver or copayments may constitute fraud under state and federal law." *See* AMA Ethics Advisory Opinion 6.12 – Forgiveness or Waiver of Insurance Copayments (June 1993) (available at: http:/www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion612.page). In the context of the federal Medicare program, the Department of Health and Human Services reached the same conclusion: "Routine waiver of deductibles and copayments by charge-based providers, practitioners or suppliers is unlawful because it results in … false claims … [and] excessive utilization of items and services paid for by Medicare." HHS OIG Special Fraud Alerts, (Dec. 19, 1994) (available at https://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html).

8. The effect of HDL's scheme is to deceive health benefit plans into paying far more for services than the plans are obligated to pay. But misleading plan members is also essential to the scheme. By convincing patients that HDL offers services at little or no cost (when, in fact, HDL was artificially increasing the cost of healthcare to Cigna and its clients), HDL increases the volume of its business and, at the same time, increases the harm to Cigna and the plans it serves.

9. Cigna was only able to confirm HDL's fraudulent billing practices through a special investigation of HDL, after which Cigna began reducing or denying payment for claims submitted by HDL.

10. But before confirming HDL's fraudulent practices, HDL induced Cigna into paying it approximately $84 million through its fee-forgiving scheme.

11. In this action, Cigna seeks to recover the payments made to HDL, and to prevent HDL from continuing its fraudulent billing scheme against Cigna.

12. By bringing this action, Cigna seeks to ensure that its clients and plan members are charged only appropriate amounts for services rendered and thereby help to maintain the affordability of healthcare coverage for individuals and employers.

PARTIES

13. Plaintiff Connecticut General Life Insurance Company is a company organized under the laws of the State of Connecticut, with its principal place of business in Connecticut.

14. Plaintiff Cigna Health and Life Insurance Company is a company organized under the laws of Connecticut, with its principal place of business in Connecticut.

15. Defendant Health Diagnostic Laboratory, Inc. is a Virginia corporation with its principal place of business in Richmond, Virginia.

JURISDICTION AND VENUE

16. This Court has personal jurisdiction over HDL, a Virginia corporation, pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et. seq.*, and its nationwide service of process provision, 29 U.S.C. § 1132(e)(2).

17. This Court also has personal jurisdiction over HDL because HDL systematically and continuously conducts business in Connecticut and otherwise has minimum contacts with this State sufficient to establish personal jurisdiction. Upon information and belief, HDL actively solicits providers and patients in Connecticut and maintains substantial commercial relationships and agreements with providers and laboratories in Connecticut, and derives revenues from services rendered in Connecticut. Upon information and belief, HDL specifically targets customers in Connecticut through the user-portal on its website, which permits providers and

patients to access personal account information. In addition, this Court has personal jurisdiction over HDL pursuant to 29 U.S.C. § 1132(e)(2).

18. This Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. § 1331 because it arises under the Constitution, laws, or treaties of the United States. Specifically, Plaintiffs assert claims in this case that arise under ERISA. The Court has jurisdiction over Cigna's remaining claims pursuant to 28 U.S.C. § 1367, because the state and common law claims alleged herein are so related to the federal claims that they form part of the same case or controversy. In addition, the Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. § 1332, as there is complete diversity between Plaintiffs and Defendant, and the amount in controversy substantially exceeds $75,000.

19. Venue is proper in the District of Connecticut under 28 U.S.C. § 1391(b), because HDL conducted and continues to conduct business in Connecticut. In addition, the electronic claims submitted by HDL to Cigna are routed through Cigna's headquarters in Bloomfield, Connecticut. Venue is also proper pursuant to 29 U.S.C. § 1132(e)(2), because plans at issue are administered in this District.

FACTUAL BACKGROUND

Relevant Facts Regarding Managed Care and Cigna-Administered Plans.

20. Cigna, among other things, insures and administers employee health and welfare benefit plans.

21. The majority of Cigna-administered plans are Administrative Services Only ("ASO") plans funded by the employers who sponsor them. Cigna is a fiduciary for these plans in its role as the plans' claims administrator. The spreadsheet attached as Exhibit A contains the

plans at issue, including both ASO and fully-insured plans, and lists the plan sponsor for each plan.[1]

22. Certain Cigna entities also offer fully-insured plans, which are funded by Cigna. Cigna also serves as the plans' claims administrator for fully-insured plans.

23. Regardless of the type of plan funding, Cigna is a fiduciary of each of the plans at issue, as it exercises discretionary authority over plan assets and plan administration, by, among other things, making benefits determinations and paying benefit claims. In this fiduciary capacity as a claims administrator, Cigna has processed claims and/or addressed appeals on behalf of all of the plans at issue. The plans at issue explicitly provide Cigna with the discretionary authority to calculate benefits and administer the plans. *See, e.g.*, Ex. B at 41 ("CG, in its discretion, will calculate Covered Expenses."); *id.* at 53 ("**Discretionary Authority:** The Plan Administrator delegates to CIGNA 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 CIGNA 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.").

24. Regardless of the type of plan funding, all of the plans at issue authorize Cigna to recover any overpayments made by the plans on the plans' behalves. *See, e.g.*, Ex. B at 41

[1] Because of the commercial sensitivity of the information contained in Exhibit A, as well as to address HIPAA identifiers, Plaintiffs have filed a redacted version herewith, and have produced an unredacted version to Defendant.

("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.").

25. This overpayment recovery provision creates an equitable lien by agreement over any overpayments made by Cigna. The provision puts plan members (and providers, as explained below) on notice that any overpayment made by Cigna will be recoverable (i.e., subject to a lien) as soon as the overpayment is made.

26. The overpayment plan provisions discussed above apply equally to providers when a plan member assigns his or her claim for reimbursement to the provider. The plans generally allow a member to assign his or her claim for reimbursement to a provider, with Cigna's consent. *See, e.g.*, Ex. B at 41. When the provider in turn submits a claim to Cigna, it indicates that the claim for benefits has been assigned. *See, e.g.*, Exhibit C (representative claim record submitted by HDL indicating benefits have been assigned). When a member assigns a claim to a provider, the provider stands in the shoes of the member and is eligible for reimbursement only to the extent the member would have been in the absence of an assignment. Moreover, the provider is on notice of the provisions governing reimbursement—including cost-share requirements, the exclusions for amounts that would not have been charged in the absence of insurance or that members are not obligated to pay—and the recovery of overpayments. Upon information and belief, each of HDL's patients have assigned their benefit claims to HDL, as indicated on the claim submission forms that HDL submits to Cigna for reimbursement. *See, e.g.*, Ex. C.

27. Accordingly, when HDL accepts assignment of a plan member's claim without charging or collecting the member's cost-share requirements, HDL is not entitled to

reimbursement for the claim, just as a plan member would not be entitled to reimbursement if she submitted the claim herself without having satisfied her cost-share obligation.

28. The majority of the plans under which HDL sought benefits are governed by ERISA. Some of the plans at issue are not governed by ERISA, because, for example, they are sponsored by governmental or church employers. The spreadsheet attached as Exhibit A indicates whether each plan is governed by ERISA.

29. Most of the plans at issue offer members the choice of receiving services either from health care providers that contract with Cigna to participate in Cigna's provider network or from providers outside of that network.

30. Cigna-administered health plans reimburse their members for certain healthcare costs, defined in the plans as "Covered Expenses." When a Cigna plan member receives medical services, Cigna determines what part of the member's cost is considered for coverage by the plan, known as the "allowed amount."

31. There are different types of member responsibility, including deductibles (minimum thresholds that the member must pay before the plan will pay any portion of the covered charge), benefit limits, co-payments (fixed rates for covered services), and co-insurance (percentages of providers' charges).

32. These member cost-sharing responsibility amounts are calculated as a percentage or portion of the allowed amount.

33. If a member receives a service from a provider that contracts to be part of Cigna's network (an "in-network" or "participating" provider), the plan pays the provider the amount that the provider agreed to accept (the provider's contracted network rate), and the member pays any

applicable co-insurance, co-payments, and deductibles based on the coverage for in-network services specified in the member's plan.

34. In exchange for agreeing to accept fixed, network rates for their services, participating providers receive certain benefits, including access to members of Cigna-administered plans as a source of patients.

35. Just as it benefits participating providers, Cigna's network arrangements benefit employers and plan members by controlling overall health care costs and increasing the quality of medical care. In addition, members benefit from obtaining services from a participating provider, because participating providers agree not to bill them for any difference between the plan's reimbursement to the participating provider and the provider's billed charges.

36. In contrast, if a member receives a service from a provider who does not contract to be part of Cigna's provider network (an "out-of-network" or "non-participating" provider), the provider can charge whatever it likes for its services—and out-of-network rates are generally higher than contracted rates. Furthermore, the provider may bill the member for any portion of the provider's charges, over and above the member's cost-sharing responsibility under the plan, which the plan does not reimburse.

37. To make out-of-network benefits an affordable option for the employers sponsoring them, Cigna's plans contain various financial incentives for members to choose participating providers and to share the increased costs associated with obtaining out-of-network services.

38. One of the key ways in which Cigna's plans allocate out-of-network costs between employees and employers is through co-insurance—a percentage of the amount that the plan covers (or "allows") that the member is required to pay towards the cost of that service. The

co-insurance that members must pay towards out-of-network services is usually much higher than the co-insurance (if any) they must pay towards in-network services.

39. This co-insurance requirement underlies the entire concept of out-of-network benefits. It sensitizes members to the true costs of out-of-network services, ensuring that, if a member receives such a service, he is willing to pay a greater portion of that expense out of his own pocket. If patients did not share in these costs, then they would have no financial incentive to moderate their demand for out-of-network services or to consider the higher costs of any particular out-of-network service, leading to increased costs for the plan.

40. Similarly, without co-insurance requirements, out-of-network providers would have no incentive to keep their rates competitive. Generally, patients would not receive services from an out-of-network provider that charges unreasonably high rates, because the member would have to pay a fixed portion of that unreasonable rate to satisfy his or her co-insurance and cost-sharing responsibilities.

41. Cigna's plans have several mechanisms to ensure that members receiving out-of-network services pay their required co-insurance and that non-participating providers do not waive it.

42. For instance, the portion of the Cigna-administered plans labeled "Exclusions, Expenses Not Covered and General Limitations" state that the plans do not cover "charges which you [the member] 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." *See*, *e.g.*, Ex. D at 37-38. This language is taken from Exhibit D, the plan covering Patient A, who is one of the patients described below. The language is representative of the language found in Cigna-administered plans covering HDL's patients.

43. Here, for example, if HDL submits "charges" of $10,000 to Cigna, but does not obligate the patient to pay the portion of that amount that is his or her responsibility under the plan; if the provider does not bill the patient for those "charges;" or if it does so only because of the coverage available under the plan, and not for the purpose of collecting any portion of the charges from the patient, then the $10,000 charges are "phantom" charges, and the plan excludes coverage for them.

44. As an additional safeguard, Cigna-administered plans generally limit reimbursement for out-of-network services to the "Maximum Reimbursable Charge" for "covered services," which may be no more than the "provider's normal charge for a similar service or supply." This provision explicitly excludes from coverage any charges, "to the extent that they are more than Maximum Reimbursable Charges."

45. Thus, if HDL submits a $10,000 bill for services, but HDL has actually agreed to accept a substantially lower amount in full payment of its services, HDL's bill exceeds its "normal charge" for those services, and the excess is not covered.

46. Finally, Cigna-administered plans do not automatically cover or reimburse a member for every "charge" the provider submits to Cigna; rather, the plans cover a portion of any "Covered Expenses," which the plans define as "expenses incurred" by or on behalf of the member. Covered Expenses are in turn subject to the applicable co-insurance, co-payments, and deductibles set forth in the plans. Cigna-administered plans define co-insurance as "the percentage of charges for Covered Expenses that an insured person is ***required*** to pay under the plan." Thus, Cigna-administered plans expressly require members to satisfy their cost-sharing responsibility (i.e. co-insurance, co-payments, and deductibles) in order for charges to be covered under the plans.

47. Thus, where HDL has agreed in advance that it will not require the plan member to pay either the member's cost-sharing responsibility or any other portion of HDL's "charges" that the plan does not cover, the plan member has "incurred" no expenses at all, and the plan is not obligated to pay HDL.

HDL's Fraudulent Fee-Forgiving Scheme

48. HDL has developed a business model designed to game the healthcare system by submitting grossly inflated, phantom "charges" to Cigna that do not reflect the actual amount HDL bills patients. The outline of HDL's scheme is simple. HDL misrepresents to members of Cigna-administered plans that they may receive services from HDL without incurring any financial obligation, and that Cigna will be responsible for the cost of services delivered under these conditions. After luring plan members in this way, HDL submits charges to Cigna at astronomical rates, which are much higher than the "normal charge" HDL actually intends to accept as payment in full. Cigna then relies on the representations in HDL's bills, by paying more for HDL's services than it is obligated to pay under the relevant plans.

49. HDL typically does not join provider networks of major managed care companies, like Cigna, instead opting to remain an "out-of-network" provider.

50. HDL entices members to use its out-of-network services by expressly promising (i) not to collect any part of the members' cost-sharing responsibility, and (ii) not to seek to recover any other portion of its "charges" for which it fails to obtain reimbursement from the plan.

51. For example, one HDL document directed to patients (attached hereto as Exhibit E) states:

- HDL, Inc. will accept the amount your insurance company allows for each diagnostic.

- In other words, your 'out-of-pocket' cost is ZERO for initial and follow-up testing.
- HDL, Inc. takes all the risk if your insurance company does not pay for the ordered diagnostics.

52. This HDL document goes on to explain to patients how to interpret the explanation of benefits (or "EOB") forms patients receive from their insurance company. (*See id*.)

53. Typically, EOBs include a section titled "Patient Responsibility," which is the amount the member is responsible for paying the provider after the plan has covered its portion of the provider's charges. Remarkably, HDL tells patients with respect to the "Patient Responsibility" amount that "[p]aying this amount is not the patient's responsibility." (*Id.*)

54. Thus, as part of its fraudulent scheme, HDL affirmatively misleads patients about the nature of their health insurance benefits.

55. Another HDL brochure likewise assures patients that "[l]ab costs and bills are worry-free with HDL, Inc." because "if it turns out your insurance company does not cover a specific test, HDL, Inc. assumes all the risk." (Ex. F.) This brochure provides a sample EOB that shows an amount labeled "Patient Responsibility," and it advises patients that "[y]ou DO NOT PAY the amount the insurance company says is the patient responsibility." (*Id.*)

56. To take a simplified example, HDL might submit a claim to Cigna for $10,000 for services provided to a Cigna member. Assuming the entire amount was "allowable" under Cigna's plan, and the patient's coinsurance responsibility for out-of-network services is 40%, the patient would pay $4,000 to HDL and Cigna would pay the remaining $6,000 to HDL (assuming the patient had already met his or her deductible, and that no other limits applied). However, HDL waives this $4,000 patient responsibility and only seeks to collect the $6,000 from Cigna.

57. Because no patient is actually paying based on HDL's listed "charges" to Cigna, patients have no incentive to moderate their demand for HDL's services or to consider the higher costs of any particular out-of-network service, leading to increased costs for the plan. Similarly, without co-insurance requirements, HDL has no incentive not to charge the plan astronomical rates, because the patients who choose to receive those services would not bear any more of the inflated cost.

58. As other courts have noted, this makes the $10,000 amount submitted to Cigna a "phantom" charge, as HDL does not collect, and never intends to collect, the full amounts that it puts on the claim forms submitted to Cigna.

59. Indeed, the charges HDL submitted to Cigna were highly inflated, with HDL often submitting "charges" that were often at least two to three (or more) times higher than Medicare rates for similar services.

60. Consequently, HDL misrepresented its actual charges for the services rendered to Cigna affirmatively and through omission. As a result, Cigna relied on the amount that HDL billed to Cigna in its claim forms when processing and paying HDL's claims.

61. Courts have repeatedly held in the context of "fee forgiving" that healthcare plans do not cover a provider's "charges" when that provider does not collect the patient's applicable cost-sharing responsibilities. *See, e.g.*, *Kennedy v. Conn. Gen. Life Ins. Co.*, 924 F.2d 698, 701 (7th Cir. 1991); *Biomed Pharms., Inc. v. Oxford Health Plans (NY), Inc.*, 522 F. App'x 81, 81-82 (2d Cir. 2013); *see also* HHS OIG Special Fraud Alerts (Dec. 19, 1994) (available at https://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html) ("Routine waiver of deductibles and copayments by charge-based providers, practitioners or suppliers is unlawful because it results in … false claims … [and] excessive utilization of items and services paid for by

Medicare."); N.Y. D.F.S. Opinion 08-0404 "Re: Health Insurance, Waiver of Deductibles and Co-Insurance" (April 2, 2008) ("If a health care provider, as a general business practice, waives otherwise required co-insurance requirements, that provider may be guilty of insurance fraud."). These decisions are in accord with public policy as expressed by the Department of Health and Human Services, which has noted that "if patients are required to pay even a small portion of their care, they will be better health care consumers, and select items or services because they are medically needed rather than simply because they are free." Department of Health and Human Services, Office of the Inspector General, Special Fraud Alert: Routine Waiver of Copayments and Deductibles Under Medicare Part B (May 1991).

62. Any other interpretation would run contrary to the purpose of health insurance, which is to reimburse members for payments they actually make to providers, not to provide windfall payments to providers.

63. Eliminating patients' responsibility to pay more towards out-of-network services also undermines Cigna's ability to offer quality in-network services. By charging patients nothing for out-of-network services, patients actually have an incentive to use HDL's higher cost services rather than lower in-network services. Without the incentive to use in-network services, providers will have a reduced incentive to join Cigna's network, leaving that network less robust and stripping employers of the ability to offer health care in an affordable way.

64. HDL's practice of forgiving plan members' financial responsibility is exactly the sort of scheme certain states have declared illegal and enacted statutes to stop. *See* Colo. Rev. Stat. Ann. §18-13-119 (West 2011); Fla. Stat. § 817.234(7); Tex. Ins. Code. Ann. § 1204.055. In light of these statutes, HDL has indicated that it will cease its fee-forgiving activities in Florida and Colorado.

HDL's Other Unlawful Conduct

65. Upon information and belief, HDL has adopted several other unlawful practices to increase its revenue from plans and plan administrators like Cigna.

66. For instance, upon information and belief, HDL (either directly or through a sales agent) encourages physicians and other healthcare providers to order a litany of medical tests, regardless of whether the provider believes such tests are needed to diagnose or treat the patient, thus inflating the total charges that HDL submits to the patient's plan. HDL assures the providers that the patient will not complain if the patient's plan does not cover these tests because, pursuant to the fee-forgiving practices described above, HDL never bills its patients anything for the services at issue.

67. Moreover, and also upon information and belief, HDL has paid providers fees in exchange for referring patients to HDL for testing, including patients who are members of Cigna-administered plans.

68. In order to control healthcare costs, Cigna's contracts with its in-network providers require those providers to refer patients to other in-network providers and facilities for non-emergency services like the ones provided by HDL. Thus, by paying fees to providers to refer patients to HDL for testing, HDL has encouraged and has caused Cigna's in-network providers to violate the terms of their contracts with Cigna.

69. Indeed, the United States Department of Health and Human Services' Office of Inspector General has investigated HDL in connection with the fees HDL pays to providers. On June 25, 2014, the Office of Inspector General issued a Special Fraud Alert stating that such payments by laboratories are not only improper, but also implicate the federal Anti-Kickback Statute.

Cigna's Investigation of HDL

70. HDL never fully disclosed the true nature, extent and scope of its cost share waiver scheme to Cigna.

71. Only through its own internal investigation did Cigna learn the existence of HDL's fee forgiving scheme.

72. In the course of its investigation of HDL, Cigna came across the HDL brochures and flyers described above (*supra* ¶¶ 51-55) which indicated that HDL waived patient cost-sharing responsibilities.

73. In order to confirm and better understand HDL's billing practices, in February 2013, Cigna's Special Investigations Unit ("SIU") began sending questionnaires to Cigna members who received HDL's services.

74. These questionnaires asked the member to report how much they were billed by HDL.

75. Cigna received responses from at least 27 members who received the questionnaires.

76. Despite the fact that all of these members owed hundreds of dollars (and in some cases over $1,000) in cost-sharing responsibilities, HDL did not bill any of the 27 members ***anything***.

77. Several of these members confirmed that HDL accepted the plan's payment as payment in full.

78. As described above, HDL's brochures and documents sought to affirmatively mislead and confuse patients about HDL's billing practices and the patients' health insurance benefits. (*Supra* ¶¶ 51-55.) HDL's patients' responses to Cigna's questionnaires further confirmed that HDL, as well as the doctors who saw Cigna patients and referred the patients to

HDL, provided the patients with false information about HDL's billing practices and the patients' health insurance benefits.

79. For example, one HDL patient reported to Cigna that "my doc says that all the billing is refunded by HDL. They are trying to get their data more widely accepted." Another HDL patient reported that the doctor's office told the patient not to pay any money to HDL "as it was covered" and "part of a pilot/test."

80. The following are just two of the many examples demonstrating how HDL's fraudulent scheme operates.

81. On or about March 19, 2012, HDL performed laboratory services for Patient A.

82. HDL submitted a claim form to Cigna listing its charges as $1,484.00. These charges were more than double Medicare rates, which would have been approximately $723.00 for the services at issue.

83. Based on HDL's representation, Cigna calculated Patient A's responsibility to be $707.52 under the patient's plan. However, HDL did not charge Patient A this amount. Instead, HDL charged Patient A ***nothing***.

84. Cigna calculated the plan's responsibility to be $461.28 based on the charges submitted by HDL, and Cigna and paid this amount to HDL.

85. Thus, as a result of the misrepresentations and material omissions contained within its claim, HDL induced Cigna to pay HDL $461.28.

86. On or about August 24, 2012, HDL performed laboratory services for Patient B.

87. HDL submitted a claim form to Cigna listing its charges as $2,979.00.

88. Based on HDL's representation, Cigna calculated Patient B's responsibility to be $649.40 under the patient's plan. However, HDL did not charge Patient B this amount. Instead, HDL charged Patient B ***nothing***.

89. Cigna calculated the plan's responsibility to be $1,742.20 based on the charges submitted by HDL, and Cigna and paid this amount to HDL.

90. Thus, as a result of the misrepresentations and material omissions contained within its claim, HDL induced Cigna to pay HDL $1,742.20.

91. Upon information and belief, each of the many thousands of claims that HDL submitted to Cigna followed this pattern of fee forgiving.

92. As the collective result of HDL's conduct, Cigna has paid HDL approximately $84 million in claims to date. A list of claims submitted by HDL to Cigna is attached as Exhibit A.

93. Cigna deposited the funds to HDL via an electronic funds transfer (EFT) account with BB&T Bank. From 2010-2012, the bank routing number for the account was XXXXXXX20 and the bank account number was XXXXXXXXXX927. Beginning in 2012, the bank routing number for the account is XXXXXX260 and the bank account number is XXXXXXXXXX878. The bank address is 901 East Byrd Street, Suite 600, Richmond, VA 23219.

94. HDL continues to submit claims to Cigna. Upon information and belief, HDL continues to waive the applicable out-of-network co-insurance, co-payment, and deductible responsibilities of Cigna plan members to entice Cigna plan members to use HDL's services, while simultaneously submitting exorbitant, fraudulent "charges" to Cigna.

95. In addition, when Cigna contacted HDL to inquire regarding its billing practices, HDL took additional steps to conceal its improper billing practices from Cigna. For example, in response to a letter from Cigna questioning HDL's billing practices, on April 12, 2011, HDL's founder and former President and CEO Tonya Mallory falsely "assure[d] Cigna that HDL will not engage in a general practice of accepting as payment in full the payments made by Cigna where deductible or copayments apply."

96. Ms. Mallory "also assure[d] Cigna that all claim forms and bills submitted to Cigna by HDL or on its behalf will indicate the actual charge for the services(s) provided."

97. These and other similar misrepresentations by HDL concealed the true nature of its billing practices from Cigna.

CAUSES OF ACTION

Count I – Unjust Enrichment

98. The preceding paragraphs are incorporated by reference as if set forth fully herein.

99. HDL has been unjustly enriched as a result of its fraudulent billing practices.

100. Cigna's plans are required to cover some portion of the actual charges for services that plan members receive from out-of-network providers like HDL. Cigna's plans are not required to cover amounts that members are not billed, are not obligated to pay, or for which they would not have been billed if they did not have insurance. Neither are they required to cover a portion of a phantom charge that does not represent the amount the provider actually plans to collect. Cigna's plans are also not required to cover amounts that exceed the Maximum Reimbursable Charge, as that term is defined in the plans.

101. HDL submitted benefit claim forms to Cigna falsely stating "charges" for services that were higher than the actual amounts that HDL required Cigna's plan members to pay for

those services. Based on these forms, Cigna processed benefits for services provided by HDL to Cigna plan members based upon these falsely-stated "charges." Cigna paid these benefits directly to HDL.

102. When Cigna paid benefits to HDL that Cigna's plan were not obligated to cover, HDL obtained a benefit from Cigna by HDL's fraud in falsely stating "charges" for its services that were higher than the actual amounts that HDL required Cigna's plan members to pay for those services. Therefore, it would be inequitable for HDL to retain these benefits. Specifically, HDL received payments of approximately $84 million from Cigna.

Count II – Fraud

103. The preceding paragraphs are incorporated by reference as if set forth fully herein.

104. HDL's conduct constitutes fraud.

105. HDL had an independent duty under state and common law, beyond any obligation under the plans, to submit honest and accurate claims to Cigna regarding the value of the services provided to Cigna plan members.

106. At the time HDL submitted claims to Cigna for reimbursement, HDL knew that the material statements and representations about its charges for services were false.

107. HDL knew and intentionally failed to disclose material information regarding the manner, extent, and nature by which HDL waived Cigna members' required out-of-network co-payments, deductibles, co-insurance, and other patient cost-sharing responsibility for the services provided to plan members.

108. HDL knew that the claims submitted to Cigna reflected false and inflated charges that HDL did not charge their patients. Exhibit A is a list of such claims, including the date when

HDL indicated to Cigna that it provided its services and the date that Cigna received HDL's claim.

109. HDL submitted these claims to Cigna with the intent to defraud Cigna by inducing Cigna to rely on HDL's false representations and omissions alleged herein to pay these fraudulent charges.

110. The misrepresentations were material, as Cigna must rely on claim forms submitted by providers like HDL, for, among other things, determining how much of the provider's charge is covered by the plan and how much the patient owes in cost-sharing responsibility.

111. Cigna reasonably relied on such material false statements and omissions and paid the false and misleading claims submitted by HDL, resulting in compensable injury to Cigna.

112. Moreover, as described above, when Cigna inquired with HDL regarding HDL's billing practices, HDL actively concealed the true nature of its billing practices.

113. As a result of this conduct, Cigna and the plans at issue suffered significant damages. Specifically, as result of this conduct, HDL received payments of approximately $84 million from Cigna as a result of HDL's fraudulent conduct. For fully-insured plans, Cigna paid HDL with Cigna's own funds, while for ASO plans, Cigna paid HDL on behalf of the plans.

Count III – Negligent Misrepresentation

114. The preceding paragraphs are incorporated by reference as if set forth fully herein.

115. HDL's conduct constitutes negligent misrepresentation.

116. HDL submitted benefit claim forms to Cigna regarding services that it provided to Cigna plan members; HDL did so in the course of its business and had a pecuniary interest in the

outcome of how Cigna processed benefits for those services, as any benefits for those services were paid directly to HDL.

117. In submitting benefit claim forms to Cigna, HDL falsely stated "charges" for its services that were higher than the actual amounts that HDL required Cigna's plan members to pay for those services; HDL supplied this false information to guide Cigna in processing benefits for those services.

118. In submitting benefit claim forms to Cigna, HDL did not identify the actual amounts that HDL required Cigna's plan members to pay for those services, only falsely-stated "charges" that were higher than these amounts; in so doing, HDL failed to exercise reasonable care or competence in communicating information regarding its charges to Cigna.

119. Based upon the forms submitted by HDL, Cigna processed benefits for services provided by HDL to its members based upon the falsely-stated "charges" stated on the forms submitted by HDL; thus, each time Cigna processed a claim based upon a falsely-stated charge, it suffered a pecuniary loss because it justifiably relied on HDL's communications. Exhibit A is a list of such claims, including the date when HDL indicated to Cigna that it provided its services and the date that Cigna received each of HDL's benefit claim forms.

120. The misrepresentations were material, as Cigna must rely on claim forms submitted by providers like HDL, for, among other things, determining how much of the provider's charge is covered by the plan, and how much the patient owes in cost-sharing responsibility.

121. Cigna reasonably relied on such material false statements and omissions and paid the false and misleading claims submitted by HDL, resulting in compensable injury to Cigna.

122. Moreover, as described above, when Cigna inquired with HDL regarding HDL's billing practices, HDL actively concealed the true nature of its billing practices.

123. As a result of this conduct, Cigna and the plans at issue suffered significant damages. Specifically, as result of this conduct, HDL received payments of approximately $84 million from Cigna as a result of HDL's conduct. For fully-insured plans, Cigna paid HDL with Cigna's own funds, while for ASO plans, Cigna paid HDL on behalf of the plans.

Count IV – Tortious Interference with Contract

124. The preceding paragraphs are incorporated by reference as if set forth fully herein.

125. HDL's conduct constitutes tortious interference with contract.

126. Each of the members for whom HDL submitted benefits claims and received payment from Cigna received health care benefits pursuant to a benefit plan insured and/or administered by Cigna.

127. Each of the plans pursuant to which HDL submitted claims and received payment contained, among other things, provisions that required the member to pay their cost-sharing responsibility (e.g., co-payments, co-insurance, and deductibles) in order for the plan to cover a portion of the submitted charges for services.

128. HDL knew that its patients' plans required the patients to pay for a portion of the charges that HDL submitted to Cigna in the form of co-payments, co-insurance, and deductibles.

129. Despite this knowledge, HDL engaged in a fee-forgiving scheme designed to bill Cigna and its ASO clients exorbitant charges, while waiving the portion of these charges that the patients were required to pay under the terms of their respective plans.

130. As part of this scheme, HDL induced its patients to breach the terms of their plans with Cigna and Cigna's ASO clients by misleading those members about their healthcare

benefits, so that the members believed they did not have to pay the amounts that they were in fact required to pay under their contracts with Cigna and Cigna's ASO clients.

131. HDL's scheme not only caused HDL's patients to breach the terms of their plans with Cigna and Cigna's ASO clients, allowing HDL to collect far more from Cigna than it was entitled to under the terms of the patients' plans, but also harmed Cigna's contractual relationship with its in-network providers and potential in-network providers by undermining and circumventing Cigna's provider network system, and upon information and belief, causing such providers to breach their contracts with Cigna.

132. Specifically, as described above, upon information and belief, HDL paid referral fees to Cigna's in-network providers to encourage those providers to refer patients to HDL for testing, even though Cigna's contracts with its providers require the providers to refer patients to in-network providers for non-emergency services like the ones provided by HDL. Thus, HDL caused those in-network providers to breach the terms of their contracts with Cigna.

133. HDL's tortious interference has caused damages to Cigna by causing it to make approximately $84 million in overpayments to HDL. HDL has caused further damages to Cigna by damaging its contractual relationship with members by misleading those members about the terms of their plans, and by causing Cigna's in-network providers to violate the terms of their contracts with Cigna by referring patients to HDL.

Count V – Claim for Unfair and Deceptive Business Practices Under Connecticut's Unfair Trade Practices Act and Unfair Insurance Practices Act

134. The preceding paragraphs are incorporated by reference as if set forth fully herein.

135. The Connecticut Unfair Trade Practices Act ("CUTPA") proscribes "unfair or deceptive acts or practices in the conduct of any trade or commerce." HDL's conduct, described above, constitutes unfair or deceptive practices in trade and commerce. *See* CUTPA § 42-110b.

136. HDL violated CUTPA by deceiving consumers into using its services through false representations about consumers' cost-sharing obligations and other responsibilities under Cigna-administered plans, thereby causing Cigna to pay tens of millions of dollars in false charges through HDL's fee-forgiving scheme.

137. HDL knew that its patients' plans required the patients to pay for a portion of the charges that HDL submitted to Cigna in the form of co-payments, co-insurance, and deductibles.

138. Despite this knowledge, HDL engaged in a fee-forgiving scheme designed to bill Cigna and its ASO clients exorbitant charges, while waiving the portion of these charges that the patients were required to pay under the terms of their respective plans.

139. In violation of the Connecticut Unfair Insurance Practices Act, Conn. Gen. Stat. § 38a-816, HDL made knowing misrepresentations to patients about the terms of their benefit plans and the significance of communications (such as EOBs) from plan administrators like Cigna. HDL also deceived Cigna by submitting false, grossly inflated charges to Cigna that did not reflect HDL's actual charges to patients.

140. Indeed, while in-network providers sign contracts with Cigna whereby Cigna and the provider agree to specified rates for medical services, HDL has not entered Cigna's provider network which specifies the rates HDL may charge.

141. HDL's fraudulent fee-forgiving scheme has and continues to harm Cigna's business.

142. As a result of HDL's deceptive and unfair practices, Cigna and the plans at issue suffered significant injury and damages. Specifically, as result of this conduct, HDL received payments of approximately $84 million from Cigna as a result of HDL's deceptive and unfair practices. For fully-insured plans, Cigna paid HDL with Cigna's own funds, while for ASO plans, Cigna paid HDL on behalf of the plans.

143. In addition, upon information and belief, HDL paid referral fees to Cigna's in-network providers to encourage those providers to refer patients to HDL for testing, even though Cigna's contracts with its providers require the providers to refer patients to in-network providers for non-emergency services like the ones provided by HDL. Thus, HDL caused those in-network providers to breach the terms of their contracts with Cigna.

144. HDL's conduct has caused damages to Cigna by causing it to make approximately $84 million in overpayments to HDL and by harming the relationship between Cigna and its plan members, as well as the relationship between Cigna and its in-network providers.

145. HDL's unethical, unscrupulous, and immoral billing practices offend public policy, as set forth above, including state and federal laws and an AMA advisory opinion. Also as set forth in detail above, these practices have harmed Cigna, Cigna's plan members, and consumers by artificially inflating the costs of healthcare services generally.

Count VI – Claim for Recovery of Overpayments Under ERISA § 502(a)(3), and for Injunctive Relief

146. The preceding paragraphs are incorporated by reference as if set forth fully herein.

147. Cigna is a fiduciary as claims administrator of the ASO and fully-insured plans that it administers and seeks to recover overpayments made by those plans to HDL.

148. The charges that HDL listed in claims forms submitted to Cigna for reimbursement on behalf of the members' plans did not represent the amount that HDL actually intended to require or accept as payment in full for its services.

149. Specifically, HDL did not require plan members to pay their out-of-network cost sharing responsibility, which is required under the terms of the members' plans. HDL also represented to plan members that they would not be responsible for any other portion of HDL's "charges" that were not reimbursed by the plan.

150. HDL's patients' plans expressly do not cover any portion of the charges that providers like HDL do not require plan members to pay, nor do they require the plan to cover anything in excess of HDL's normal charges to its patients.

151. By paying HDL what HDL deceived Cigna into believing to be the covered portions of charges that HDL never, in fact, intended to collect in full, and, in connection with which, HDL never intended to charge for or collect the obligations of plan members, these plans overpaid HDL.

152. These overpayments were made directly by Cigna to HDL.

153. These overpayments belong in good conscience to the plans because the plans managed by Cigna made benefit payments to HDL for services provided to plan members based on the charges that HDL listed on the claim forms that it submitted to Cigna.

154. The plan documents authorize Cigna to recover any overpayments made by the plans on the plans' behalves. This recovery provision creates an equitable lien by agreement over any overpayments made by Cigna. The provision puts plan members—and HDL, as the authorized recipient of these funds and/or their assignee—on notice that any overpayment made by Cigna will be recoverable (i.e., subject to a lien) as soon as the overpayment is made.

155. These overpayments are within the possession and control of HDL and are specifically identifiable.

156. These overpayments were made in contravention of plan terms.

157. Cigna seeks recovery of these overpayments on behalf of the plans.

158. Additionally, Cigna seeks a permanent injunction directing HDL to submit to Cigna only charges that HDL actually charges the plan member as payment in full for HDL's services and not to submit charges which include amounts that HDL does not actually require the member to pay (including, without limitation, the waiver of any portion of the members' required out-of-network co-insurance, co-payment, and deductible amounts).

Count VII – Declaratory Relief

159. The preceding paragraphs are incorporated by reference as if set forth fully herein.

160. Under the Declaratory Judgment Act, the Court "may declare the rights and other legal relations of any interested party seeking such declaration, whether or not further relief is or could be sought." 28 U.S.C. § 2201(a).

161. HDL provides services to patients receiving medical care who are covered under employee health and welfare benefit plans that are insured or administered by Cigna.

162. The claims that HDL submitted, and continues to submit, are claims for reimbursement for services provided to patients who are purportedly covered under employee health and welfare benefit plans that are insured or administered by Cigna.

163. As described in the preceding paragraphs, the claims HDL submits are for charges that are not covered under the relevant plans because the claims are based on false charges submitted to Cigna, HDL failed to bill and collect the true out-of-network cost share

responsibility from the Cigna plan members, and HDL did not hold the plan members responsible for the amounts charged to Cigna.

164. As a result, any claims submitted by HDL are not reimbursable, and any payments HDL received under such claims should be returned to Cigna.

165. An actual controversy exists between HDL and Cigna regarding whether claims for reimbursement are covered and payable under employee health and welfare benefit plans that are insured or administered by Cigna.

166. Cigna seeks a declaration that the claims for reimbursement submitted by HDL are not for covered services and are not payable under employee health and welfare benefit plans that are insured or administered by Cigna. Cigna also seeks a declaration that HDL must return all sums received from Cigna.

167. Cigna also seeks recovery of its reasonable and necessary attorneys' fees and costs.

JURY DEMAND
(As to Non-ERISA Claims Only)

168. The preceding paragraphs are incorporated by reference as if set forth fully herein.

169. With respect to Cigna's non-ERISA claims, Cigna hereby demands a trial by jury.

PRAYER FOR RELIEF

Based on the foregoing, Cigna prays that the Court enter a judgment awarding the following:

a. a declaration that the products and services provided by HDL do not constitute covered services under the employee health and welfare benefit plans administered and/or insured by Cigna and that HDL is not entitled to

receive any payments on the claims for reimbursement that it has submitted or may submit in the future as part of the fee-forgiving practices described above in Paragraphs 48-69;

b. return of any all monies paid to HDL on claims for reimbursement submitted by HDL;

c. monetary damages for all harm suffered as a result of HDL's conduct;

d. exemplary and punitive damages;

e. pre-judgment and post-judgment interest;

f. the reasonable and necessary attorneys' fees incurred;

g. costs of court; and

h. such other and further relief to which they may show themselves entitled in law or equity.

DATED this 16th day of January, 2015.

Respectfully submitted,

By: */s/ John C. Pitblado*
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** Admitted Pro Hac Vice*

CERTIFICATION

I hereby certify that, on this 16th day of January, 2015, a copy of the foregoing was filed electronically. Notice of this filing will be sent by e-mail to all parties by operation of the court's electronic filing system or by mail to anyone unable to accept electronic filing as indicated on the Notice of Electronic Filing. Parties may access this filing through the court's CM/ECF System.

John C. Pitblado
John C. Pitblado

EXHIBIT A

File submitted in Microsoft Access Format
Unable to convert to PDF/Excel due to size limit

See Notice of Manual Filing

EXHIBIT B

REDACTED

OPEN ACCESS PLUS MEDICAL BENEFITS

HRA Plan

EFFECTIVE DATE: June 1, 2012

ASO5

3333260

This document printed in May, 2012 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY REDACTED WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CIGNA HEALTH AND LIFE INSURANCE COMPANY (CIGNA) PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CIGNA DOES NOT INSURE THE BENEFITS DESCRIBED.

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

Explanation of Terms

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

The Schedule

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

CIGNA HealthCare

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.

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Case Management

Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options 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.

- You, your dependent or an attending Physician can request Case Management services by calling the **toll-free number** shown on your ID card during normal business hours, Monday through Friday. In addition, your employer, a claim office or a utilization review program (see the PAC/CSR section of your certificate) may refer an individual for Case Management.
- The Review Organization assesses each case to determine whether Case Management is appropriate.
- 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.
- 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.
- 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).
- 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).
- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

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

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Additional Programs

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

CIGNA HealthCare

provided by other parties to the Policyholder. Contact us for details regarding any such arrangements.

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Important Notices

Direct Access to Obstetricians and Gynecologists

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

Selection of a Primary Care Provider

This plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, Cigna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www mycigna.com or contact customer service at the phone number listed on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

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How To File Your Claim

There's no paperwork for In-Network care. Just show your identification card and pay your share of the cost, if any; your provider will submit a claim to Cigna for reimbursement. Out-of-Network claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim forms from the website listed on your identification card or by calling Member Services using the toll-free number on your identification card.

CLAIM REMINDERS

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

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

  YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

Timely Filing of Out-of-Network Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within 180 days for Out-of-Network benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within 180 days for Out-of-Network benefits, the claim will not be considered valid and will be denied.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

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Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.

Eligibility for Employee Insurance

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

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least 32 hours a week; and
- you pay any required contribution.

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

CIGNA HealthCare

Class of Eligible Employees within one year after your insurance ceased.

Eligibility for Dependent Insurance

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

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

Waiting Period

91st day of employment.

Classes of Eligible Employees

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

Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date you become eligible.

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

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

Dependent Insurance

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance

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

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction (if required).

Exception for Newborns

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

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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 CIGNA 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.

Changing Primary Care Physicians:

You may request a transfer from one Primary Care Physician to another by contacting us at the member services number on your ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician, if you choose.

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CIGNA HealthCare

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 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.

Deductibles

Deductibles are also expenses to be paid by you or your Dependent. 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.

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.
- Plan Deductibles.

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

- 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:

- non-compliance penalties.
- provider charges in excess of the Maximum Reimbursable Charge.

Accumulation of Plan Deductibles and Out-of-Pocket Maximums

Deductibles and Out-of-Pocket Maximums will accumulate in one direction (that is, 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.

Note:
Refer to your CIGNA Choice Fund Member Handbook for information about your health fund benefit and how it can help you pay for expenses that may not be covered under this plan.

Contract Year

Contract Year means a twelve month period beginning on each 06/01.

CIGNA HealthCare

Open Access Plus Medical Benefits

The Schedule

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 a percentage of the surgeon's allowable charge as specified in Cigna Reimbursement Policies. (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 for charges made by co-surgeons will be limited to the amount specified in Cigna Reimbursement Policies.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	
The Percentage of Covered Expenses the Plan Pays **Note:** "No charge" means an insured person is not required to pay Coinsurance.	80%	60% of the Maximum Reimbursable Charge

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
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 percentage of a schedule that we have developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for similar services within the geographic market. In some cases, a Medicare based schedule will not be used and 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 • the 80th 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 the Insurance Company. **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	110%
Contract Year Deductible Individual Family Maximum Family Maximum Calculation **Collective Deductible:** All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.	\$2,000 per person \$4,000 per family	\$6,000 per person \$12,000 per family

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Combined Medical/Pharmacy Contract Year Deductible		
Combined Medical/Pharmacy Deductible: includes retail and home delivery prescription drugs	Yes	Yes
Home Delivery Pharmacy Costs Contribute to the Combined Medical/Pharmacy Deductible	Yes	In-Network coverage only
Out-of-Pocket Maximum		
Individual	$4,000 per person	$8,000 per person
Family Maximum	$8,000 per family	$16,000 per family
Family Maximum Calculation **Collective Out-of-Pocket Maximum:** All family members contribute towards the family Out-of-Pocket. An individual cannot have claims covered at 100% until the total family Out-of-Pocket has been satisfied.		

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Combined Medical/Pharmacy Out-of-Pocket Maximum		
Combined Medical/Pharmacy Out-of-Pocket: includes retail and home delivery prescription drugs	Yes	Yes
Home Delivery Pharmacy Costs Contribute to the Combined Medical/Pharmacy Out-of-Pocket Maximum	Yes	In-Network coverage only
Physician's Services		
Primary Care Physician's Office visit	80% after plan deductible	60% after plan deductible
Specialty Care Physician's Office Visits	80% after plan deductible	60% after plan deductible
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 the Insurance Company.		
Surgery Performed In the Physician's Office	80% after plan deductible	60% after plan deductible
Second Opinion Consultations (provided on a voluntary basis)	80% after plan deductible	60% after plan deductible
Allergy Treatment/Injections	80% after plan deductible	60% after plan deductible
Allergy Serum (dispensed by the Physician in the office)	80% after plan deductible	60% after plan deductible
Preventive Care		
Routine Preventive Care - all ages	No charge	60% after plan deductible
Immunizations - all ages	No charge	60% after plan deductible
Mammograms, PSA, PAP Smear		
Preventive Care Related Services (i.e. "routine" services)	No charge	60% after plan deductible
Diagnostic Related Services (i.e. "non-routine" services)	Subject to the plan's x-ray & lab benefit; based on place of service	Subject to the plan's x-ray & lab benefit; based on place of service

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital - Facility Services	80% after plan deductible	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% after plan deductible	60% after plan deductible
Inpatient Hospital Physician's Visits/Consultations	80% after plan deductible	60% after plan deductible
Inpatient Hospital Professional Services	80% after plan deductible	60% after plan deductible
Surgeon		
Radiologist		
Pathologist		
Anesthesiologist		
Outpatient Professional Services	80% after plan deductible	60% after plan deductible
Surgeon		
Radiologist		
Pathologist		
Anesthesiologist		

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Emergency and Urgent Care Services		
Physician's Office Visit	80% after plan deductible	80% after plan deductible
Hospital Emergency Room	80% after plan deductible	80% after plan deductible
Outpatient Professional services (radiology, pathology and ER Physician)	80% after plan deductible	80% after plan deductible
Urgent Care Facility or Outpatient Facility	80% after plan deductible	80% 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% after plan deductible	80% after plan deductible
Independent x-ray and/or Lab Facility in conjunction with an ER visit	80% after plan deductible	80% after plan deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)	80% after plan deductible	80% after plan deductible
Ambulance	80% after plan deductible	80% after plan deductible
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Contract Year Maximum: 90 days combined	80% after plan deductible	60% after plan deductible
Laboratory and Radiology Services (includes pre-admission testing)		
Physician's Office Visit	80% after plan deductible	60% after plan deductible
Outpatient Hospital Facility	80% after plan deductible	60% after plan deductible
Independent X-ray and/or Lab Facility	80% after plan deductible	60% after plan deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)		
Physician's Office Visit	80% after plan deductible	60% after plan deductible
Inpatient Facility	80% after plan deductible	60% after plan deductible
Outpatient Facility	80% after plan deductible	60% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Short-Term Rehabilitative Therapy Contract Year Maximum: 60 days for all therapies combined Includes: Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy	80% after plan deductible	60% after plan deductible
Outpatient Cardiac Rehabilitation Contract Year Maximum: 36 days	80% after plan deductible	60% after plan deductible
Chiropractic Care Contract Year Maximum: 20 days		
Physician's Office Visit	80% after plan deductible	60% after plan deductible
Home Health Care Contract Year Maximum: 60 days (includes outpatient private nursing when approved as medically necessary)	80% after plan deductible	60% after plan deductible
Hospice		
Inpatient Services	80% after plan deductible	60% after plan deductible
Outpatient Services (same coinsurance level as Home Health Care)	80% after plan deductible	60% after plan deductible
Bereavement Counseling Services provided as part of Hospice Care		
Inpatient	80% after plan deductible	60% after plan deductible
Outpatient	80% after plan deductible	60% after plan deductible
Services provided by Mental Health Professional	Covered under Mental Health Benefit	Covered under Mental Health Benefit

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
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 the Insurance Company.	80% after plan deductible	60% after plan deductible
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	80% after plan deductible	60% after plan deductible
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	80% after plan deductible	60% after plan deductible
Delivery - Facility (Inpatient Hospital, Birthing Center)	80% after plan deductible	60% after plan deductible
Abortion Includes elective and non-elective procedures		
Physician's Office Visit	80% after plan deductible	60% after plan deductible
Inpatient Facility	80% after plan deductible	60% after plan deductible
Outpatient Facility	80% after plan deductible	60% after plan deductible
Physician's Services	80% after plan deductible	60% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Family Planning Services		
Office Visits, Lab and Radiology Tests and Counseling	80% after plan deductible	60% after plan deductible
Note: The standard benefit will include coverage for contraceptive devices (e.g. Depo-Provera and Intrauterine Devices (IUDs)). Diaphragms will also be covered when services are provided in the physician's office.		
Surgical Sterilization Procedure for Vasectomy/Tubal Ligation (excludes reversals)		
Physician's Office Visit	80% after plan deductible	60% after plan deductible
Inpatient Facility	80% after plan deductible	60% after plan deductible
Outpatient Facility	80% after plan deductible	60% after plan deductible
Physician's Services	80% after plan deductible	60% after plan deductible
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

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Organ Transplants Includes all medically appropriate, non-experimental transplants		
Physician's Office Visit	80% after plan deductible	In-Network coverage only
Inpatient Facility	100% at Lifesource center after plan deductible, otherwise 80% after plan deductible	In-Network coverage only
Physician's Services	100% at Lifesource center after plan deductible, otherwise 80% after plan deductible	In-Network coverage only
Lifetime Travel Maximum: $10,000 per transplant	No charge (only available when using Lifesource facility)	In-Network coverage only
Durable Medical Equipment Contract Year Maximum: Unlimited	80% after plan deductible	60% after plan deductible
External Prosthetic Appliances Contract Year Maximum: Unlimited	80% after plan deductible	60% after plan deductible
Nutritional Evaluation Contract Year Maximum: 3 visits per person		
Physician's Office Visit	80% after plan deductible	60% after plan deductible
Inpatient Facility	80% after plan deductible	60% after plan deductible
Outpatient Facility	80% after plan deductible	60% after plan deductible
Physician's Services	80% after plan deductible	60% after plan deductible
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.		
Physician's Office Visit	80% after plan deductible	60% after plan deductible
Inpatient Facility	80% after plan deductible	60% after plan deductible
Outpatient Facility	80% after plan deductible	60% after plan deductible
Physician's Services	80% after plan deductible	60% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
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.
Treatment Resulting From Life Threatening Emergencies Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.		
Mental Health		
Inpatient	80% after plan deductible	60% after plan deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)		
Physician's Office Visit	80% after plan deductible	60% after plan deductible
Outpatient Facility	80% after plan deductible	60% after plan deductible
Substance Abuse		
Inpatient	80% after plan deductible	60% after plan deductible
Outpatient (Includes Individual and Intensive Outpatient)		
Physician's Office Visit	80% after plan deductible	60% after plan deductible
Outpatient Facility	80% after plan deductible	60% after plan deductible

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Open Access Plus Medical Benefits

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 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: prior to the date of admission; or in the case of an emergency admission, within 48 hours after the date of admission.

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will not include:

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

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

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

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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;
- non-emergency ambulance; or
- transplant services.

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V1

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 Cigna. **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.

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- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.
- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.
- charges made for an annual prostate-specific antigen test (PSA).
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
- charges made for the following preventive care services (detailed information is available at www.healthcare.gov/center/regulations/prevention/recommendations html):
  (1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
  (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
  (3) for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
  (4) for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- charges made for surgical or nonsurgical treatment of Temporomandibular Joint Dysfunction.

Clinical Trials

Charges made for routine patient services associated with cancer clinical trials approved and sponsored by the federal government. In addition the following criteria must be met:

- the cancer clinical trial is listed on the NIH web site www.clinicaltrials.gov as being sponsored by the federal government;
- the trial investigates a treatment for terminal cancer and: the person has failed standard therapies for the disease; cannot tolerate standard therapies for the disease; or no effective nonexperimental treatment for the disease exists;
- the person meets all inclusion criteria for the clinical trial and is not treated "off-protocol";
- the trial is approved by the Institutional Review Board of the institution administering the treatment; and
- coverage will not be extended to clinical trials conducted at nonparticipating facilities if a person is eligible to participate in a covered clinical trial from a Participating Provider.

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

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

Genetic Testing

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

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

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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 contract year for both pre- and post-genetic 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.

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V3

Orthognathic Surgery

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

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

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V1

Cardiac Rehabilitation

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

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

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V1

Home Health Services

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

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

  Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals. A visit is defined as a period of 2 hours or less. Home Health Services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health Services are covered. Home Health Services do not include

services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Health Care Professional. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations. Physical, occupational, and other Short-Term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Short-term Rehabilitative Therapy Maximum shown in The Schedule.

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;
- 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 and Mental Health Residential Treatment Services.

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

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

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

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

Outpatient Mental Health Services

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

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

Inpatient Substance Abuse Rehabilitation Services

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

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

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

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

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

Outpatient Substance Abuse Rehabilitation Services

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

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

Substance Abuse Detoxification Services

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

Exclusions

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

- any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this 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 CIGNA for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

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

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

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

External Prosthetic Appliances and Devices

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

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

Prostheses/Prosthetic Appliances and Devices

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

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

Orthoses and Orthotic Devices

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

- Nonfoot orthoses – only the following nonfoot orthoses are covered:
  - rigid and semirigid custom fabricated orthoses;
  - semirigid prefabricated and flexible orthoses; and
  - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
  - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);

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- when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
- when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
- for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

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

The following are specifically excluded external prosthetic appliances and devices:

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

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Short-Term Rehabilitative Therapy

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

The following limitation applies to Short-term Rehabilitative Therapy:

- occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Illness or Injury or Sickness.

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

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

Multiple outpatient services provided on the same day constitute one day.

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

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Chiropractic Care Services

Charges made for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function. For these services you have direct access to qualified chiropractic Physicians.

The following limitation applies to Chiropractic Care Services:

- occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.

Chiropractic Care services that are not covered include but are not limited to:

- services of a chiropractor which are not within his scope of practice, as defined by state law;
- charges for care not provided in an office setting;
- maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status;
- vitamin therapy.

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Breast Reconstruction and Breast Prostheses

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

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: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, noncosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

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Transplant Services

- charges made for human organ and tissue Transplant services which include solid organ and bone marrow/stem cell procedures 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, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral.

All Transplant services, other than cornea, are covered 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, received at participating facilities specifically contracted with CIGNA for those Transplant services, other than CIGNA LIFESOURCE Transplant Network® facilities, are payable at the In-Network level. Transplant services received at any other facilities, including Non-Participating Providers and Participating Providers not specifically contracted with CIGNA for Transplant services, 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

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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: evaluation, candidacy, transplant event, or post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); lodging while at, or traveling to and from the transplant site; and food while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver. The following are specifically excluded travel expenses: travel costs incurred due to travel within 60 miles of your home; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

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

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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. That portion includes any applicable Copayment, Deductible and/or Coinsurance.

Coinsurance

The term Coinsurance means the percentage of Charges for covered Prescription Drugs and Related Supplies that you or your Dependent are required to pay under this plan.

Charges

The term Charges means the amount charged by the Insurance Company to the plan when the Pharmacy is a Participating Pharmacy, and it means the actual billed charges when the Pharmacy is a non-Participating Pharmacy.

Copayments

Copayments are expenses to be paid by you or your Dependent for Covered Prescription Drugs and Related Supplies.

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Lifetime Maximum	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Contract Year Deductible		
Individual	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Family	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Out-of-Pocket Maximum		
Individual	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Family	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Retail Prescription Drugs	**The amount you pay for each 30-day supply**	**The amount you pay for each 30-day supply**
Tier 1		
Generic* drugs on the Prescription Drug List	No charge after $10 copay after plan deductible	50% after plan deductible

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BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Tier 2 Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	No charge after $30 copay after plan deductible	50% after plan deductible
Tier 3 Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	No charge after $60 copay after plan deductible	50% after plan deductible
* Designated as per generally-accepted industry sources and adopted by the Insurance Company		
Home Delivery Prescription Drugs	**The amount you pay for each 90-day supply**	**The amount you pay for each 90-day supply**
Tier 1 Generic* drugs on the Prescription Drug List	No charge after $30 copay after plan deductible	In-network coverage only
Tier 2 Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	No charge after $90 copay after plan deductible	In-network coverage only
Tier 3 Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	No charge after $180 copay after plan deductible	In-network coverage only
* Designated as per generally-accepted industry sources and adopted by the Insurance Company		

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Prescription Drug Benefits

For You and Your Dependents

Covered Expenses

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

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 CIGNA, 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 90 day supply at a home delivery 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 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 CIGNA to request a 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 Drug Administration (FDA) are designated as either non-Preferred or non-Prescription Drug List 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 hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

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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 Drugs which are packaged together for your, or your Dependent's convenience, a Copayment will apply to each Prescription Drug.

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Exclusions

No payment will be made for the following expenses:

- drugs available over the counter that do not require a prescription by federal or state law;
- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents.
- 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 the standard reference compendia (AHFS or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in peer-reviewed English-language bio-medical journals;
- prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- implantable contraceptive products;
- any fertility drug;
- drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, and decreased libido;
- diet pills or appetite suppressants (anorectics);
- prescription smoking cessation 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;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance;
- drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- prescriptions more than one year from the original date of issue;
- any drugs that are experimental or investigational as described under the Medical “Exclusions” section of your certificate.

Other limitations are shown in the Medical “Exclusions” section of your certificate.

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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.

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

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

See your Employer's Benefit Plan Administrator to obtain the appropriate claim form.

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Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

- care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.

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

  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the “Clinical Trials” section of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except as provided in the “Clinical Trials” section of this plan.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one’s appearance.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Surgical treatment of varicose veins; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial

insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.

- reversal of male or female voluntary sterilization procedures.
- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).
- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- treatment by acupuncture.
- all noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.
- all 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.

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- 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.

General Limitations

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

- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- 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.
- 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.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- charges made by any covered provider who is a member of your family or your Dependent's Family.
- expenses incurred outside the United States other than expenses for medically necessary urgent or emergent care while temporarily traveling abroad.

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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:

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

Each 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:

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the

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difference in cost between a private and semiprivate room is not an Allowable Expense.

- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

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

Reasonable Cash Value

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

Order of Benefit Determination Rules

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

- The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child, and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

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

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

Effect on the Benefits of This Plan

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

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

CIGNA HealthCare

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

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

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

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

Right to Receive and Release Information

CIGNA, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Medicare Eligibles

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

(a) a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

(b) a former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

(c) an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;

(d) the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;

(e) an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;

(f) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

CIGNA will assume the amount payable under:

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

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

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

Domestic Partners

Under federal law, the Medicare Secondary Payer Rules do not apply to Domestic Partners covered under a group health plan when Medicare coverage is due to age. Therefore, when Medicare coverage is due to age, Medicare is always the Primary Plan for a person covered as a Domestic Partner, and Cigna is the Secondary Plan. However, when Medicare coverage is due to disability, the Medicare Secondary Payer rules explained above will apply.

CIGNA HealthCare

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

- 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.
- 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:

- 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.
- Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

Lien of the Plan

By accepting benefits under this plan, a Participant:

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

Additional Terms

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

limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

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Payment of Benefits

To Whom Payable

Medical Benefits are assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. Because of CIGNA's contracts with providers, all claims from contracted providers should be assigned.

CIGNA may, at its option, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of CIGNA is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, CIGNA may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

When one of our participants passes away, CIGNA may receive notice that an executor of the estate has been established. The executor has the same rights as our insured and benefit payments for unassigned claims should be made payable to the executor.

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

Recovery of Overpayment

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

Calculation of Covered Expenses

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

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

HC-POB1 04-10 V1

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the last day of the calendar month in which your Active Service ends except as described below.

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

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date as determined by your Employer.

Injury or Sickness

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

Dependents

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

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

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

HC-TRM1 04-10 V1 M

CIGNA HealthCare

Rescissions

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

HC-TRM80 01-11

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.

HC-FED1 10-10

Notice of Provider Directory/Networks

Notice Regarding Provider/Pharmacy Directories and Provider/Pharmacy Networks

If your Plan utilizes a network of Providers, a separate listing of Participating Providers who participate in the network is available to you without charge 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.

HC-FED2 10-10

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.

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

Qualified Medical Child Support Order Defined

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

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

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

Payment of Benefits

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

HC-FED4 10-10

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

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

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

Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will

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

Individuals who enroll in the Plan due to a special enrollment event will not be considered Late Entrants. Any Pre-existing Condition limitation will be applied upon enrollment, reduced by prior Creditable Coverage, but will not be extended as for a Late Entrant.

Domestic Partners and their children (if not legal children of the Employee) are not eligible for special enrollment.

HC-FED5 10-10

Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage Elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if your Employer agrees and you enroll for or change coverage within 30 days of the following:

- the date you meet the Special Enrollment criteria described above; or
- the date you meet the criteria shown in the following Sections B through F.

B. Change of Status

A change in status is defined as:

- change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
- change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
- change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
- changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
- change in residence of Employee, spouse or Dependent to a location outside of the Employer's network service area; and
- changes which cause a Dependent to become eligible or ineligible for coverage.

C. Court Order

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

D. Medicare or Medicaid Eligibility/Entitlement

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

E. Change in Cost of Coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.

When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

F. Changes in Coverage of Spouse or Dependent Under Another Employer's Plan

You may make a coverage election change if the plan of your spouse or Dependent: incurs a change such as adding or deleting a benefit option; allows election changes due to Special Enrollment, Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or this Plan and the other plan have different periods of coverage or open enrollment periods.

HC-FED7 10-10

Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exception for Newborns" section of this document that describe requirements for enrollment and

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effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

HC-FED8 10-10

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.

HC-FED11 10-10

Women's Health and Cancer Rights Act (WHCRA)

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

HC-FED12 10-10

Group Plan Coverage Instead of Medicaid

If your income and liquid resources do not exceed certain limits established by law, 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.

HC-FED13 10-10

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.

HC-FED15 10-10

Requirements of Medical Leave Act of 1993 (as amended) (FMLA)

Any provisions of the policy that provide for: continuation of insurance during a leave of absence; and 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, as amended, 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, as amended; and
- you are an eligible Employee under the terms of that Act.

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

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, as amended, 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.

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

HC-FED17 10-10

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

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

Continuation of Coverage

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

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

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

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

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

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

Reinstatement of Benefits (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 your current Employer, coverage for you and your Dependents may be reinstated if you gave your Employer advance written or verbal notice of your military service leave, and the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

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

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

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.

HC-FED18 10-10

Claim Determination Procedures under ERISA

The following complies with federal law. 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, Cigna 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 Cigna's control, Cigna 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 Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice

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of missing information, and the determination period will resume on the date you or your representative responds to the notice.

If the determination periods above would seriously jeopardize your life or health, your ability to regain maximum function, or in the opinion of a Physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna's Physician will defer to the determination of the treating Physician, regarding whether an expedited determination is necessary. Cigna 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, Cigna 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 Cigna within 48 hours after receiving the notice. Cigna 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 Cigna's procedures for requesting a required preservice medical necessity determination, Cigna 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, Cigna 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, Cigna will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control Cigna 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 Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna 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, Cigna 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 Cigna's control, Cigna 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 Cigna 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: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; 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; information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

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Medical - 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, contractual benefits, or a rescission of coverage, 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

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing to Cigna 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 Cigna to register your appeal by telephone. Call or write us at the toll-free number on your Benefit Identification card, explanation of benefits, or claim form.

Level-One Appeal

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

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

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.

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

Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, Cigna 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.

Requests for a level-two appeal regarding the medical necessity or clinical appropriateness of your issue will be conducted by a Committee, which consists of one or more people not previously involved in the prior decision. The Committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by Cigna's Physician reviewer. You may present your situation to the Committee in person or by conference call.

For 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.

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

You will be notified in writing of the Committee's decision within 5 business days after the Committee meeting, and

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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, 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 your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, Cigna 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 Cigna's level-two appeal review and the appeal involves medical judgment or a rescission of coverage, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna HealthCare, or any of its affiliates. A decision to request an appeal to an Independent Review Organization will not affect the claimant's rights to any other benefits under the plan.

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

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of Cigna's level-two appeal review denial. Cigna will then forward the file to the Independent Review Organization. The Independent Review Organization will render an opinion within 45 days.

When requested, and if a delay would be detrimental to your medical condition, as determined by Cigna's Physician reviewer, or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility, the review shall be completed within 72 hours.

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: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; 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; 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); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of an adverse determination will include a discussion of the decision.

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

Relevant Information

Relevant information is any document, record or other information which: was relied upon in making the benefit determination; 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; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or 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 Cigna until you have completed the Level-One and Level-Two appeal processes. If your appeal is expedited, there is no need to complete the Level-Two process prior to bringing legal action.

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COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a

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"qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan's coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

For you and your Dependents, COBRA continuation is available for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct, or
- your reduction in work hours.

For your Dependents, COBRA continuation coverage is available for up to 36 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your death;
- your divorce or legal separation; or
- for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, same sex spouses, grandchildren (unless adopted by you), stepchildren (unless adopted by you). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The sections titled "Secondary Qualifying Events" and "Medicare Extension For Your Dependents" are not applicable to these individuals.

Although federal law does not extend COBRA continuation rights to domestic partners and same sex spouses, this plan will extend these same continuation benefits to domestic partners and same sex spouses (and their children if not legal children of the employee) to the same extent they are provided to spouses of the opposite sex and legal children of the employee.

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under Title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation coverage may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, all of the following requirements must be satisfied:

- SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
- A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate for all covered persons on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for "Termination of COBRA Continuation" listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in

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Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA Continuation

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with Cigna;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

Moving Out of Employer's Service Area or Elimination of a Service Area

If you and/or your Dependents move out of the Employer's service area or the Employer eliminates a service area in your location, your COBRA continuation coverage under the plan will be limited to out-of-network coverage only. In-network coverage is not available outside of the Employer's service area. If the Employer offers another benefit option through Cigna or another carrier which can provide coverage in your location, you may elect COBRA continuation coverage under that option.

Employer's Notification Requirements

Your Employer is required to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
  - in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA continuation.

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including

both employer and employee contributions) for coverage of a similarly situated active Employee or family member.

For example: If the Employee alone elects COBRA continuation coverage, the Employee will be charged 102% (or 150%) of the active Employee premium. If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

You Must Give Notice of Certain Qualifying Events

If you or your Dependent(s) experience one of the following qualifying events, you must notify the Plan Administrator within 60 calendar days after the later of the date the qualifying event occurs or the date coverage would cease as a result of the qualifying event:

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.
- The occurrence of a secondary qualifying event as discussed under "Secondary Qualifying Events" above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled "Disability Extension" for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer's Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation coverage will cease upon the occurrence of any of the events listed under "Termination of COBRA Continuation" above.

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Trade Act of 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TYY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

In addition, if you initially declined COBRA continuation coverage and, within 60 days after your loss of coverage under the Plan, you are deemed eligible by the U.S. Department of Labor or a state labor agency for trade adjustment assistance (TAA) benefits and the tax credit, you may be eligible for a special 60 day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless you experience one of the events discussed under "Termination of COBRA Continuation" above. Coverage will not be retroactive to the initial loss of coverage. If you receive a determination that you are TAA-eligible, you must notify the Plan Administrator immediately.

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.

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ERISA Required Information

The name of the Plan is:

REDACTED

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

REDACTED

Employer Identification Number (EIN)
REDACTED

Plan Number

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

Employer named above

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

Employer named above

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

The CIGNA Claim Office responsible for this Plan

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

The Plan's fiscal year ends on 05/31.

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 a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.

Discretionary Authority

The Plan Administrator delegates to CIGNA 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 CIGNA the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. The procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated, is contained in the Employer's Plan

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Document, which is available for inspection and copying from the Plan Administrator designated by the Employer. No consent of any participant is required to terminate, modify, amend or change the Plan.

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

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

- the date you leave Active Service (or later as explained in the Termination Section;)
- 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 a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure room of the 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 employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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 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

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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.

HC-FED25 10-10

Definitions

Active Service

You will be considered in Active Service:

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

HC-DFS1 04-10
V1

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.

HC-DFS2 04-10
V2

Charges

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

HC-DFS3 04-10
V1

Chiropractic Care

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

HC-DFS55 04-10
V1

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: walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that can be self administered, and

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

HC-DFS4 04-10
V1

Dependent

Dependents are:

- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is:
  - less than 26 years old.
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

    Proof of the child's condition and dependence must be submitted to CIGNA within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, CIGNA may require proof of the continuation of such condition and dependence.

The term child means a child born to you or a child legally adopted by you. It also includes a stepchild, or a child for whom you are the legal guardian. If your Domestic Partner has a child, that child will also be included as a Dependent.

Benefits for a Dependent child will continue until the last day of the calendar month in which the limiting age is reached.

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

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

HC-DFS414 04-10
V1 M

Domestic Partner

A Domestic Partner is defined as a person of the same or opposite sex who:

- shares your permanent residence;
- has resided with you for no less than one year;
- is no less than 18 years of age;
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is considered by Cigna to be sufficient to establish financial interdependency under the circumstances of your particular case;
- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit attesting to the above which can be made available to Cigna upon request.

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:

- has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
- is currently legally married to another person; or
- has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

You and your Domestic Partner must have registered as Domestic Partners, if you reside in a state that provides for such registration.

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

See your Employer for continuation benefits that apply to your Domestic Partner and that Domestic Partner’s child.

HC-DFS47 04-10
V1

Emergency Medical Condition

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

HC-DFS394 11-10

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Emergency Services

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

HC-DFS393 11-10

Employee

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 32 hours a week for the Employer.

HC-DFS7 04-10
V3

Employer

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

HC-DFS8 04-10
V1

Essential Health Benefits

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

HC-DFS411 01-11

Expense Incurred

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

HC-DFS10 04-10
V1

Free-Standing Surgical Facility

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

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

HC-DFS11 04-10
V1

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.

HC-DFS51 04-10
V1

Hospice Care Services

The term Hospice Care Services means any services provided by: a Hospital, a Skilled Nursing Facility or a similar institution, a Home Health Care Agency, a Hospice Facility,

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or any other licensed facility or agency under a Hospice Care Program.

HC-DFS52 04-10
V1

Hospice Facility

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

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

HC-DFS53 04-10
V1

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and 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: specializes in treatment of Mental Health and Substance Abuse or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

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

HC-DFS48 04-10
V1

Hospital Confinement or Confined in a Hospital

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

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

HC-DFS49 04-10
V1

Injury

The term Injury means an accidental bodily injury.

HC-DFS12 04-10
V1

Maintenance Treatment

The term Maintenance Treatment means:

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

HC-DFS56 04-10
V1

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 percentage of a schedule developed by Cigna that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

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

In some cases, a Medicare based schedule will not be used and 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

CIGNA HealthCare

- the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna.

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

HC-DFS13 04-10
V1

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.

HC-DFS16 04-10
V1

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.

HC-DFS19 04-10
V1

Medicare

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

HC-DFS17 04-10
V1

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.

HC-DFS21 04-10
V1

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."

HC-DFS22 04-10
V1

Other Health Care Facility/Other Health Professional

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 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. Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.

HC-DFS23 04-10
V1

CIGNA HealthCare

Participating Pharmacy

The term Participating Pharmacy means a retail Pharmacy with which Cigna has contracted to provide prescription services to insureds, or a designated home delivery Pharmacy with which Cigna has contracted to provide home delivery prescription services to insureds. A home delivery Pharmacy is a Pharmacy that provides Prescription Drugs through mail order.

HC-DFS60 04-10
V1

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.

HC-DFS45 04-10
V1

Patient Protection and Affordable Care Act of 2010 ("PPACA")

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

HC-DFS412 01-11

Pharmacy

The term Pharmacy means a retail Pharmacy, or a home delivery Pharmacy.

HC-DFS61 04-10
V1

Pharmacy & Therapeutics (P & T) Committee

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

HC-DFS62 04-10
V1

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.

HC-DFS25 04-10
V1

Prescription Drug

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

HC-DFS63 04-10
V1

Prescription Drug List

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

HC-DFS64 04-10
V1

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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.

HC-DFS65 04-10
V1

Preventive Treatment

The term Preventive Treatment means treatment rendered to prevent disease or its recurrence.

HC-DFS57 04-10
V1

Primary Care Physician

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

HC-DFS40 04-10
V1

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.

HC-DFS26 04-10
V1

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.

HC-DFS68 04-10
V1

Review Organization

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

HC-DFS30 04-10
V1

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.

HC-DFS50 04-10
V1

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: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of Physicians; and provides Nurses' services.

HC-DFS31 04-10
V1

Stabilize

Stabilize means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is

likely to result from or occur during the transfer of the individual from a facility.

HC-DFS413 01-11

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.

HC-DFS54 04-10
V1

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

HC-DFS34 04-10
V1

CIGNA HealthCare

The following pages describe the features of your CIGNA Choice Fund - Health Reimbursement Arrangement. Please read them carefully.

CIGNA HealthCare

What You Should Know about CIGNA Choice Fund® – Health Reimbursement Arrangement

CIGNA Choice Fund is designed to give you:

Control

More control over how your health care dollars are spent. The health services you get and where you get them are up to you.

Choice

You have the freedom to choose any licensed doctor. However, your costs will be lower for services from CIGNA contracted health care professionals because they have agreed to accept discounted payments to help you make the most of your health care dollars.

Flexibility

Flexibility to help you manage your health proactively and maximize your plan coverage. If you don't use all of the money in your health reimbursement account, some or all of the unused money may be added to your account for the following year, as long as you stay in the plan. Ask your employer if this option is available to you.

Your plan covers medical care when you're sick, but also includes coverage for preventive care services to help keep you well.

Health Information and Education

Just call the toll-free number on your ID card to reach CIGNA's 24-Hour Health Information Line. You'll have access to trained nurses and an audio library of health topics 24 hours a day. In addition, the CIGNA HealthCare Healthy Babies® program provides prenatal education and support for mothers-to-be.

Tools & Support

We help you keep track with online benefits information, transactions, and account activity; medical and drug cost comparisons; monthly statements; and more. You also have toll-free access to dedicated Member Service teams, specially trained to answer your questions and address your needs

Savings on Health and Wellness Products and Services

Through CIGNA Healthy Rewards®, you can save money on a variety of health-related products and services. Offerings include laser vision correction, acupuncture, chiropractic care, Weight Watchers®, and more.

Opportunity to earn funds for future use

If your employer offers the CIGNA Healthy Future Account®, you can earn funds to cover qualified expenses for future use, such as retirement. All or a portion of unused HRA funds at the end of each plan year will transfer to this account until you meet the eligibility requirements (such as retirement, reaching age 65, or accumulating a certain number of years of service with your employer). Once you reach your qualifying event, you may then use the Healthy Future Account to pay yourself back for certain expenses defined by your employer. See your benefits administrator for more details.

The Basics

How does it work?

The CIGNA Choice Fund Health Reimbursement Account combines medical coverage with a reimbursement account that includes contributions only from your employer.

1. **Employer contribution** — Your employer deposits a specific amount of money in a health account to help you pay for some of the costs of covered medical expenses. The health services you receive and where you get them are up to you. The money used from your HRA counts toward your annual deductible (the amount you pay before your plan starts to pay), reducing your share.
2. **Your share** — Once you've used the money in your health account, you pay your expenses up to the deductible.
3. **Your health plan** — After your deductible is met, you pay pre-determined coinsurance or copayments for eligible expenses and the plan pays the rest. When you meet your out-of-pocket maximum (the most you can pay in a plan year), your plan pays eligible expenses at 100%.

If you leave the plan or your employer, the account stays behind.

Which services are covered by my Health Reimbursement Account?

According to federal law, HRA funds can be used to cover only qualified medical expenses for you and your dependents. However, your employer may choose not to allow coverage for certain qualified expenses. Please refer to myCIGNA.com for information on the services for which your HRA funds may be used.

Which services are covered by my medical plan, and which will I have to pay out of my own pocket?

Covered services vary depending on your plan, so visit myCIGNA.com or check your plan materials in this booklet for specific information. In addition to your premiums deducted from your paycheck, you'll be responsible for paying:

- Costs for any services needed after you've spent your health fund, if you haven't met your deductible.
- Your coinsurance or copayments after you meet the deductible and your medical plan coverage begins.

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If all of your medical expenses are covered services and the total cost doesn't exceed the amount in your HRA, you may not have additional out-of-pocket costs. Unused money may be available to you if you enroll in the plan again the following year. Check with your employer to see if this option is available to you.

Are services covered if I use out-of-network doctors?

You can visit any licensed doctor or facility. However, if you choose a provider who participates with CIGNA HealthCare, your costs will be lower.

Tools and Resources at Your Fingertips

myCIGNA.com.

myCIGNA.com provides fast, reliable and personalized information and services, including:

- Online access to your current account balance, past transactions and claim status, as well as your Explanation of Benefits and health statements.
- Medical cost and drug cost information, including average costs for your state.
- Frequently asked questions – about health care in general and CIGNA Choice Fund specifically.
- A number of convenient, helpful tools that let you:

Compare costs

Use tools to compare costs and help you decide where to get care. You can get average price ranges for certain ambulatory surgical procedures and radiology services. You can also find estimated costs in your region for common medical services and conditions.

Find out more about your local hospitals

Learn how hospitals rank by number of procedures performed, patients' average length of stay, and cost. Go to our online provider directory for estimated average cost ranges for certain procedures, including total charges and your out-of-pocket expense, based on a CIGNA plan. You can also find hospitals that earn the Centers of Excellence designation based on effectiveness in treating selected procedures/conditions and cost.

Get the facts about your medication, cost, treatment options and side effects

Use the pharmacy tools to: check your prescription drug costs, listed by specific pharmacy and location (including CIGNA Home Delivery Pharmacy); and review your claims history for the past 16 months. Look at condition-specific drug treatments and compare characteristics of more than 200 common medications. Evaluate up to 10 medications at once to better understand side effects, drug interactions and alternatives.

Take control of your health

Take the health risk assessment, an online questionnaire that can help you identify and monitor your health status. You can learn about preventive care and check your progress toward healthy goals. And if your results show that you may benefit from other services, you can learn about related CIGNA programs on the same site.

Explore topics on medicine, health and wellness

Get information on more than 5,000 health conditions, health and wellness, first aid and medical exams through **Healthwise®** Medical Encyclopedia, an interactive library.

Keep track of your personal health information

Health Record is your central, secure location for your medical conditions, medications, allergies, surgeries, immunizations, and emergency contacts. You can add your health risk assessment results to **Health Record**, so you can easily print and share the information with your doctor. Your lab results from certain facilities can be automatically entered into your Personal Health Record.

Chart progress of important health indicators

Input key data such as blood pressure, blood sugar, cholesterol (Total/LDL/HDL), height and weight, and exercise regimen. **Health Tracker** makes it easy to chart the results and share them with your doctor.

Getting the Most from Your HRA

You make decisions every day – from buying the family car to choosing the breakfast cereal. Make yourself a more educated health care consumer and you'll find that you, too, can make a difference in the health care services you receive and what you ultimately pay.

Fast Facts

If you choose to see a CIGNA participating health care professional, the cost is based on discounted rates, so your costs will be lower. If you visit a health care professional or facility not in the network, you may still use CIGNA Choice Fund to pay for the cost of those services, but you will pay a higher rate, and you may have to file claims.

If you need hospital care, there are several tools to help you make informed decisions about quality and cost.

- With the Hospital Comparison tool on myCIGNA.com, you can learn how hospitals rank by number of procedures performed, patients' average length of stay, and cost.
- Visit our provider directory for CIGNA Centers of Excellence, providing hospital scores for specific procedures/conditions, such as cardiac care, hip and knee replacement, and bariatric surgery. Scores are based on cost and effectiveness in treating the procedure/condition, based on publicly available data.

CIGNA HealthCare

- www.cigna.com also includes a Provider Excellence Recognition Directory. This directory includes information on:
  - Participating physicians who have achieved recognition from the National Committee for Quality Assurance (NCQA) for diabetes and/or heart and stroke care.
  - Hospitals that fully meet The Leapfrog Group patient safety standards.

If you're not sure where to begin, you have access to health advocates.

You now have access to health specialists – including individuals trained as nurses, coaches, nutritionists and clinicians – who will listen, understand your needs and help you find solutions, even when you're not sure where to begin. Partner with a health coach and get help to maintain good eating and exercise habits; support and encouragement to set and reach health improvement goals; and guidance to better manage conditions, including coronary artery disease, low back pain, osteoarthritis, high blood pressure, high cholesterol and more. From quick answers to health questions to assistance with managing more serious health needs, call the toll-free number on your CIGNA ID card or visit myCIGNA.com. See your benefits administrator for more details about all of the services you have access to through your plan.

Wherever you go in the U.S., you take the CIGNA 24-Hour Health Information Line℠ with you.

Whether it's late at night, and your child has a fever, or you're traveling and you're not sure where to get care, or you don't feel well and you're unsure about the symptoms, you can call the CIGNA 24-Hour Health Information Line whenever you have a question. Call the toll-free number on your CIGNA ID card and you will speak to a nurse who will help direct you to the appropriate care.

A little knowledge goes a long way.

Getting the facts about your care, such as treatment options and health risks is important to your health and well-being — and your pocketbook. For instance:

- Getting appropriate preventive care is key to staying healthy. Visit myCIGNA.com to learn more about proper preventive care and what's covered under your plan.
- When it comes to medications, talk to your doctor about whether generic drugs are right for you. The brand name drugs you are prescribed may have generic alternatives that could lower your costs. If a generic version of your brand name drug is not available, other generic drugs with the same treatment effect may meet your needs.
- Tools on myCIGNA.com can help you take control of your health and health care spending. You can learn about medical topics and wellness, and keep track of your personal health information. You can also print personalized reports to discuss with your doctor.

NOT154 V5

EXHIBIT C

INDEX HEADER PAGE: 3

EE FCO: 65 EE COPY: Y EE SSN: REDACTED

EE LNAME: REDACTED PAT FNAME: REDACTED

SUBMITTER DCN: 060512762231211 BILLING ID: 263740119

VENDOR-ID: 9165 PROVIDER-ID:

CLAIM DATA

TOTAL CHARGES: 2,792.50

CLM FILING IND: CLAIM TYPE: MD

ACC COUNTRY: PAT NBR: REDACTED ASSIGN BENS: Y

RELEASE INFO: Y RELEASE INFO DATE: EE SIGN IND: B

MEDI ASSIGN: Y HMO CODE: E-CODE:

PRINC DIAG: V700 OTHER DIAG: 2729

OTHER DIAG: 2689

OTHER DIAG: 5990

HOSPITAL ONLY DATA

TYPE BILL 1: 81 TYPE BILL 2: TYPE BILL 3: 1

PROV SIGNATURE: Y

SERVICE LINE DATA RECORD: 001

LINE TYPE: M PROC CODE: 82172 PROC MOD 1:

POS: 81 TOS: CHARGE: 102.00

MED UNIT OF MEASURE: UN UNITS: 2

DIAG POINT 1: 01 DIAG POINT 2: 00 DIAG POINT 3: 00

MED/HOS FROM: 20120523 MED/HOS THRU: 20120523

LAB CHARGE: TEST RESULTS:

LINE ITEM CONTROL NUMBER: EP060512762231211-01

AMBULANCE CERTIFICATION

PAT WEIGHT: TRIP ORIG: TRANSPORT CODE:

DISTANCE: DESTINATION: TRANSPORT RSN:

REDACTED

EXHIBIT D

REDACTED

OPEN ACCESS PLUS MEDICAL
BENEFITS

EFFECTIVE DATE: October 1, 2011

CN020
3212756

This document printed in May, 2012 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

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

CONNECTICUT GENERAL LIFE INSURANCE COMPANY
a CIGNA company (called CG) certifies that it insures certain Employees for the benefits provided by the following policy(s):

POLICYHOLDER: REDACTED

GROUP POLICY(S) — COVERAGE
3212756 - OAP OPEN ACCESS PLUS MEDICAL BENEFITS

EFFECTIVE DATE: October 1, 2011

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.
This certificate takes the place of any other issued to you on a prior date which described the insurance.

Shermona Mapp, Corporate Secretary

CER7V21

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.

CIGNA HealthCare

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.

FPINTRO4V1

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.

FPCCL10V1

Case Management

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

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

1. You, your dependent or an attending Physician can request Case Management services by calling the toll-free number shown on your ID card during normal business hours, Monday through Friday. In addition, your employer, a claim office or a utilization review program (see the PAC/CSR section of your certificate) may refer an individual for Case Management.
2. The Review Organization assesses each case to determine whether Case Management is appropriate.
3. You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.

FPCM6

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

CIGNA HealthCare

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.

FPCM2

Additional Programs

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

GM6000 NOT160

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.

Changing Primary Care Physicians:

You may request a transfer from one Primary Care Physician to another by contacting us at the member services number on your ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician, if you choose.

NOT123 V1

Important Notices

Notice of Grandfathered Plan Status

This plan is being treated as a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your coverage may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at the phone number or address provided in your plan documents, to your employer or plan sponsor or an explanation can be found on CIGNA's website at http://www.cigna.com/sites/healthcare_reform/customer.html.

If your plan is subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

If your plan is a nonfederal government plan or a church plan, you may also contact the U.S. Department of Health and Human Services at www.heatlthcare.gov.

NOT220

CIGNA HealthCare

Patient Protection and Affordable Care Act Endorsement

The group contract or certificate is amended as stated below.

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

Definitions

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

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

Lifetime Dollar Limits

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

Annual Dollar Limits

Any annual limits on the dollar value of essential health benefits are deleted.

Rescissions

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

Extension of Coverage to Dependents

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

Preexisting Condition Limitations

Any Preexisting Condition Limitation provision described in the plan document does not apply to anyone who is under 19 years of age.

NOT231 V1

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.

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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.

GM6000 CI 3 CLA9V41

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

Proof of Loss

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

Physical Examination

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

Legal Actions

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

GM6000 CLA43V6

Eligibility – Effective Date

Eligibility for Employee Insurance

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

- you are in a Class of Eligible Employees or organization; and
- you are an eligible, full-time, Government, Port Authority or Medical Centers Employee who normally work at least 40 hours a week; or
- you are an eligible, full-time University of the Virgin Island Employee who normally work at least the number of hours as determined and reported to the insurance company by your Employer.

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

Eligibility for Dependent Insurance

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

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

Waiting Period

First of the month following date of hire (to be managed by the client and actual effective dates will be submitted to CIGNA. If your date of hire is on or before the 6th day of the month, your coverage will take effect on the first day of the month following date of hire. If your date of hire is on or after the 7th day of the month, your coverage will take effect on the first day of the next month.)

CIGNA HealthCare

Classes of Eligible Employees

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

GM6000 EL 2 V-32

ELI6 M

Employee Insurance

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

Effective Date of Your Insurance

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

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

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you cancel your payroll deduction.

GM6000 EF 1 ELI7V82

Dependent Insurance

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

Effective Date of Dependent Insurance

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

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

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction.

Exception for Newborns

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

GM6000 EF 2 ELI11V44

CIGNA HealthCare

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.

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:

- 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:

- non-compliance penalties.
- provider charges in excess of the Maximum Reimbursable Charge.

Accumulation of Plan Deductibles and Out-of-Pocket Maximums

Deductibles and Out-of-Pocket Maximums do not cross-accumulate (that is, In-Network will accumulate to In-Network and Out-of-Network will accumulate to Out-of-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.

CIGNA HealthCare

Open Access Plus Medical Benefits

The Schedule

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 62.5 percent of the surgeon's allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeons prior to any reductions due to coinsurance or deductible amounts.)

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	
Coinsurance Levels	80%	60% of the Maximum Reimbursable Charge

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
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 percentage of a schedule that we have developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for similar services within the geographic market. In some cases, a Medicare based schedule will not be used and 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 • the 80th 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 the Insurance Company. **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	150%
Calendar Year Deductible Individual Family Maximum 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.	 $200 per person $600 per family	 $400 per person $1,200 per family

CIGNA HealthCare

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Out-of-Pocket Maximum		
Individual	$3,000 per person	$7,500 per person
Family Maximum	$6,000 per family	$15,000 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%.		
Physician's Services		
Primary Care Physician's Office visit	No charge after $20 per office visit copay	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 the Insurance Company.	No charge after $30 Specialist per office visit copay	60% after plan deductible
Surgery Performed In the Physician's Office	No charge after the $20 PCP or $30 Specialist per office visit copay	60% after plan deductible
Second Opinion Consultations (provided on a voluntary basis)	No charge after the $20 PCP or $30 Specialist per office visit copay	60% after plan deductible
Allergy Treatment/Injections	No charge after either the $20 PCP or $30 Specialist per office visit copay or the actual charge, whichever is less	60% after plan deductible
Allergy Serum (dispensed by the Physician in the office)	No charge	60% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Preventive Care Routine Preventive Care **Note:** Well-woman OB/GYN visits will be considered either a PCP or Specialist depending on how the provider contracts with the Insurance Company.		
Physician's Office Visit	No charge after the $20 PCP or $30 Specialist per office visit copay	In-Network coverage only
Immunizations	No charge	In-Network coverage only
Mammograms, PSA **Note**: Diagnostic & Preventive services are covered and all related charges.	100%	60% after plan deductible
Pap Smear	80% after plan deductible if billed by an independent diagnostic facility or outpatient hospital **Note:** The associated wellness exam will be covered at no charge after the $20 PCP or $30 Specialist per visit copay.	60% after plan deductible
Inpatient Hospital - Facility Services	80% after plan deductible	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% after plan deductible	60% after plan deductible
Inpatient Hospital Physician's Visits/Consultations	80% after plan deductible	60% after plan deductible
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	80% after plan deductible	60% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	80% after plan deductible	60% after plan deductible
Emergency and Urgent Care Services		
Physician's Office Visit	No charge after the $20 PCP or $30 Specialist per office visit copay	No charge after the $20 PCP or $30 Specialist per office visit copay
Hospital Emergency Room	80% after plan deductible	80% after plan deductible
Outpatient Professional services (radiology, pathology and ER Physician)	80% after plan deductible	80% after plan deductible
Urgent Care Facility or Outpatient Facility	80% after plan deductible	80% 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% after plan deductible	80% after plan deductible
Independent x-ray and/or Lab Facility in conjunction with an ER visit	80% after plan deductible	80% after plan deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)	80% after plan deductible	80% after plan deductible
Ambulance	80% after plan deductible	80% after plan deductible
Air Ambulance (Medical Necessity Only limited by plan out-of-pocket amounts)	80% after plan deductible	80% after plan deductible (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: 120 days combined	80% after plan deductible	60% after plan deductible
Private Duty Nurse (includes Inpatient and Outpatient) Calendar Year Maximum: Unlimited	80% after plan deductible	60% after plan deductible

CIGNA HealthCare

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Laboratory and Radiology Services (includes pre-admission testing)		
Physician's Office Visit	No charge after the $20 PCP or $30 Specialist per visit copay	60% after plan deductible
Outpatient Hospital Facility	80% after plan deductible	60% after plan deductible
Independent X-ray and/or Lab Facility	80% after plan deductible	60% after plan deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)		
Physician's Office Visit	No charge	60% after plan deductible
Inpatient Facility	80% after plan deductible	60% after plan deductible
Outpatient Facility	80% after plan deductible	60% after plan deductible
Outpatient Short-Term Rehabilitative Therapy and Chiropractic Services Calendar Year Maximum: 60 days for all therapies combined Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy Chiropractic Therapy (includes Chiropractors)	No charge after the $20 PCP or $30 Specialist per office visit copay **Note:** Outpatient Short Term Rehab copay applies, regardless of place of service, including the home.	60% after plan deductible
Home Health Care Calendar Year Maximum: 40 days (includes outpatient private nursing when approved as medically necessary)	80% after plan deductible	60% after plan deductible
Private Duty Nurse Calendar Year Maximum: Unlimited	80% after plan deductible	60% after plan deductible
Hospice		
Inpatient Services	80% after plan deductible	60% after plan deductible
Outpatient Services (same coinsurance level as Home Health Care)	80% after plan deductible	60% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Bereavement Counseling		
Services provided as part of Hospice Care		
Inpatient	80% after plan deductible	60% after plan deductible
Outpatient	80% after plan deductible	60% after plan deductible
Services provided by Mental Health Professional	Covered under Mental Health Benefit	Covered under Mental Health Benefit
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 the Insurance Company.	No charge after the $20 PCP or $30 Specialist per office visit copay	60% after plan deductible
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	80% after plan deductible	60% 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 $20 PCP or $30 Specialist per office visit copay	60% after plan deductible
Delivery - Facility (Inpatient Hospital, Birthing Center)	80% after plan deductible	60% after plan deductible
Abortion		
Includes elective and non-elective procedures		
Physician's Office Visit	No charge after the $20 PCP or $30 Specialist per office visit copay	60% after plan deductible
Inpatient Facility	80% after plan deductible	60% after plan deductible
Outpatient Facility	80% after plan deductible	60% after plan deductible
Physician's Services	80% after plan deductible	60% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Family Planning Services		
Office Visits, Lab and Radiology Tests and Counseling	No charge after the $20 PCP or $30 Specialist per office visit copay	60% after plan deductible
Note: The standard benefit will include coverage for contraceptive devices (e.g. Depo-Provera and Intrauterine Devices (IUDs). Diaphragms will also be covered when services are provided in the physician's office.		
Surgical Sterilization Procedure for Vasectomy/Tubal Ligation (excludes reversals)		
Physician's Office Visit	No charge after the $20 PCP or $30 Specialist per office visit copay	60% after plan deductible
Inpatient Facility	80% after plan deductible	60% after plan deductible
Outpatient Facility	80% after plan deductible	60% after plan deductible
Physician's Services	80% after plan deductible	60% after plan deductible
Infertility Treatment Coverage will be provided for the following services: • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). Surgical Treatment: Limited to procedures for the correction of infertility (excludes In-vitro, GIFT, ZIFT, Artificial Insemination.etc.)		
Physician's Office Visit (Lab and Radiology Tests, Counseling)	No charge after the $20 PCP or $30 Specialist per office visit copay	60% after plan deductible
Inpatient Facility	80% after plan deductible	60% after plan deductible
Outpatient Facility	80% after plan deductible	60% after plan deductible
Physician's Services	80% after plan deductible	60% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Organ Transplants Includes all medically appropriate, non-experimental transplants		
Physician's Office Visit	No charge after the $20 PCP or $30 Specialist per office visit copay	60% after plan deductible
Inpatient Facility	100% at Lifesource center, otherwise 80% after plan deductible	60% after plan deductible
Physician's Services	100% at Lifesource center, otherwise 80% after plan deductible	60% after plan deductible
Lifetime Travel Maximum: $10,000 per transplant	No charge (only available when using Lifesource facility)	In-Network coverage only
Durable Medical Equipment Calendar Year Maximum: Unlimited	80% after plan deductible	60% after plan deductible
External Prosthetic Appliances Calendar Year Maximum: Unlimited	80% after plan deductible	60% after plan deductible
Nutritional Evaluation Calendar Year Maximum: 3 visits per person		
Physician's Office Visit	No charge after the $20 PCP or $30 Specialist per office visit copay	60% after plan deductible
Inpatient Facility	80% after plan deductible	60% after plan deductible
Outpatient Facility	80% after plan deductible	60% after plan deductible
Physician's Services	80% after plan deductible	60% after plan deductible
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.		
Physician's Office Visit	No charge after the $20 PCP or $30 Specialist per office visit copay	60% after plan deductible
Inpatient Facility	80% after plan deductible	60% after plan deductible
Outpatient Facility	80% after plan deductible	60% after plan deductible
Physician's Services	80% after plan deductible	60% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Obesity/Bariatric Surgery **Note:** Coverage is provided subject to medical necessity and clinical guidelines subject to any limitations shown in the "Exclusions, Expenses Not Covered and General Limitations" section of this certificate.		
Physician's Office Visit	No charge after the $20 PCP or $30 Specialist per office visit copay	In-Network coverage only
Inpatient Facility	80% after plan deductible	In-Network coverage only
Outpatient Facility	80% after plan deductible	In-Network coverage only
Physician's Services	80% after plan deductible	In-Network coverage only
Lifetime Maximum: $10,000 Coinsurance charges for obesity surgery will not accumulate to the plan Out-of-Pocket maximum.		
Eye Care Services		
Calendar Year Maximum: 1 eye exam per calendar year	No charge after the $15 per office visit copay	No charge after the $15 per office visit deductible
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.
Treatment Resulting From Life Threatening Emergencies Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.		
Mental Health		
Inpatient	80% after plan deductible	60% after plan deductible
Outpatient (Includes Individual, Group and Intensive Outpatient)		
Physician's Office Visit	No charge	60% after plan deductible
Outpatient Facility	No charge	60% after plan deductible

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BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Substance Abuse		
Inpatient	80% after plan deductible	60% after plan deductible
Outpatient (Includes Individual and Intensive Outpatient)		
Physician's Office Visit	No charge	60% after plan deductible
Outpatient Facility	No charge	60% after plan deductible

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Open Access Plus Medical Benefits

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 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 72 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 72 hours after the date of admission.

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will not include:

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

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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.

GM6000 PAC2 V9

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;
- nonemergency ambulance; or
- transplant services.

GM6000 05BPT16 V14

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.

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- charges for Air Ambulance, if medically necessity is established by a medical professional. Once medical necessity is determined, the Air Ambulance will be directed to the nearest trauma center qualified to treat the prevailing condition. Travel for a family member to accompany the injured member is determined on a case by case basis. Return travel from the trauma facility is not a covered benefit.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.

GM6000 CM5 FLX107V126

- 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.
- surgical or nonsurgical treatment of TMJ dysfunction.

GM6000 CM6 FLX108V748M

- charges made for a mammogram for women ages 35 to 69, every one to two years, or at any age for women at risk, when recommended by a Physician.
- charges made for an annual Papanicolaou laboratory screening test.
- charges made for an annual prostate-specific antigen test (PSA).
- charges for appropriate counseling, medical services connected with surgical therapies, including vasectomy and tubal ligation.
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives; after appropriate counseling, medical services connected with surgical therapies, tubal ligations and vasectomies.
- 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 3 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 two years of that Dependent child's life, including immunizations.

GM6000 CM6 FLX108V746

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

GM6000 06BNR1 V1

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

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

GM6000 06BNR10

Clinical Trials

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

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

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

Genetic Testing

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

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

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

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

Nutritional Evaluation

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

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.

GM6000 05BPT2 V1

Home Health Services

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

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

Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals. A visit is defined as a period of 2 hours or less. Home Health Services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health Services are covered. Home Health Services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Health Care Professional. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations. Physical, occupational, and other Short-Term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Short-term Rehabilitative Therapy Maximum shown in The Schedule.

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Hospice Care Services

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

GM6000 CM34 FLX124V38

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

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

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

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Mental Health and Substance Abuse Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

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

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Inpatient Mental Health Services

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

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

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

GM6000 INDEM9 V71

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

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

Outpatient Mental Health Services

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

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

GM6000 INDEM10 V60

Inpatient Substance Abuse Rehabilitation Services

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

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

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

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

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

Outpatient Substance Abuse Rehabilitation Services

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

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

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Substance Abuse Detoxification Services

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

Exclusions

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 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.

External Prosthetic Appliances and Devices

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

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effective alternative as determined by the utilization review Physician.

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

Prostheses/Prosthetic Appliances and Devices

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

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

Orthoses and Orthotic Devices

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

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

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The following are specifically excluded orthoses and orthotic devices:

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

Braces

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

The following braces are specifically excluded: Copes scoliosis braces.

Splints

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

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

- Replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- Coverage for replacement is limited as follows:
  - No more than once every 24 months for persons 19 years of age and older and
  - No more than once every 12 months for persons 18 years of age and under.
  - Replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:

- External and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- Myoelectric prostheses peripheral nerve stimulators.

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Infertility Services

- charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; and diagnostic evaluations.

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

- Infertility drugs;
- Artificial Insemination;
- In vitro fertilization (IVF); gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT) and variations of these procedures;
- Reversal of male and female voluntary sterilization;
- Infertility services when the infertility is caused by or related to voluntary sterilization;
- Donor charges and services;
- Cryopreservation of donor sperm and eggs; and
- Any experimental, investigational or unproven infertility procedures or therapies.

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Short-Term Rehabilitative Therapy 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 limitation applies to Short-term Rehabilitative Therapy and Chiropractic Care Services:

- 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;
- 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;

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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.

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

GM6000 07BNR2

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, heart/lung,

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kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral.

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

All Transplant services, other than cornea, are covered 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.

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

Transplant Travel Services

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

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver. The following are specifically excluded travel expenses:

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

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

GM6000 05BPT7 V11M

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.

GM6000 05BPT2 V2

Medical Conversion Privilege

For You and Your Dependents

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy). A Converted Policy will be issued by CG only to a person who is Entitled to Convert, and only if he applies in writing and pays the first premium for the Converted Policy to CG within 31 days after the date his insurance ceases. Evidence of good health is not needed.

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Employees Entitled to Convert

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

- you have been insured for at least three consecutive months under the policy or under it and a prior policy issued to the Policyholder.
- your insurance ceased because you were no longer in Active Service or no longer eligible for Medical Expense Insurance.
- you are not eligible for Medicare.
- you would not be Overinsured.

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

Dependents Entitled to Convert

The following Dependents are also Entitled to Convert:

- a child whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse whose insurance under this plan ceases due to divorce, annulment of marriage or your death;
- your Dependents, if you are not Entitled to Convert solely because you are eligible for Medicare;

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

GM6000 CON1

Overinsured

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

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

Converted Policy

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

GM6000 CON26

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

The Converted Policy may not exclude any pre-existing condition not excluded by this plan. During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan.

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

GM6000 CON29

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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. That portion includes any applicable Copayment, Deductible and/or Coinsurance.

Coinsurance

The term Coinsurance means the percentage of Charges for covered Prescription Drugs and Related Supplies that you or your Dependent are required to pay under this plan.

Charges

The term Charges means the amount charged by the Insurance Company to the plan when the Pharmacy is a Participating Pharmacy, and it means the actual billed charges when the Pharmacy is a non-Participating Pharmacy.

Copayments

Copayments are expenses to be paid by you or your Dependent for Covered Prescription Drugs and Related Supplies.

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Retail Prescription Drugs	**The amount you pay for each 30-day supply**	**The amount you pay for each 30-day supply**
Tier 1 Generic* drugs on the Prescription Drug List	No charge after $10 copay	50%
Tier 2 Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	No charge after $20 copay	50%
Tier 3 Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	50%, subject to a minimum of $40 and a maximum of $100, then the plan pays 100%	50%, subject to a minimum of $40
* Designated as per generally-accepted industry sources and adopted by the Insurance Company		
Mail-Order Drugs	**The amount you pay for each 90-day supply**	**The amount you pay for each 90-day supply**
Tier 1 Generic* drugs on the Prescription Drug List	No charge after $20 copay	In-network coverage only

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BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
Tier 2 Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	No charge after $40 copay	In-network coverage only
Tier 3 Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	50%, subject to a minimum of $80 and a maximum of $200, then the plan pays 100%	In-network coverage only
* Designated as per generally-accepted industry sources and adopted by the Insurance Company		

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Prescription Drug Benefits

For You and Your Dependents

Covered Expenses

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, 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 90-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.

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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 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-Prescription Drug List 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 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 Drugs which are packaged together for your, or your Dependent's convenience, a Copayment will apply to each Prescription Drug.

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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 Prescription Drug List, 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;
- 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;
- any fertility drug;
- drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, and decreased libido;
- prescription vitamins (other than prenatal vitamins), dietary supplements; 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;
- prescriptions more than one year from the original date of issue.

Other limitations are shown in the Medical "Exclusions" section.

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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.

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

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

See your Employer's Benefit Plan Administrator to obtain the appropriate claim form.

GM6000 PHARM94 V17

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.

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

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

  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of this plan.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- regardless of clinical indication for acupressure; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an Injury to sound natural teeth; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; (c) charges made by a Free-Standing Surgical Facility or the outpatient department of a Hospital in connection with surgery.
- medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the

"Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.

- private Hospital rooms.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- medical benefits for eyeglasses, contact lenses or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery.
- charges made for or in connection with eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.
- treatment by acupuncture.
- all noninjectable prescription drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.
- nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
- medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- telephone, e-mail, and Internet consultations, and telemedicine.
- massage therapy.
- for charges which would not have been made if the person had no insurance.
- to the extent that they are more than Maximum Reimbursable Charges.
- expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure.
- charges made by any covered provider who is a member of your family or your Dependent's family.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.

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GM6000 05BPT105
GM6000 06BNR2 V51 M

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.

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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.

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 Employer of such prior coverage, and fewer than 63 days elapse between coverage under the prior plan and coverage under this plan, exclusive of any waiting period.

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.

GM6000 CM10 INDEM82 V3

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

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

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

Closed Panel Plan

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

Primary Plan

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

Secondary Plan

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

GM6000 COB11

Allowable Expense

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

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

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

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

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

(4) If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the

basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.

(5) If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

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

GM6000 COB12

Reasonable Cash Value

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

Order of Benefit Determination Rules

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

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

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

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

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

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

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

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

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

GM6000 COB13

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

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

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

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

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

Effect on the Benefits of This Plan

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

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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.

GM6000 COB14

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.

GM6000 COB15

Medicare Eligibles

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

(a) a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

(b) a former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

(c) an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;

(d) the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;

(e) an Employee or a Dependent of an Employee of an Employer who has fewer

than 20 Employees, if that person is eligible for Medicare due to age;

(f) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

GM6000 MEL23 V4

CG will assume the amount payable under:

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

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

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

Domestic Partners

Under federal law, the Medicare Secondary Payer Rules do not apply to Domestic Partners covered under a group health plan when Medicare coverage is due to age. Therefore, when Medicare coverage is due to age, Medicare is always the Primary Plan for a person covered as a Domestic Partner, and CIGNA is the Secondary Plan. However, when Medicare coverage is due to disability, the Medicare Secondary Payer Rules explained above will apply.

GM6000 MEL45 V5

Expenses For Which A Third Party May Be Liable

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

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

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

GM6000 CCP7 CCL7

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.

GM6000 TRM366

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the last day of the calendar month in which your Active Service ends except as described below.

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

Temporary Layoff

If your Active Service ends due to temporary layoff, your insurance will be continued until the last day of calendar month in which your Active Service ends.

Leave of Absence

If your Active Service ends due to leave of absence, your insurance will be continued provided premium payments are received.

Retirement

If your Active Service ends because you retire, your insurance will be continued until the date on which your Employer stops paying premium for you or otherwise cancels the insurance.

GM6000 TRM15V44 M

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.

GM6000 TRM62

Special Continuation

Plant Closing

In the case of a plant closing, or a partial closing as determined by law, the Medical Insurance for you and your Dependents will be continued until the earlier of: (a) 90 days from the date your Active Service ends; or (b) as shown in (1), (2) or (3) of the "Other Dates of Termination" section. For continuation to take effect: (a) you must continue to pay any portion of the premium for which you were responsible prior to the end of your Active Service, and, (b) your Employer must continue to pay any portion of the premium for which he was responsible before the plant closing or partial closing. If the insurance terminates because your Employer fails to pay the premium, he will be liable for any Covered Expenses incurred between the last premium payment and the end of the 90-day continuation period.

Any current collective bargaining agreement with an extension at least equal to the continuation outlined here, will prevail.

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Other Dates of Termination

(1) The date you become eligible for Medical Insurance under any other group policy or Medicare;

(2) The last day for which any required premium has been paid;

(3) With respect to any one Dependent, the earlier of: (a) the date that Dependent becomes eligible for Medical Insurance under another group policy or under Medicare, or, (b) the date that Dependent no longer qualifies as a Dependent for any reason other than your death.

Conversion Available Following Continuation

The "Medical Conversion Privilege" section will apply when the insurance ceases.

GM6000 TER1 V103

TRM386

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.

FDRL1 V2

Notice of Provider Directory/Networks

Notice Regarding Provider/Pharmacy Directories and Provider/Pharmacy Networks

If your Plan utilizes a network of Providers, a separate listing of Participating Providers who participate in the network is available to you without charge 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.

FDRL79

Qualified Medical Child Support Order (QMCSO)

A. Eligibility for Coverage Under a QMCSO

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

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

B. Qualified Medical Child Support Order Defined

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

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

The QMCSO may not require the health 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.

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C. Payment of Benefits

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

FDRL2 V1

Effect of Section 125 Tax Regulations on This Plan

If employed by the University of the Virgin Islands your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits. Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage Elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if your Employer agrees and you enroll for or change coverage within 30 days of the following:

- the date you meet the Special Enrollment criteria described above; or
- the date you meet the criteria shown in the following Sections B through F.

B. Change of Status

A change in status is defined as:

(a) change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;

(b) change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;

(c) change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;

(d) changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;

(e) change in residence of Employee, spouse or Dependent to a location outside of the Employer's network service area; and

(f) changes which cause a Dependent to become eligible or ineligible for coverage.

C. Court Order

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

D. Medicare or Medicaid Eligibility/Entitlement

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

E. Change in Cost of Coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may, in accordance with plan terms, automatically change your elective contribution.

When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

F. Changes in Coverage of Spouse or Dependent Under Another Employer's Plan

You may make a coverage election change if the plan of your spouse or Dependent: (a) incurs a change such as adding or deleting a benefit option; (b) allows election changes due to Special Enrollment, Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or (c) this Plan and the other plan have different periods of coverage or open enrollment periods.

FDRL5 M

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

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

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or

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placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; spouse only; Employee and spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, spouse and Dependent child(ren). Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage. Dependent children who were already Dependents of the Employee but not currently enrolled in the Plan are not entitled to special enrollment.

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

FDRL3 V4

- **Eligibility for employment assistance under State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective on the first day of the calendar month following receipt of the request for special enrollment.

Individuals who enroll in the Plan due to a special enrollment event will not be considered Late Entrants. Any Pre-existing Condition limitation will be applied upon enrollment, reduced by prior Creditable Coverage, but will not be extended as for a Late Entrant.

Domestic Partners and their children (if not legal children of the Employee) are not eligible for special enrollment.

FDRL4 V3

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Coverage of Students on Medically Necessary Leave of Absence

(Applies to Students Age 26 or Over When Covered Under This Plan)

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

Coverage will terminate on the earlier of:

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

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

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

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

FDRL80

Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

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

FDRL6

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.

FDRL8

Women's Health and Cancer Rights Act (WHCRA)

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

FDRL51

Group Plan Coverage Instead of Medicaid

If your income and liquid resources do not exceed certain limits established by law, 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.

FDRL75

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Pre-Existing Conditions Under the Health Insurance Portability & Accountability Act (HIPAA)

(Not Applicable To Anyone Under 19)

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.

A. 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.

B. Exceptions to Pre-existing Condition Limitation

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

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 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.

C. 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 Employer of such prior coverage, and fewer than 63 days elapse between coverage under the prior plan and coverage under this Plan, exclusive of any waiting period. Credit will be given for coverage under all prior Creditable Coverage, provided fewer than 63 days elapsed between coverage under any two plans.

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

D. 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 Production Services, 900 Cottage Grove Road, Routing C2ECC, Hartford, CT 06152. 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.

E. 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.

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F. Obtaining a Certificate of Creditable Coverage Under This Plan (Applicable to All Enrollees Regardless of Age)

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 1-800-CIGNA24 or 1-800-244-6224.

FDRL81

Requirements of Medical Leave Act of 1993 (as amended) (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, as amended, where applicable:

A. Continuation of Health Insurance During Leave

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

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

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

B. Reinstatement of Canceled Insurance Following Leave

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

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

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

FDRL74

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

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

A. Continuation of Coverage

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

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

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

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

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

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

B. Reinstatement of Benefits (applicable to all coverages)

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

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

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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.

FDRL58

Notice of an Appeal or a Grievance

The appeal or grievance provision in this certificate may be superseded by the law of your state. Please see your explanation of benefits for the applicable appeal or grievance procedure.

GM6000 NOT90

The Following Will Apply to Residents of the Virgin Islands

When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "you," "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

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

Start with Member Services

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

> Customer Services Toll-Free Number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

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

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

Appeals Procedure

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

GM6000 APL424 V1

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 (decision). We will respond within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves 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, we will respond orally with a decision within 72 hours, followed up in writing.

GM6000 APL425

Level Two Appeal

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

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or

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clinical appropriateness, the Committee will consult with at least one Physician reviewer in the same or similar specialty as the care under consideration, as determined by 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. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review 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 function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves 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, we will respond orally with a decision within 72 hours, followed up in writing.

Independent Review Procedure

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

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

In order to request a referral to an Independent Review Organization, certain conditions apply. 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 condition, as determined by CG's Physician reviewer, the review shall be completed within three days.

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

Appeal to REDACTED

You have the right to contact REDACTED for assistance at any time. REDACTED REDACTED may be contacted at the following address and telephone number:

REDACTED

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.

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

Legal Action

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

GM6000 APL428

Definitions

Active Service

You will be considered in Active Service:

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

DFS1

Bed and Board

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

DFS14

Charges

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

DFS940

Custodial Services

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

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

DFS1812

Dependent

Dependents are:

- your lawful spouse; and
- any child of yours who is
  - less than 26 years old;
  - 26 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition

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and dependence must be submitted to CG within 31 days after the date the child ceases to qualify above. During the next two years CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

A child includes a legally adopted child. It also includes a stepchild who lives with you, or a child for whom you are the legal guardian.

Benefits for a Dependent child or student will continue until the last day of the calendar month in which the limiting age is reached.

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

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

DFS57 M

Employee

The term Employee means a full-time employee of the Employer who is currently in Active Service according to the following specific definition:

- Government Employee Definition - Full Time, 40 hours per week
- Port Authority & Medical Centers Employee Definition - Full Time, 40 hours per week
- University of the VI Employee Definition - Full Time,

As determined and reported to the insurance company by your Employer.

The term does not include employees who are part-time or temporary or who do not satisfy the specific definitions shown above.

DFS1427 M

Employer

The term Employer means the Policyholder and all Affiliated Employers.

DFS212

Expense Incurred

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

DFS60

Free-Standing Surgical Facility

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

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

DFS682

Hospice Care Program

The term Hospice Care Program means:

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

DFS70

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Hospice Care Services

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

DFS599

Hospice Facility

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

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

DFS72

Hospital

The term Hospital means:

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

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

DFS1693

Hospital Confinement or Confined in a Hospital

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

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

DFS1815

Injury

The term Injury means an accidental bodily injury.

DFS147

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 percentage of a schedule developed by CG that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

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

In some cases, a Medicare based schedule will not be used and 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
- the 80th 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 Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by CG. Additional information about how CG determines the Maximum Reimbursable Charge is available upon request.

GM6000 DFS1997 V14

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Medicaid

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

DFS192

Medically Necessary/Medical Necessity

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

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

DFS1813

Medicare

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

DFS149

Necessary Services and Supplies

The term Necessary Services and Supplies includes:

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

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

DFS151

Nurse

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

DFS155

Other Health Care Facility

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

DFS1686

Other Health Professional

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

DFS1685

Participating 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.

DFS1937

Participating Provider

The term Participating Provider means a hospital, a Physician or any other health care practitioner or entity that

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has a direct or indirect contractual arrangement with CIGNA to provide covered services with regard to a particular plan under which the participant is covered.

DFS1910

Pharmacy

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

DFS1934

Pharmacy & Therapeutics (P & T) Committee

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

DFS1919

Physician

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

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

DFS164

Prescription Drug

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

DFS1708

Prescription Drug List

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

DFS1924

Prescription Order

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

DFS1711

Primary Care Physician

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

DFS622

Psychologist

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

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

DFS170

Related Supplies

Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes

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for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

DFS1710

Review Organization

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

DFS1688

Sickness – For Medical Insurance

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

DFS531

Skilled Nursing Facility

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

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

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

DFS193

Terminal Illness

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

DFS197

Urgent Care

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

DFS1534

EXHIBIT E

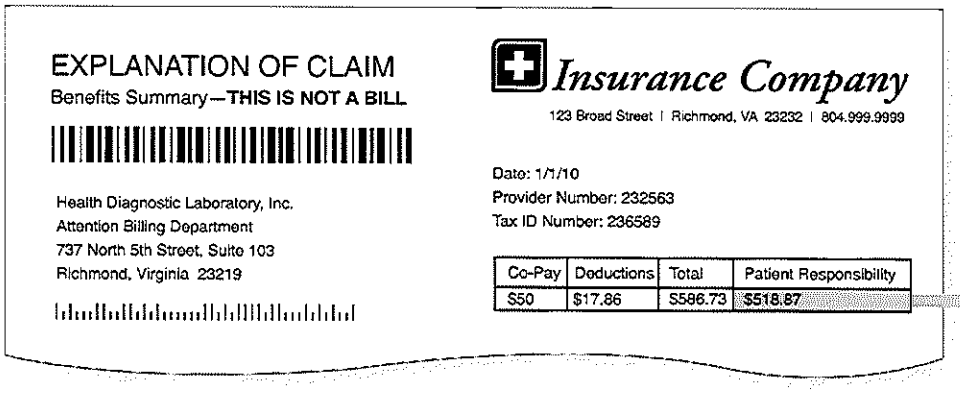
HealthDiagnosticLaboratoryInc.

Health Diagnostic Laboratory, Inc. (HDL, Inc.) Pricing Overview

- **MEDICARE / MEDICAID**
  - The entire cost of services performed by HDL, Inc. is covered.
- **PPO's, POS & HMO Plans:**
  - HDL, Inc. will accept the amount your insurance company allows for each diagnostic.
  - In other words, your "out-of-pocket" cost is ZERO for initial and follow-up testing.
  - HDL, Inc. takes all the risk if your insurance company does not pay for the ordered diagnostics.

Below you will find an example of a document that you may receive from your insurance company. This is an explanation of the insurance claim. IT IS NOT A BILL, so do not send payment. Read the document carefully as different insurance companies label their documents differently.

THE BENEFITS SUMMARY OF YOUR CLAIM IS NOT A BILL.



EXPLANATION OF CLAIM
Benefits Summary—**THIS IS NOT A BILL**

Health Diagnostic Laboratory, Inc.
Attention Billing Department
737 North 5th Street, Suite 103
Richmond, Virginia 23219

Insurance Company
123 Broad Street | Richmond, VA 23232 | 804.999.9999

Date: 1/1/10
Provider Number: 232563
Tax ID Number: 236589

Co-Pay	Deductions	Total	Patient Responsibility
$50	$17.86	$586.73	$518.87

THIS IS NOT A BILL
Your insurance company will send you a summary of benefits. Paying this amount is not the patient's responsibility.

IMPORTANT

If your insurance company sends a check directly to you, rather than HDL, Inc., please sign the back of the check and write "Pay to the Order of HDL, Inc." and forward to the address to the right.

Health Diagnostic Laboratory, Inc.
Attention: Billing Department
737 N. 5th Street, Suite 103
Richmond, VA 23219

WILL PATIENTS EVER RECEIVE A BILL FROM HDL, Inc.?

There are only **THREE** instances in which a patient would receive a bill from HDL, Inc.:

1) If HDL, Inc. learns that payment for services was sent directly to the patient and not forwarded to our billing department as requested above.
2) If the patient does not have Medical Insurance or opts for services at the Cash Price.
3) If HDL, Inc. is "In-Network" with the patient's insurance company and the patient has NOT met the patient contribution requirements (i.e. deductibles, co-pays, etc.) for lab services.

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF CONNECTICUT

CONNECTICUT GENERAL LIFE INSURANCE COMPANY; CIGNA HEALTH AND LIFE INSURANCE COMPANY **PLAINTIFFS,** **V.** **HEALTH DIAGNOSTIC LABORATORY, INC.** **DEFENDANT**	**Civil Action No.: _____**

PLAINTIFFS' ORIGINAL COMPLAINT

Plaintiffs Connecticut General Life Insurance Company and Cigna Health and Life Insurance Company (collectively, "Cigna") file this Original Complaint against Defendant Health Diagnostic Laboratory, Inc. ("HDL") and allege as follows:

INTRODUCTION

1. This case arises out of a scheme by HDL to circumvent safeguards against unreasonable and excessive charges for routine healthcare services. By means of that scheme, HDL has unlawfully obtained at least $84,000,000.00 from Cigna and the benefit plans it serves.

2. Cigna is a Connecticut managed care company that administers employee health and welfare benefit plans (including, but not limited to, plans insured by Cigna). It is part of Cigna's responsibilities to those plans to control overall healthcare costs. One way Cigna discharges that responsibility is by entering into agreements with networks of healthcare providers, under which the providers agree to accept fixed rates for services in consideration of other benefits, including access to plan members. In the plans at issue here, plan members remain

free to use providers outside these networks, but they are given incentives to remain in the network, and thereby to lower costs for the plan as a whole.

3. One such incentive involves requiring plan members to bear a portion of the cost (either through co-payment, co-insurance or deductible obligations) of treatment by out-of-network providers, who generally charge higher rates than doctors in the network. Without this obligation, out-of-network providers could demand prices from healthcare plans which have no relation either to their actual costs or to the actual market for medical services, and members would have no incentive to avoid those providers.

4. HDL, a provider of routine laboratory services that does not participate in Cigna's provider networks, undermines these safeguards by means of a fraudulent "fee forgiving" scheme. HDL lures patients from health plans that are administered or insured by Cigna by misrepresenting those patients' responsibilities under the plans, by promising not to collect any co-payment, co-insurance or deductible obligation, and by further promising not to seek reimbursement for any other portion of its bill that the plan does not cover. HDL then misleadingly bills the plans themselves at exorbitant and unjustified "phantom" rates—rates that misrepresent what HDL actually intended to collect.

5. For example, for one of the patients described below, HDL submitted "charges" of $2,979.00 to Cigna. Based on these charges, the patient's cost-sharing responsibilities under his or her plan were $649.40. However, HDL charged the patient ***nothing*.**

6. "Fee forgiving" of this kind has long been recognized as a variety of medical billing fraud. More than two decades ago, the American Medical Association advised its members: "[P]hysicians should be aware that … [r]outine forgiveness of waiver or copayments may constitute fraud under state and federal law." *See* AMA Ethics Advisory Opinion 6.12 –

Forgiveness or Waiver of Insurance Copayments (June 1993) (available at: http:/www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion612.page). In the context of the federal Medicare program, the Department of Health and Human Services reached the same conclusion: "Routine waiver of deductibles and copayments by charge-based providers, practitioners or suppliers is unlawful because it results in … false claims … [and] excessive utilization of items and services paid for by Medicare." HHS OIG Special Fraud Alerts, (Dec. 19, 1994) (available at https://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html).

7. The effect of HDL's scheme is to deceive health benefit plans into paying far more for services than the plans are obligated to pay. But misleading plan members is also essential to the scheme. By convincing patients that HDL offers services at little or no cost (when, in fact, HDL was artificially increasing the cost of healthcare to Cigna and its clients), HDL increases the volume of its business and, at the same time, increases the harm to Cigna and the plans it serves.

8. Cigna was only able to confirm HDL's fraudulent billing practices through a special investigation of HDL, after which Cigna began reducing or denying payment for claims submitted by HDL.

9. But before confirming HDL's fraudulent practices, HDL induced Cigna into paying it approximately $84 million through its fee-forgiving scheme.

10. In this action, Cigna seeks to recover the payments made to HDL and to prevent HDL from continuing its fraudulent billing scheme against Cigna.

11. By bringing this action, Cigna seeks to ensure that its clients and plan members are charged only appropriate amounts for services rendered and thereby help to maintain the affordability of healthcare coverage for individuals and employers.

PARTIES

12. Plaintiff Connecticut General Life Insurance Company is a company organized under the laws of the State of Connecticut, with its principal place of business in Connecticut.

13. Plaintiff Cigna Health and Life Insurance Company is a company organized under the laws of Connecticut, with its principal place of business in Connecticut.

14. Defendant Health Diagnostic Laboratory, Inc. is a Virginia corporation with its principal place of business in Richmond, Virginia.

JURISDICTION AND VENUE

15. This Court has personal jurisdiction over HDL, a Virginia corporation, pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et. seq.*, and its nationwide service of process provision, 29 U.S.C. § 1132(e)(2).

16. This Court also has personal jurisdiction over HDL because HDL systematically and continuously conducts business in Connecticut and otherwise has minimum contacts with this State sufficient to establish personal jurisdiction. Upon information and belief, HDL actively solicits providers and patients in Connecticut and maintains substantial commercial relationships and agreements with providers and laboratories in Connecticut, and derives revenues from services rendered in Connecticut. Upon information and belief, HDL specifically targets customers in Connecticut through the user-portal on its website, which permits providers and patients to access personal account information. In addition, this Court has personal jurisdiction over HDL pursuant to 29 U.S.C. § 1132(e)(2).

17. This Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. § 1331 because it arises under the Constitution, laws, or treaties of the United States. Specifically, Plaintiffs assert claims in this case that arise under ERISA. The Court has jurisdiction over Cigna's remaining claims pursuant to 28 U.S.C. § 1367, because the state and common law claims alleged herein are so related to the federal claims that they form part of the same case or controversy. In addition, the Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. § 1332, as there is complete diversity between Plaintiffs and Defendant, and the amount in controversy substantially exceeds $75,000.

18. Venue is proper in the District of Connecticut under 28 U.S.C. § 1391(b), because HDL conducted and continues to conduct business in Connecticut. In addition, the electronic claims submitted by HDL to Cigna are routed through Cigna's headquarters in Bloomfield, Connecticut. Venue is also proper pursuant to 29 U.S.C. § 1132(e)(2), because plans at issue are administered in this District.

FACTUAL BACKGROUND

Relevant Facts Regarding Managed Care and Cigna-Administered Plans.

19. Cigna, among other things, insures and administers employee health and welfare benefit plans.

20. The vast majority of Cigna-administered plans are Administrative Services Only ("ASO") plans funded by the employers who sponsor them, and a Cigna entity serves as the plans' claims administrator.

21. Certain Cigna entities also offer fully-insured plans, which are funded by the Cigna entity. Cigna also serves as the plans' claims administrator for fully-insured plans.

22. Regardless of the type of plan funding, Cigna is a fiduciary of each of the plans at issue, as it exercises discretionary authority over plan assets and plan administration.

23. Regardless of the type of plan funding, the plan documents authorize Cigna to recover any overpayments made by the plans on the plans' behalves.

24. The vast majority of the plans under which HDL sought benefits are governed by ERISA.

25. Most of the plans at issue offer members the choice of receiving services either from health care providers that contract with Cigna to participate in Cigna's provider network or from providers outside of that network.

26. Cigna-administered health plans reimburse their members for certain healthcare costs, defined in the plans as "Covered Expenses." When a Cigna plan member receives medical services, Cigna determines what part of the member's cost is considered for coverage by the plan, known as the "allowed amount."

27. There are different types of member responsibility, including deductibles (minimum thresholds that the member must pay before the plan will pay any portion of the covered charge), benefit limits, co-payments (fixed rates for covered services), and co-insurance (percentages of providers' charges).

28. These member cost-sharing responsibility amounts are calculated as a percentage or portion of the allowed amount.

29. If a member receives a service from a provider that contracts to be part of Cigna's network (an "in-network" or "participating" provider), the plan pays the provider the amount that the provider agreed to accept (the provider's contracted network rate), and the member pays any

applicable co-insurance, co-payments, and deductibles based on the coverage for in-network services specified in the member's plan.

30. In exchange for agreeing to accept fixed, network rates for their services, participating providers receive certain benefits, including access to members of Cigna-administered plans as a source of patients.

31. Just as it benefits participating providers, Cigna's network arrangements benefit employers and plan members by controlling overall health care costs and increasing the quality of medical care. In addition, members benefit from obtaining services from a participating provider, because participating providers agree not to bill them for any difference between the plan's reimbursement to the participating provider and the provider's billed charges.

32. In contrast, if a member receives a service from a provider who does not contract to be part of Cigna's provider network (an "out-of-network" or "non-participating" provider), the provider can charge whatever it likes for its services—and out-of-network rates are generally higher than contracted rates. Furthermore, the provider may bill the member for any portion of the provider's charges, over and above the member's cost-sharing responsibility under the plan, which the plan does not reimburse.

33. To make out-of-network benefits an affordable option for the employers sponsoring them, Cigna's plans contain various financial incentives for members to choose participating providers and to share the increased costs associated with obtaining out-of-network services.

34. One of the key ways in which Cigna's plans allocate out-of-network costs between employees and employers is through co-insurance—a percentage of the amount that the plan covers (or "allows") that the member is required to pay towards the cost of that service. The

co-insurance that members must pay towards out-of-network services is usually much higher than the co-insurance (if any) they must pay towards in-network services.

35. This co-insurance requirement underlies the entire concept of out-of-network benefits. It sensitizes members to the true costs of out-of-network services, ensuring that, if a member receives such a service, he is willing to pay a greater portion of that expense out of his own pocket. If patients did not share in these costs, then they would have no financial incentive to moderate their demand for out-of-network services or to consider the higher costs of any particular out-of-network service, leading to increased costs for the plan.

36. Similarly, without co-insurance requirements, out-of-network providers would have no incentive to keep their rates competitive. Generally, patients would not receive services from an out-of-network provider that charges unreasonably high rates, because the member would have to pay a fixed portion of that unreasonable rate to satisfy his or her co-insurance and cost-sharing responsibilities.

37. Cigna's plans have several mechanisms to ensure that members receiving out-of-network services pay their required co-insurance and that non-participating providers do not waive it.

38. For instance, the portion of the Cigna-administered plans labeled "Exclusions, Expenses Not Covered and General Limitations" state that the plans do not cover "charges which you [the member] 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." This language is taken from Exhibit A, the plan covering Patient A, who is one of the patients described below. The language is representative of the language found in Cigna-administered plans covering HDL's patients.

39. Here, for example, if HDL submits "charges" of $10,000 to Cigna, but does not obligate the patient to pay the portion of that amount that is his or her responsibility under the plan; if the provider does not bill the patient for those "charges;" or if it does so only because of the coverage available under the plan, and not for the purpose of collecting any portion of the charges from the patient, then the $10,000 charges are "phantom" charges, and the plan excludes coverage for them.

40. As an additional safeguard, Cigna-administered plans generally limit reimbursement for out-of-network services to the "Maximum Reimbursable Charge" for "covered services," which may be no more than the "provider's normal charge for a similar service or supply." This provision explicitly excludes from coverage any charges, "to the extent that they are more than Maximum Reimbursable Charges."

41. Thus, if HDL submits a bill $10,000 for services, but HDL has actually agreed to accept a substantially lower amount in full payment of its services, HDL's bill exceeds its "normal charge" for those services, and the excess is not covered.

42. Finally, Cigna-administered plans do not automatically cover or reimburse a member for every "charge" the provider submits to Cigna; rather, the plans cover a portion of any "Covered Expenses," which the plans define as "expenses incurred" by or on behalf of the member. Covered Expenses are in turn subject to the applicable co-insurance, co-payments, and deductibles set forth in the plans. Cigna-administered plans define co-insurance as "the percentage of charges for Covered Expenses that an insured person is ***required*** to pay under the plan." Thus, Cigna-administered plans expressly require members to satisfy their cost-sharing responsibility (i.e. co-insurance, co-payments, and deductibles) in order for charges to be covered under the plans.

43. Thus, where HDL has agreed in advance that it will not require the plan member to pay either the member's cost-sharing responsibility or any other portion of HDL's "charges" that the plan does not cover, the plan member has "incurred" no expenses at all, and the plan is not obligated to pay HDL.

HDL's Fraudulent Fee-Forgiving Scheme

44. HDL has developed a business model designed to game the healthcare system by submitting grossly inflated, phantom "charges" to Cigna that do not reflect the actual amount HDL bills patients. The outline of HDL's scheme is simple. HDL misrepresents to members of Cigna-administered plans that they may receive services from HDL without incurring any financial obligation, and that Cigna will be responsible for the cost of services delivered under these conditions. After luring plan members in this way, HDL submits charges to Cigna at astronomical rates, which are much higher than the "normal charge" HDL actually intends to accept as payment in full. Cigna then relies on the representations in HDL's bills, by paying more for HDL's services than it is obligated to pay under the relevant plans.

45. HDL typically does not join provider networks of major managed care companies, like Cigna, instead opting to remain an "out-of-network" provider.

46. HDL entices members to use its out-of-network services by expressly promising (i) not to collect any part of the members' cost-sharing responsibility, and (ii) not to seek to recover any other portion of its "charges" for which it fails to obtain reimbursement from the plan.

47. For example, one HDL document directed to patients (attached hereto as Exhibit B) states:

- HDL, Inc. will accept the amount your insurance company allows for each diagnostic.

- In other words, your 'out-of-pocket' cost is ZERO for initial and follow-up testing.
- HDL, Inc. takes all the risk if your insurance company does not pay for the ordered diagnostics.

48. This HDL document goes on to explain to patients how to interpret the explanation of benefits (or "EOB") forms patients receive from their insurance company. (*See id*.)

49. Typically, EOBs include a section titled "Patient Responsibility," which is the amount the member is responsible for paying the provider after the plan has covered its portion of the provider's charges. Remarkably, HDL tells patients with respect to the "Patient Responsibility" amount that "[p]aying this amount is not the patient's responsibility." (*Id.*)

50. Thus, as part of its fraudulent scheme, HDL affirmatively misleads patients about the nature of their health insurance benefits.

51. Another HDL brochure likewise assures patients that "[l]ab costs and bills are worry-free with HDL, Inc." because "if it turns out your insurance company does not cover a specific test, HDL, Inc. assumes all the risk." (Ex. C.) This brochure provides a sample EOB that shows an amount labeled "Patient Responsibility," and it advises patients that "[y]ou DO NOT PAY the amount the insurance company says is the patient responsibility." (*Id.*)

52. To take a simplified example, HDL might submit a claim to Cigna for $10,000 for services provided to a Cigna member. Assuming the entire amount was "allowable" under Cigna's plan, and the patient's coinsurance responsibility for out-of-network services is 40%, the patient would pay $4,000 to HDL and Cigna would pay the remaining $6,000 to HDL (assuming the patient had already met his or her deductible, and that no other limits applied). However, HDL waives this $4,000 patient responsibility and only seeks to collect the $6,000 from Cigna.

53. Because no patient is actually paying based on HDL's listed "charges" to Cigna, patients have no incentive to moderate their demand for HDL's services or to consider the higher costs of any particular out-of-network service, leading to increased costs for the plan. Similarly, without co-insurance requirements, HDL has no incentive not to charge the plan astronomical rates, because the patients who choose to receive those services would not bear any more of the inflated cost.

54. As other courts have noted, this makes the $10,000 amount submitted to Cigna a "phantom" charge, as HDL does not collect, and never intends to collect, the full amounts that it puts on the claim forms submitted to Cigna.

55. Indeed, the charges HDL submitted to Cigna were highly inflated, with HDL often submitting "charges" that were often at least two to three (or more) times higher than Medicare rates for similar services.

56. Consequently, HDL misrepresented its actual charges for the services rendered to Cigna affirmatively and through omission. As a result, Cigna relied on the amount that HDL billed to Cigna in its claim forms when processing and paying HDL's claims.

57. Courts have repeatedly held in the context of "fee forgiving" that healthcare plans do not cover a provider's "charges" when that provider does not collect the patient's applicable cost-sharing responsibilities. *See, e.g.*, *Kennedy v. Conn. Gen. Life Ins. Co.*, 924 F.2d 698, 701 (7th Cir. 1991); *Biomed Pharms., Inc. v. Oxford Health Plans (NY), Inc.*, 522 F. App'x 81, 81-82 (2d Cir. 2013); *see also* HHS OIG Special Fraud Alerts (Dec. 19, 1994) (available at https://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html) ("Routine waiver of deductibles and copayments by charge-based providers, practitioners or suppliers is unlawful because it results in … false claims … [and] excessive utilization of items and services paid for by

Medicare."); N.Y. D.F.S. Opinion 08-0404 "Re: Health Insurance, Waiver of Deductibles and Co-Insurance" (April 2, 2008) ("If a health care provider, as a general business practice, waives otherwise required co-insurance requirements, that provider may be guilty of insurance fraud.").

58. Any other interpretation would run contrary to the purpose of health insurance, which is to reimburse members for payments they actually make to providers, not to provide windfall payments to providers.

59. Eliminating patients' responsibility to pay more towards out-of-network services also undermines Cigna's ability to offer quality in-network services. By charging patients nothing for out-of-network services, patients actually have an incentive to use HDL's higher cost services rather than lower in-network services. Without the incentive to use in-network services, providers will have a reduced incentive to join Cigna's network, leaving that network less robust and stripping employers of the ability to offer health care in an affordable way.

60. HDL's practice of forgiving plan members' financial responsibility is exactly the sort of scheme certain states have declared illegal and enacted statutes to stop. *See* Colo. Rev. Stat. Ann. §18-13-119 (West 2011); Fla. Stat. § 817.234(7); Tex. Ins. Code. Ann. § 1204.055. In light of these statutes, HDL has indicated that it will cease its fee-forgiving activities in Florida and Colorado.

HDL's Other Unlawful Conduct

61. Upon information and belief, HDL has adopted several other unlawful practices to increase its revenue from plans and plan administrators like Cigna.

62. For instance, upon information and belief, HDL (either directly or through a sales agent) encourages physicians and other healthcare providers to order a litany of medical tests, regardless of whether the provider believes such tests are needed to diagnose or treat the patient,

thus inflating the total charges that HDL submits to the patient's plan. HDL assures the providers that the patient will not complain if the patient's plan does not cover these tests because, pursuant to the fee-forgiving practices described above, HDL never bills its patients anything for the services at issue.

63. Moreover, and also upon information and belief, HDL has paid providers fees in exchange for referring patients to HDL for testing, including patients who are members of Cigna-administered plans.

64. In order to control healthcare costs, Cigna's contracts with its in-network providers require those providers to refer patients to other in-network providers and facilities for non-emergency services like the ones provided by HDL. Thus, by paying fees to providers to refer patients to HDL for testing, HDL has encouraged and has caused Cigna's in-network providers to violate the terms of their contracts with Cigna.

65. Indeed, the United States Department of Health and Human Services' Office of Inspector General has investigated HDL in connection with the fees HDL pays to providers. On June 25, 2014, the Office of Inspector General issued a Special Fraud Alert stating that such payments by laboratories are not only improper, but also implicate the federal Anti-Kickback Statute.

Cigna's Investigation of HDL

66. HDL never fully disclosed the true nature, extent and scope of its cost share waiver scheme to Cigna.

67. Only through its own internal investigation did Cigna learn the existence of HDL's fee forgiving scheme.

68. In the course of its investigation of HDL, Cigna came across the HDL brochures and flyers described above (*supra* ¶¶ 44-65) which indicated that HDL waived patient cost-sharing responsibilities.

69. In order to confirm and better understand HDL's billing practices, in February 2013, Cigna's Special Investigations Unit ("SIU") began sending questionnaires to Cigna members who received HDL's services.

70. These questionnaires asked the member to report how much they were billed by HDL.

71. Cigna received responses from at least 27 members who received the questionnaires.

72. Despite the fact that all of these members owed hundreds of dollars (and in some cases over $1,000) in cost-sharing responsibilities, HDL did not bill any of the 27 members ***anything***.

73. Several of these members confirmed that HDL accepted the plan's payment as payment in full.

74. As described above, HDL's brochures and documents sought to affirmatively mislead and confuse patients about HDL's billing practices and the patients' health insurance benefits. (*Supra* ¶¶ 44-65.) HDL's patients' responses to Cigna's questionnaires further confirmed that HDL, as well as the doctors who saw Cigna patients and referred the patients to HDL, provided the patients with false information about HDL's billing practices and the patients' health insurance benefits.

75. For example, one HDL patient reported to Cigna that "my doc says that all the billing is refunded by HDL. They are trying to get their data more widely accepted." Another

HDL patient reported that the doctor's office told the patient not to pay any money to HDL "as it was covered" and "part of a pilot/test."

76. The following are just two of the many examples demonstrating how HDL's fraudulent scheme operates.

77. On or about March 19, 2012, HDL performed laboratory services for Patient A.

78. HDL submitted a claim form to Cigna listing its charges as $1,484.00. These charges were more than double Medicare rates, which would have been approximately $723.00 for the services at issue.

79. Based on HDL's representation, Cigna calculated Patient A's responsibility to be $707.52 under the patient's plan. However, HDL did not charge Patient A this amount. Instead, HDL charged Patient A ***nothing***.

80. Cigna calculated the plan's responsibility to be $461.28 based on the charges submitted by HDL, and Cigna and paid this amount to HDL.

81. Thus, as a result of the misrepresentations and material omissions contained within its claim, HDL induced Cigna to pay HDL $461.28.

82. On or about August 24, 2012, HDL performed laboratory services for Patient B.

83. HDL submitted a claim form to Cigna listing its charges as $2,979.00.

84. Based on HDL's representation, Cigna calculated Patient B's responsibility to be $649.40 under the patient's plan. However, HDL did not charge Patient B this amount. Instead, HDL charged Patient B ***nothing***.

85. Cigna calculated the plan's responsibility to be $1,742.20 based on the charges submitted by HDL, and Cigna and paid this amount to HDL.

86. Thus, as a result of the misrepresentations and material omissions contained within its claim, HDL induced Cigna to pay HDL $1,742.20.

87. Upon information and belief, each of the many thousands of claims that HDL submitted to Cigna followed this pattern of fee forgiving.

88. As the collective result of HDL's conduct, Cigna has paid HDL approximately $84 million in claims to date.

89. HDL continues to submit claims to Cigna. Upon information and belief, HDL continues to waive the applicable out-of-network co-insurance, co-payment, and deductible responsibilities of Cigna plan members to entice Cigna plan members to use HDL's services, while simultaneously submitting exorbitant, fraudulent "charges" to Cigna.

90. In addition, when Cigna contacted HDL to inquire regarding its billing practices, HDL took additional steps to conceal its improper billing practices from Cigna. For example, in response to a letter from Cigna questioning HDL's billing practices, on April 12, 2011, HDL's founder and former President and CEO Tonya Mallory "assure[d] Cigna that HDL will not engage in a general practice of accepting as payment in full the payments made by Cigna where deductible or copayments apply."

91. Ms. Mallory "also assure[d] Cigna that all claim forms and bills submitted to Cigna by HDL or on its behalf will indicate the actual charge for the services(s) provided."

92. These and other similar misrepresentations by HDL concealed the true nature of its billing practices from Cigna.

CAUSES OF ACTION

Count I – Claim for Overpayments Under ERISA § 502(a)(3)

93. The preceding paragraphs are incorporated by reference as if set forth fully herein.

94. Cigna is a fiduciary of the ASO and fully-insured plans that it administers and seeks to recover overpayments made by those plans to HDL.

95. The charges that HDL listed in claims forms submitted to Cigna for reimbursement on behalf of the members' plans did not represent the amount that HDL actually intended to require or accept as payment in full for its services.

96. Specifically, HDL did not require plan members to pay their out-of-network cost sharing responsibility, which is required under the terms of the members' plans. HDL also represented to plan members that they would not be responsible for any other portion of HDL's "charges" that were not reimbursed by the plan.

97. HDL's patients' plans expressly do not cover any portion of the charges that providers like HDL do not require plan members to pay, nor do they require the plan to cover anything in excess of HDL's normal charges to its patients.

98. By paying HDL what HDL deceived Cigna into believing to be the covered portions of charges that HDL never, in fact, intended to collect in full, and, in connection with which, HDL never intended to charge for or collect the obligations of plan members, these plans overpaid HDL.

99. These overpayments were made directly by Cigna to HDL.

100. These overpayments belong in good conscience to the plans because the plans managed by Cigna made benefit payments to HDL for services provided to plan members based on the charges that HDL listed on the claim forms that it submitted to Cigna.

101. The plan documents authorize Cigna to recover any overpayments made by the plans on the plans' behalves.

102. These overpayments are within the possession and control of HDL and are specifically identifiable.

103. These overpayments were made in contravention of plan terms.

104. Cigna seeks recovery of these overpayments on behalf of the plans.

105. Additionally, Cigna seeks a permanent injunction directing HDL to submit to Cigna only charges that HDL actually charges the plan member as payment in full for HDL's services and not to submit charges which include amounts that HDL does not actually require the member to pay (including, without limitation, the waiver of any portion of the members' required out-of-network co-insurance, co-payment, and deductible amounts).

Count II – Unjust Enrichment

106. Paragraphs 1-92 are incorporated by reference as if set forth fully herein.

107. HDL has been unjustly enriched as a result of its fraudulent billing practices.

108. Cigna's plans are required to cover some portion of the actual charges for services that plan members receive from out-of-network providers like HDL. Cigna's plans are not required to cover amounts that members are not billed, are not obligated to pay, or for which they would not have been billed if they did not have insurance. Neither are they required to cover a portion of a phantom charge that does not represent the amount the provider actually plans to

collect. Cigna's plans are also not required to cover amounts that exceed the Maximum Reimbursable Charge, as that term is defined in the plans.

109. HDL submitted benefit claim forms to Cigna falsely stating "charges" for services that were higher than the actual amounts that HDL required Cigna's plan members to pay for those services. Based on these forms, Cigna processed benefits for services provided by HDL to Cigna plan members based upon these falsely-stated "charges." Cigna paid these benefits directly to HDL.

110. When Cigna paid benefits to HDL that Cigna's plan were not obligated to cover, HDL obtained a benefit from Cigna by HDL's fraud in falsely stating "charges" for its services that were higher than the actual amounts that HDL required Cigna's plan members to pay for those services. Therefore, it would be inequitable for HDL to retain these benefits.

111. As a result of this conduct, Cigna suffered significant damages. Specifically, HDL received payments of approximately $84 million from Cigna.

Count III – Fraud

112. Paragraphs 1-92 are incorporated by reference as if set forth fully herein.

113. HDL's conduct constitutes fraud.

114. At the time HDL submitted claims to Cigna for reimbursement, HDL knew that the material statements and representations about its charges for services were false.

115. HDL knew and intentionally failed to disclose material information regarding the manner, extent, and nature by which HDL waived Cigna members' required out-of-network co-payments, deductibles, co-insurance, and other patient cost-sharing responsibility for the services provided to plan members.

116. HDL knew that the claims submitted to Cigna reflected false and inflated charges that HDL did not charge their patients.

117. HDL submitted the claims to Cigna with the intent to defraud Cigna by inducing Cigna to rely on their false representations and omissions alleged herein to pay these fraudulent charges.

118. The misrepresentations were material, as Cigna must rely on claim forms submitted by providers like HDL, for, among other things, determining how much of the provider's charge is covered by the plan and how much the patient owes in cost-sharing responsibility.

119. Cigna reasonably relied on such material false statements and omissions and paid the false and misleading claims submitted by HDL, resulting in compensable injury to Cigna.

120. Moreover, as described above, when Cigna inquired with HDL regarding HDL's billing practices, HDL actively concealed the true nature of its billing practices.

121. As a result of this conduct, Cigna suffered significant damages. Specifically, as result of this conduct, HDL received payments of approximately $84 million from Cigna as a result of HDL's fraudulent conduct.

Count IV – Negligent Misrepresentation

122. Paragraphs 1-92 are incorporated by reference as if set forth fully herein.

123. HDL's conduct constitutes negligent misrepresentation.

124. HDL submitted benefit claim forms to Cigna regarding services that it provided to Cigna plan members; HDL did so in the course of its business and had a pecuniary interest in the outcome of how Cigna processed benefits for those services, as any benefits for those services were paid directly to HDL.

125. In submitting benefit claim forms to Cigna, HDL falsely stated "charges" for its services that were higher than the actual amounts that HDL required Cigna's plan members to pay for those services; HDL supplied this false information to guide Cigna in processing benefits for those services.

126. In submitting benefit claim forms to Cigna, HDL did not identify the actual amounts that HDL required Cigna's plan members to pay for those services, only falsely-stated "charges" that were higher than these amounts; in so doing, HDL failed to exercise reasonable care or competence in communicating information regarding its charges to Cigna.

127. Based upon the forms submitted by HDL, Cigna processed benefits for services provided by HDL to its members based upon the falsely-stated "charges" stated on the forms submitted by HDL; thus, each time Cigna processed a claim based upon a falsely-stated charge, it suffered a pecuniary loss because it justifiably relied on HDL's communications.

128. The misrepresentations were material, as Cigna must rely on claim forms submitted by providers like HDL, for, among other things, determining how much of the provider's charge is covered by the plan, and how much the patient owes in cost-sharing responsibility.

129. Cigna reasonably relied on such material false statements and omissions and paid the false and misleading claims submitted by HDL, resulting in compensable injury to Cigna.

130. Moreover, as described above, when Cigna inquired with HDL regarding HDL's billing practices, HDL actively concealed the true nature of its billing practices.

131. As a result of this conduct, Cigna suffered significant damages. Specifically, as result of this conduct, HDL received payments of approximately $84 million from Cigna as a result of HDL's conduct.

Count V – Tortious Interference with Contract

132. Paragraphs 1-92 are incorporated by reference as if set forth fully herein.

133. HDL's conduct constitutes tortious interference with contract.

134. Each of the members for whom HDL submitted benefits claims and received payment from Cigna received health care benefits pursuant to a benefit plan insured and/or administered by Cigna.

135. Each of the plans pursuant to which HDL submitted claims and received payment contained, among other things, provisions that required the member to pay their cost-sharing responsibility (e.g., co-payments, co-insurance, and deductibles) in order for the plan to cover a portion of the submitted charges for services.

136. HDL knew that its patients' plans required the patients to pay for a portion of the charges that HDL submitted to Cigna in the form of co-payments, co-insurance, and deductibles.

137. Despite this knowledge, HDL engaged in a fee-forgiving scheme designed to bill Cigna and its ASO clients exorbitant charges, while waiving the portion of these charges that the patients were required to pay under the terms of their respective plans.

138. As part of this scheme, HDL induced its patients to breach the terms of their plans with Cigna and Cigna's ASO clients by misleading those members about their healthcare benefits, so that the members believed they did not have to pay the amounts that they were in fact required to pay under their contracts with Cigna and Cigna's ASO clients.

139. HDL's scheme not only caused HDL's patients to breach the terms of their plans with Cigna and Cigna's ASO clients, allowing HDL to collect far more from Cigna than it was entitled to under the terms of the patients' plans, but also harmed Cigna's contractual relationship with its in-network providers and potential in-network providers by undermining

and circumventing Cigna's provider network system, and upon information and belief, causing such providers to breach their contracts with Cigna.

140. Specifically, as described above, upon information and belief, HDL paid referral fees to Cigna's in-network providers to encourage those providers to refer patients to HDL for testing, even though Cigna's contracts with its providers require the providers to refer patients to in-network providers for non-emergency services like the ones provided by HDL. Thus, HDL caused those in-network providers to breach the terms of their contracts with Cigna.

141. HDL's tortious interference has caused damages to Cigna by causing it to make approximately $84 million in overpayments to HDL. HDL has caused further damages to Cigna by damaging its contractual relationship with members by misleading those members about the terms of their plans, and by causing Cigna's in-network providers to violate the terms of their contracts with Cigna by referring patients to HDL.

Count VI – Claim for Unfair and Deceptive Business Practices Under Connecticut's Unfair Trade Practices Act and Unfair Insurance Practices Act

142. Paragraphs 1-92 are incorporated by reference as if set forth fully herein.

143. The Connecticut Unfair Trade Practices Act ("CUTPA") proscribes "unfair or deceptive acts or practices in the conduct of any trade or commerce." HDL's conduct, described above, constitutes unfair or deceptive practices in trade and commerce. *See* CUTPA § 42-110b.

144. HDL violated CUTPA by deceiving consumers into using its services through false representations about consumers' cost-sharing obligations and other responsibilities under Cigna-administered plans, thereby causing Cigna to pay tens of millions of dollars in false charges through HDL's fee-forgiving scheme.

145. HDL knew that its patients' plans required the patients to pay for a portion of the charges that HDL submitted to Cigna in the form of co-payments, co-insurance, and deductibles.

146. Despite this knowledge, HDL engaged in a fee-forgiving scheme designed to bill Cigna and its ASO clients exorbitant charges, while waiving the portion of these charges that the patients were required to pay under the terms of their respective plans.

147. HDL made knowing misrepresentations to patients about the terms of their benefit plans and the significance of communications (such as EOBs) from plan administrators like Cigna. HDL also deceived Cigna by submitting false, grossly inflated charges to Cigna that did not reflect HDL's actual charges to patients.

148. Indeed, while in-network providers sign contracts with Cigna whereby Cigna and the provider agree to specified rates for medical services, HDL has not entered Cigna's provider network which specifies the rates HDL may charge.

149. HDL's fraudulent fee-forgiving scheme has and continues to harm Cigna's business.

150. Cigna has suffered injury and damages as a result of HDL's deceptive and unfair practices.

151. In addition, upon information and belief, HDL paid referral fees to Cigna's in-network providers to encourage those providers to refer patients to HDL for testing, even though Cigna's contracts with its providers require the providers to refer patients to in-network providers for non-emergency services like the ones provided by HDL. Thus, HDL caused those in-network providers to breach the terms of their contracts with Cigna.

152. HDL's conduct has caused damages to Cigna by causing it to make approximately $84 million in overpayments to HDL and by harming the relationship between Cigna and its plan members, as well as the relationship between Cigna and its in-network providers.

153. HDL's unethical, unscrupulous, and immoral billing practices offend public policy, as set forth above, including state and federal laws and an AMA advisory opinion. Also as set forth in detail above, these practices have harmed Cigna, Cigna's plan members, and consumers by artificially inflating the costs of healthcare services generally.

Count VII – Declaratory Relief

154. Paragraphs 1-92 are incorporated by reference as if set forth fully herein.

155. Under the Declaratory Judgment Act, the Court "may declare the rights and other legal relations of any interested party seeking such declaration, whether or not further relief is or could be sought." 28 U.S.C. § 2201(a).

156. HDL provides services to patients receiving medical care who are covered under employee health and welfare benefit plans that are insured or administered by Cigna.

157. The claims that HDL submitted, and continues to submit, are claims for reimbursement for services provided to patients who are purportedly covered under employee health and welfare benefit plans that are insured or administered by Cigna.

158. As described in the preceding paragraphs, the claims HDL submits are for charges that are not covered under the relevant plans because the claims are based on false charges submitted to Cigna, HDL failed to bill and collect the true out-of-network cost share responsibility from the Cigna plan members, and HDL did not hold the plan members responsible for the amounts charged to Cigna.

159. As a result, any claims submitted by HDL are not reimbursable, and any payments HDL received under such claims should be returned to Cigna.

160. An actual controversy exists between HDL and Cigna regarding whether claims for reimbursement are covered and payable under employee health and welfare benefit plans that are insured or administered by Cigna.

161. Cigna seeks a declaration that the claims for reimbursement submitted by HDL are not for covered services and are not payable under employee health and welfare benefit plans that are insured or administered by Cigna. Cigna also seeks a declaration that HDL must return all sums received from Cigna.

162. Cigna also seeks recovery of its reasonable and necessary attorneys' fees and costs.

JURY DEMAND
(As to Non-ERISA Claims Only)

163. Paragraphs 1-92 are incorporated by reference as if set forth fully herein.

164. With respect to Cigna's non-ERISA claims, Cigna hereby demands a trial by jury.

PRAYER FOR RELIEF

Based on the foregoing, Cigna prays that the Court enter a judgment awarding the following:

a. a declaration that the products and services provided by HDL do not constitute covered services under the employee health and welfare benefit plans administered or insured by Cigna and that HDL is not entitled to receive any payments on the claims for reimbursement that it has submitted or may submit in the future as part of the fee-forgiving practices described above in Paragraphs 44-65;

b. return of any all monies paid to HDL on claims for reimbursement submitted by HDL;

c. monetary damages for all harm suffered as a result of HDL's conduct;

d. exemplary and punitive damages;

e. pre-judgment and post-judgment interest;

f. the reasonable and necessary attorneys' fees incurred;

g. costs of court; and

h. such other and further relief to which they may show themselves entitled in law or equity.

DATED this 15th day of October, 2014.

Respectfully submitted,

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**To Be Admitted Pro Hac Vice*