Vermont Association of Chamber Executives

OPEN ACCESS PLUS
MEDICAL BENEFITS

$1,000 Deductible Plan

EFFECTIVE DATE: January 1, 2009

CN021
3212892

This document, printed in May, 2009, takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

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

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

a CIGNA company (called CG) certifies that it insures certain Members for the benefits provided by the following policy(s):

POLICYHOLDER: Vermont Association of Chamber Executives

$1,000 Deductible Plan

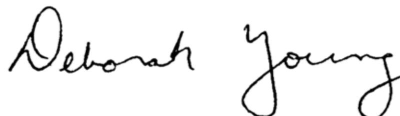
GROUP POLICY(S) — COVERAGE

3212892-OAP3 — OPEN ACCESS PLUS MEDICAL BENEFITS

EFFECTIVE DATE: January 1, 2009

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.



Deborah Young, Corporate Secretary

CER7V21 M

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 within the text, or in the "Definitions" section.

Unless the context dictates otherwise, use of the male pronoun in this certificate will be deemed to include the female.

The Schedule

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

Special Plan Provisions

When you select a Participating Provider, this Plan pays a greater share of the costs than if you select a non-Participating Provider. Participating Providers include Physicians, Hospitals and Other Health Care Professionals and Other Health Care Facilities. Consult your Physicians Guide, which is available on-line at www.mycigna.com, 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 telephone number shown on the back of your ID card.

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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 telephone 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 telephone 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.

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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.

(1) You, your Dependent, or an attending Physician can request Case Management services by calling the toll-free telephone 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 M

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

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

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

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

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

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Additional Programs

CG may, from time to time, offer or arrange for various entities to offer discounts, benefits or other consideration to Members for the purpose of promoting their general health and well-being. Contact CG for details of these programs.

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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 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 date on 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 M

Important Notices

Vermont Mandatory Civil Unions Endorsement for Health Insurance

Purpose:

Vermont law requires that health insurers offer coverage to parties to a civil union that is equivalent to coverage provided to married persons. This endorsement is part of, and amends, this policy, contract, or certificate to comply with Vermont law.

Definitions, Terms, Conditions, and Provisions

The definitions, terms, conditions, and any other provisions of the policy, contract, certificate, and/or riders and endorsements to which this mandatory endorsement is attached are hereby amended and superseded as follows:

Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage," "spouse," "husband," "wife," "dependent," "next of kin," "relative," "beneficiary," "survivor," "immediate family" and any other such terms include the relationship created by a civil union established according to Vermont law.

Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage," "divorce decree," "termination of marriage" and any other such terms include the inception or dissolution of a civil union established according to Vermont law.

Terms that mean or refer to family relationships arising from a marriage, such as "family," "immediate family," "dependent," "children," "next of kin," "relative," "beneficiary," "survivor" and any other such terms include family relationships created by a civil union established according to Vermont law.

"Dependent" means a spouse, party to a civil union established according to Vermont law, and a child or children (natural, stepchild, legally adopted or a minor or disabled child who is dependent upon the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

"Child" or "covered child" means a child (natural, stepchild, legally adopted or a minor or disabled child who is dependent upon the insured for support and maintenance) who is born to or brought to a marriage or to a civil union established according to Vermont law.

GM6000 NOT64

Caution: Federal Rights May or May Not Be Available

Vermont law grants parties to a civil union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections, and responsibilities related to health insurance that are available to married persons under federal law may not be available to parties to a civil union. For example, federal law controls group health insurance continuation rights under "COBRA" for employer groups with 20 or more employees, as well as the Internal Revenue Code treatment of health insurance premiums. As a result, parties to a civil union and their families may or may not have access to certain benefits under this policy, contract, certificate, rider or endorsement that derive from federal law. You are advised to seek expert advice to determine your rights under this contract.

GM6000 NOT65 M

Our Commitment to Quality

One of our goals is to work with network doctors to give you access to quality care and programs. The CIGNA HealthCare Quality Management Program is based on industry standards and objective measures. These help us evaluate the quality of care and

services received by our members. The Program helps us focus our improvement efforts. The Program allows for input from our members and providers. This is done through regular analysis of certain items. The findings are reported to quality committees. They help us target areas in need of improvement and monitor change. The items are:

- credentialing process for qualified doctors;
- ongoing assessment of clinical activities and services provided to our members;
- Utilization Management activities and programs for our members;
- program dedicated to communicating and administering member rights and responsibilities.

Our providers and members serve on local health plan Quality Committees. If you wish to be on the committee, call 1-800-531-4584, x67170. Or write to us at the address on your ID card.

Program Results

Measuring Success with HEDIS® and CAHPS®

We evaluate our health plan by using the Healthcare Effectiveness Data and Information Set (HEDIS®)* which measures success in providing preventive health care benefits, and the Consumer Assessment of Healthcare Providers Systems (CAHPS®)** survey tool which measures member satisfaction. We look for opportunities for improvement in the next year. Here are the results from the Vermont 2008 HEDIS® measurement and CAHPS® survey:

2008 HEDIS Rates (2007 Data Reported in 2008) **Depicts rates among CIGNA HealthCare members in Vermont for receiving preventive healthcare services**	
Breast Cancer Screening: Total (Age 40-69)	72.12%
Cervical Cancer Screening	72.40%
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	91.39%
Comprehensive Diabetes Care Hemoglobin A1c (HbA1c) testing Medical attention for nephropathy	 80.81% 79.63%
Use of Appropriate Medications for People With Asthma: Total (Age 5-56)	91.29%
Certain HEDIS measures allow plans the option to choose medical record data collection methodology. Please note that this option currently applies only to HMO/POS plans. PPO data is based on claims data collection methodology only. Comparisons between PPO and HMO/POS rates should therefore be considered with caution for certain measures.	

2008 CAHPS Rates (2007 Data Reported in 2008) **Depicts member satisfaction with CIGNA HealthCare in Vermont**	
Claims Processing	90.03%
Customer Service	81.97%
Getting Care Quickly	91.63%
Getting Needed Care	88.93%
Doctor's Communication	95.15%

* HEDIS® is a registered trademark of the National Committee for Quality Assurance.

** CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

To learn more about our quality management program or to request a report on our progress in meeting our goals, call 1-800-531-4584, x67170.

Resources

CIGNA Healthcare is committed to giving you access to the latest information about our programs, as well as details about key guidelines and procedures. Log on to www.mycigna.com and go to the My Health page to view:

- Cost and Quality Resources, including tools that provide patient safety-related information
- Health Management Resources such as a health risk assessment tool, on-line coaching programs and A-Z resource topics
- Condition and Wellness Resources such as weight and nutrition, tobacco cessation and fitness
- Preventive Health Guidelines/Recommendations
- On-line Provider Directory

Your Role

CIGNA HealthCare values your input and suggestions to improve care to our members. Your participation in plan surveys gives us feedback on plan performance and policy developments. You have the opportunity to provide input on our policies, serve on our health plan quality committee, and volunteer to participate in focus groups and surveys. Should you wish to provide feedback to the Quality Management Department, or to receive more information about the CIGNA HealthCare Quality Management Program, the annual program evaluation or chronic care or preventive health measures, please call 1-800-531-4584, x67170.

GM6000 NOT124 V2 M

Specialist Physician Serving as Primary Care Physician for a Life-Threatening, Degenerative or Disabling Condition

In Vermont, a member may, upon CIGNA approval, use a Specialist as their PCP for a life-threatening, degenerative or disabling condition. The request must include a signed statement from the member requesting the Specialist to serve as the

member's PCP and certification from the Specialist of the medical need to serve as the member's PCP.

Upon receipt of this documentation:

- A CIGNA Medical Director validates the medical necessity of the request.
- A decision is made within 10 business days or less from receipt of the request.
  - If approved, CIGNA will reach out for a signed statement from the Specialist accepting responsibility to serve as the member's PCP, coordinate member care needs and accept the PCP contracted reimbursement rate for primary care services.
  - If the CIGNA Medical Director denies the request for a Specialist to serve as the member's PCP, the denial notification includes the reason(s) for denial, appeal rights and confirmation that the determination was made by a CIGNA Medical Director.
- The member will be notified in writing within 21 to 30 business days of the decision.

Mailing Address:
CIGNA HealthCare
4100 International Pkwy
Suite 1010
Carrollton, TX 75007

NOT186

NOTICE

Please see our website at www.CIGNA.com for the most current listing of formulary drugs, or call the Member Services telephone number on the back of your benefit identification card.

GM6000 NOT168 M

How To File Your Claim

When you or your Dependents receive care from a Participating Provider, you do not need to file a claim form. However, if you or your Dependents receive care from a non-Participating Provider, you must submit a claim form to be reimbursed.

The provisions that follow apply only to non-Participating Provider claims:

You may get any required claim forms from your Plan Administrator. All fully completed claim forms and bills should be sent directly to your servicing CG claim office.

Depending on your group insurance plan benefits, file your claim forms as described below.

Hospital Confinement

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

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

Doctor's Bills and Other Medical Expenses

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

CLAIM REMINDERS

BE SURE TO USE YOUR MEMBER ID AND ACCOUNT NUMBER (BOTH OF WHICH CAN BE FOUND ON YOUR BENEFIT IDENTIFICATION CARD) WHEN YOU FILE CG'S CLAIM FORMS, OR WHEN YOU CALL YOUR CG CLAIM OFFICE.

- 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 imprisonment.

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Accident and Health Provisions

Notice of Claim

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

Claim Forms

When CG receives the notice of claim, it will give to the claimant--or to the Plan Administrator appointed by 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 Member Insurance

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

- you are an eligible, regularly-scheduled Member; and
- you are in an Eligible Class.

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

As determined by your Employer (who is a participant in the Vermont Association of Chamber Executives benefit program)

Eligible Classes

Each Member, as reported by the Vermont Association of Chamber Executives to CG

GM6000 EL2 V-32 ELI6 M

Member Insurance

This plan is offered to you as a Member. To be insured, you may be required to pay part of the cost.

Effective Date of Your Insurance

You will become insured on the date you elect the insurance, but no earlier than the date you become eligible. However, if you do not elect the insurance within 30 days after the date you become eligible, you will be required to wait until the next Open Enrollment Period to become insured [unless you qualify under the section of this certificate entitled, "Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)"]. You will not be denied enrollment for Medical Insurance due to your health status.

You will become insured as described above, if: (a) you are in Active Service on that date; or (b) you are not in Active Service on that date due to your health status.

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Dependent Insurance

For your Dependents to be insured, you may 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, but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

If you do not elect Dependent Insurance within 30 days after the date you become eligible for it, you will be required to wait until the next Open Enrollment Period to insure your Dependents [unless you qualify under the section of this certificate entitled, "Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)"]. Your Dependents will not be denied enrollment for Medical Insurance due to health status.

Your Dependents will be insured only if you are insured.

Exception for Newborns

Any Dependent child born while you are insured for Medical Insurance for yourself, but not for your Dependents, 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, insurance for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

Exception for Newborn Grandchildren

Any child born to your Dependent child while you are insured for Dependent Medical Insurance will be covered for the first 31 days of his life. However, in no event will coverage for such child continue beyond the 31st day; and no benefits for expenses incurred beyond the 31st day will be payable.

GM6000 EF 2 ELI11V53 M

OPEN ACCESS PLUS MEDICAL BENEFITS

The Schedule

For You and Your Dependents

Open Access Plus Medical Benefits provide coverage for services and supplies obtained from Participating Providers (i.e., In-Network) and non-Participating Providers (i.e., 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 consists of Copayments, the Deductible, and the Coinsurance.

If you are unable to locate an Participating Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the toll-free telephone number on the back of your benefit identification card to obtain authorization to receive the service or supply Out-of-Network (i.e., from a non-Participating Provider). If you obtain authorization to receive such services or supplies Out-of-Network, benefits for those services or supplies will be paid at the In-Network benefit level.

Copayments

Copayments are expenses to be paid by you before benefits for certain *In-Network* Covered Expenses are payable.

Deductibles

Deductibles (Plan and benefit) are expenses to be paid by you or your Dependent. Deductible amounts are in addition to any Coinsurance.

Once the Plan Deductible shown in The Schedule has been satisfied, you and your family need not satisfy any further Plan Deductible amounts for the rest of that calendar year.

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the plan after any applicable deductible amounts have been met.

Out-of -Pocket Expenses

Out-of-Pocket Expenses are charges incurred for which no benefits are payable because of any:

- Plan Deductible amounts;
- Coinsurance;
- inpatient Hospital facility copayments or deductibles;
- outpatient Hospital facility copayments or deductibles.

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

- non-compliance penalties; or
- provider charges that exceed the Maximum Reimbursable Charge.

When the Out-of-Pocket Maximum shown in The Schedule is reached, benefits for Covered Expenses incurred under this Plan are payable at 100%.

Accumulation of Plan Deductibles and Out-of-Pocket Maximums

All plan deductibles, maximums, and benefit- or service-specific maximums (expressed in dollars, visits, or occurrences) 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. Benefits for the most expensive procedure will be paid according to the terms of this plan as described herein.

Assistant Surgeon/Co-Surgeon Limitation

Benefits payable for charges made by an assistant surgeon or co-surgeon are limited to 20 percent of the surgeon's allowable charge. (For the 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	$1,000,000 per person (reduced by any In-Network benefits paid)
Coinsurance Levels	80% of the negotiated charge	60% of the Maximum Reimbursable Charge
Maximum Reimbursable Charge	*Not Applicable*	80th Percentile

The Maximum Reimbursable Charge is determined based on the lesser of : (a) the out-of-network provider's normal charge for a similar service or supply; or (b) an Employer-selected percentile of charges made by providers of such service or supply in the geographic area where the service is received. (These charges are compiled in a database selected by CG.)

Note: *An out-of-network provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to any Coinsurance that may be applicable.*

Plan Deductible		
Per Individual	$1,000 per calendar year	$3,000 per calendar year
Family Maximum	$2,000 per calendar year	$6,000 per calendar year

Family Maximum Deductible Calculation

When a member of your family meets his or her *individual plan deductible* in a calendar year, the plan coinsurance (if any) will be applied toward all subsequent claims incurred by that person during the remainder of that calendar year.

However, if the *family plan deductible maximum*--which is a cumulative total of all the individual plan deductible amounts paid by the members of your family--has been met in a calendar year prior to any or all of your family's individual deductibles being met, then the plan coinsurance (if any) will be applied toward subsequent claims incurred by all covered members of your family during the remainder of that calendar year without the need to satisfy any further plan deductible amounts.

Out-of-Pocket Maximum		
Per Individual	$4,000 per calendar year	$ 8,000 per calendar year
Family Maximum	$8,000 per calendar year	$16,000 per calendar year

Family Out-of-Pocket Maximum Calculation

When a member of your family meets his or her *individual Out-of-Pocket Maximum* in a calendar year, Out-of-Pocket Expenses for subsequent claims incurred by that person during the remainder of that calendar year will be payable at 100%.

However, if the *family Out-of-Pocket Maximum*--which is a cumulative total of all the individual Out-of-Pocket amounts paid by the members of your family--has been met in a calendar year prior to any or all of your family's individual Out-of-Pocket Maximums being met, then Out-of-Pocket Expenses for subsequent claims incurred by all covered members of your family during the remainder of that calendar year will be payable at 100%.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician's Services		
Primary Care Physician's Office Visit	No Charge after $30 office visit copay	60% after plan deductible
Specialty Care Physician's Office Visits	No Charge after $30 office visit copay	60% after plan deductible
Consultant and Referral Physician's Services		
Surgery Performed in Physician's Office	No Charge after $30 office visit copay	60% after plan deductible
Second Opinion Consultations (provided on a voluntary basis)	No Charge after $30 office visit copay	60% after plan deductible
Allergy Treatment/Injections	No Charge after the lesser of: (a) $30 office visit copay; or (b) actual charge	60% after plan deductible
Allergy Serum (dispensed by the Physician in the office)	No Charge	60% after plan deductible
Preventive Care		
Routine Preventive Care		
Calendar Year Maximum (including immunizations): Unlimited		
Physician's Office Visit	No Charge after $30 office visit copay	*In-Network coverage only*
Immunizations	No Charge	*In-Network coverage only*
Mammograms, PSA, Pap Test, Colorectal Cancer Screenings*		
- Routine	No Charge *(plan deductible waived)*	60% after plan deductible
- Diagnostic	80% after plan deductible	60% after plan deductible
***Note:** *Benefits include charges for readings/interpretation.*		
Inpatient Hospital - Facility Services	$150 copay per admission, then 80% after plan deductible	$150 benefit deductible per admission, then 60% after plan deductible
Covered Expense Daily Limit For:		
Semi-Private Room and Board	Limited to the negotiated rate	Limited to semi-private room rate
Private Room	Limited to the negotiated rate	Limited to semi-private room rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to ICU/CCU daily room rate

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room, and Observation Room **Note:** Non-surgical treatment not subject to facility copay/deductible.	$75 copay per admission, then 80% after plan deductible	$75 benefit deductible per admission, then 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, and Anesthesiologist	80% after plan deductible	60% after plan deductible
Outpatient Professional Services Surgeon, Radiologist, Pathologist, and Anesthesiologist	80% after plan deductible	60% after plan deductible
Emergency and Urgent Care Services		
Physician's Office Visit	No Charge after $30 office visit copay	No Charge after $30 benefit deductible*
Hospital Emergency Room †	No Charge after $150 copay per visit	No Charge after $150 benefit deductible per visit*
Outpatient Professional Services (radiology, pathology, and ER Physician)	No Charge	No Charge*
Urgent Care Facility or Outpatient Facility †	No Charge after $75 copay per visit	No Charge after $75 benefit deductible per visit*
X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)	No Charge	No Charge*
Independent x-ray and/or Lab Facility in conjunction with an ER visit	No Charge	No Charge*
Ambulance	80% after plan deductible	80% after plan deductible*

** If not a true emergency, Out-of-Network charges for these services are paid at **60% after plan deductible**.*

† Copay/benefit deductible waived if admitted to a Hospital directly from Emergency Room or Facility.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital, and Sub-Acute Facilities	80% after plan deductible	60% after plan deductible
Covered Expense Daily Limit:	Limited to the negotiated rate	Limited to the semi-private room rate
Calendar Year Maximum: 60 days combined		
Laboratory and Radiology Services (includes pre-admission testing)		
Advanced Radiological Imaging (i.e., MRIs, MRAs, CAT and PET Scans)	80% after plan deductible	60% after plan deductible
Other Laboratory and Radiology Services:		
Physician's Office Visit	No Charge after $30 office 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
Outpatient Short-Term Rehabilitative Therapy *(subject to Medical Necessity)* Includes: Cardiac Rehabilitation Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehabilitation Cognitive Therapy Massage Therapy Calendar Year Maximum: 60 days for all therapies combined	No Charge after $30 office visit copay	60% after plan deductible
Chiropractic Care Calendar Year Maximum: Unlimited	No Charge after $30 office visit copay	60% after plan deductible
Home Health Care (includes outpatient private nursing when approved as Medically Necessary) Calendar Year Maximum: 40 days	80% after plan deductible	60% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Hospice		
Inpatient Services	80% after plan deductible	60% after plan deductible
Covered Expense Daily Limit:	Limited to the negotiated rate	Limited to the semi-private room rate
Outpatient Services	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*
Maternity Care Services		
Initial Visit to Confirm Pregnancy	No Charge after $30 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 $30 office visit copay	60% after plan deductible
Delivery - Facility (Inpatient Hospital, Birthing Center)	$150 copay per admission, then 80% after plan deductible	$150 benefit deductible per admission, then 60% after plan deductible
Abortion (Includes elective and non-elective procedures)		
Physician's Office Visit	No Charge after $30 office visit copay	60% after plan deductible
Inpatient Facility	$150 copay per admission, then 80% after plan deductible	$150 benefit deductible per admission, then 60% after plan deductible
Outpatient Facility	$75 copay per admission, then 80% after plan deductible	$75 benefit deductible per admission, then 60% after plan deductible
Physician's Services	80% after plan deductible	60% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Family Planning Services		
Office Visits, Lab and Radiology Tests and Counseling*	No Charge after $30 office visit copay	60% after plan deductible
Benefit Maximum: Unlimited		
***Notes:** (1) Benefits for In-Network Lab and X-ray services administered in an independent facility are payable at 80% after plan deductible; (2) Coverage includes benefits for contraceptive devices [e.g., Depo-Provera, Intrauterine Devices (IUDs)]. Diaphragms also covered when services are provided in Physician's office.*		
Surgical Sterilization Procedures for Vasectomy/Tubal Ligation (excludes reversals)		
Physician's Office	No Charge after $30 office visit copay	60% after plan deductible
Inpatient Facility	$150 copay per admission, then 80% after plan deductible	$150 benefit deductible per admission, then 60% after plan deductible
Outpatient Facility	$75 copay per admission, then 80% after plan deductible	$75 benefit deductible per admission, then 60% after plan deductible
Facility's Physician 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), except as noted below. Surgical Treatment: Limited to procedures for the correction of infertility (excludes Artificial Insemination [AI], In-Vitro Fertilization [IVF], GIFT, ZIFT, etc.)		
Physician's Office Visit (Lab and Radiology Tests, Counseling)	No Charge after $30 office visit copay	*In-Network coverage only*
Inpatient Facility	$150 copay per admission, then 80% after plan deductible	*In-Network coverage only*
Outpatient Facility	$75 copay per admission, then 80% after plan deductible	*In-Network coverage only*
Physician's Services	80% after plan deductible	*In-Network coverage only*

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Organ Transplants (Includes all medically appropriate, non-experimental transplants)		
Office Visit	No Charge after $30 office visit copay	*In-Network coverage only*
Inpatient Facility & Physician's Services (for Participating In-Network Transplant Facilities)	No Charge after $150 copay per admission if transplant received at Lifesource center; otherwise, $150 copay per admission, then 80% after plan deductible	*In-Network coverage only*
Transplant Travel Benefits *(Covered only when transplant procedure is performed at a Lifesource Facility)* Transplant Travel Maximum: $10,000 per transplant	No Charge *(plan deductible waived)*	*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 *(subject to Medical Necessity)*		
Physician's Office Visit Calendar Year Maximum: 3 visits per person* * *This limit will not apply to treatment for diabetes*	No Charge after $30 office visit copay	60% after plan deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
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 $30 office visit copay	60% after plan deductible
Inpatient Facility	$150 copay per admission, then 80% after plan deductible	$150 benefit deductible per admission, then 60% after plan deductible
Outpatient Facility	$75 copay per admission, then 80% after plan deductible	$75 benefit deductible per admission, then 60% after plan deductible
Physician's Services	80% after plan deductible	60% after plan deductible
Mental Health and Substance Abuse		
Inpatient Calendar Year Maximum - In-Network: Unlimited - Out-of-Network: 30 days *Acute: Based on ratio of 1:1* *Partial: Based on ratio of 2:1* *Residential: Based on ratio of 2:1*	$150 copay per admission, then 80% after plan deductible	$150 benefit deductible per admission, then 60% after plan deductible
Outpatient (Individual and Group Therapy)* Calendar Year Maximum - In-Network: Unlimited - Out-of-Network: 20 visits **Group Therapy available for Mental Health treatment **only**.*	No Charge after $30 office visit copay	60% after plan deductible
Intensive Outpatient Therapy Calendar Year Maximum: Unlimited *Based on a ratio of 1:1*	$50 copay per program, then 80% *(plan deductible waived)*	60% after plan deductible

Open Access Plus Medical Benefits

Certification Requirements

*(The inpatient and outpatient certification requirements described in the following section apply to care received **Out-of-Network** only.)*

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

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

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

GM6000 PAC1 V33 M

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 V9C

Outpatient Certification Requirements

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

Covered Expenses incurred will be reduced by 50% for charges made for any outpatient diagnostic testing or procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

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

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

Diagnostic Testing and Outpatient Procedures

Including, but not limited to:

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

Hysterectomy

GM6000 SC1 PAC4 OCR8V5 M

Prior Authorization/Pre-Authorized

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

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

- inpatient Hospital services;
- inpatient services at any participating Other Health Care Facility;
- residential treatment;
- outpatient facility services;
- advanced radiological imaging;

- non-emergency ambulance; or
- transplant services.

GM6000 05BPT16 V6 M

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, as determined by CG. *Any applicable Deductibles, Coinsurance, benefit limits or maximums are shown in The Schedule.*

Covered Expenses will include:

- 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 Hospital Bed and Board Daily Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made by an Other Health Care Facility--including a Skilled Nursing Facility, a Rehabilitation Hospital, or a subacute facility--on its own behalf, for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which is 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 M

- 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.

GM6000 CM6 FLX108V748

- charges made for an annual Papanicolaou ("Pap") laboratory screening test.
- charges made for an annual prostate-specific antigen (PSA) test.
- charges made for colorectal cancer screenings.
- charges for appropriate counseling and medical services connected with surgical sterilization therapies, including vasectomy and tubal ligation.
- charges made for laboratory services, radiation therapy, and other diagnostic and therapeutic radiological procedures.
- charges made due to Routine Preventive Care for persons aged 3 or older. Routine Preventive Care means health care assessments, wellness visits, immunizations, and any related services.
- charges made for visits for the routine preventive care of a Dependent child during the first two years of that child's life, including immunizations.

GM6000 CM6 FLX108V770 M

- charges made for or in connection with mammograms for breast cancer screenings, not to exceed an annual mammogram for women aged 40 or older; or mammograms for women under age 40, upon recommendation of a Physician.
- charges for inpatient maternity and newborn care. The length of stay for the mother will be based on the health of the mother and newborn, the ability and confidence of the mother to care for her newborn, the adequacy of support at home and access to appropriate follow-up care. If a newborn is discharged in less than 24 hours, that newborn must be examined by a Physician either in a home, Hospital, or clinic within 24 hours of discharge. The first visit may also be by phone call, and if it is, then a home health care visit will also be covered within 48 hours of discharge. The mother will have follow-up care available for a maximum of 6 post-partum weeks.
- charges for medical foods and low protein modified food products prescribed for Medically Necessary treatment of inherited metabolic diseases. Benefits are limited to a maximum of $2,500 per calendar year.
- charges made for off-label use of prescription drugs administered in the treatment of cancer, even when the drug is not approved by the FDA for the specific type of cancer treatment prescribed. The drug must be a medically accepted treatment for cancer in order to be covered. Coverage includes Medically Necessary services associated with administration of the drug.

GM6000 CM6 INDEM146V20 M

- charges made for the Medically Necessary treatment of the bones and joints of the face, neck and head resulting from accident, trauma, congenital defect, developmental defect or pathology.

- prescription contraceptive methods approved by the U.S. Food and Drug Administration, including prescription drugs and devices.

GM6000 INDEM146V11 M

- charges made for medical and surgical services for the treatment or control of clinically severe obesity. Clinically severe 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 from coverage:
  - Medical and surgical services to alter appearances or physical changes resulting from any medical or surgical services performed for the treatment or control of obesity or clinically severe obesity, when those services are cosmetic and not otherwise Medically Necessary; and
  - Weight loss programs (other than Physician-supervised weight loss programs required by CG in order to clinically qualify for potential bariatric surgery).

GM6000 06BNR1 V4 M

- The following benefits will apply to insulin-using and insulin-dependent diabetics, gestational diabetics and noninsulin-dependent diabetics, when treatment is prescribed by a licensed health care professional:
- charges for Durable Medical Equipment related to diabetes, including: glucometers; blood glucose meters for the legally blind; insulin pumps; infusion devices and related accessories, including those adaptable for the legally blind, after review for Medical Necessity; and glucagon emergency kits. A special maximum will not apply.
- charges for training by a certified registered or licensed health care professional with recent education in diabetes management, limited to the following:
  - (a) Medically Necessary visits when diabetes is diagnosed;
  - (b) visits following a Physician's diagnosis of a significant change in the symptoms or conditions that warrant changes in self-management;
  - (c) visits when reeducation or refresher training is prescribed by a health care practitioner with authorizing authority; and
  - (d) medical nutrition therapy related to diabetes management.

  Comprehensive diabetes self-management education, survival skills diabetes self-management education, and customized diabetes self-management education will be covered.

GM6000 FLX292 INDEM146V18 M

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

GM6000 05BPT1 V8 M

- 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 and genetic diagnosis prior to embryo transfer are 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 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 non-functional body parts are covered. Medically Necessary repair, maintenance, or replacement of a covered appliance is also covered.

GM6000 05BPT2 V1 M

Cancer Clinical Trials

Routine patient care services directly associated with a patient's participation in a phase I, II, III or IV approved cancer clinical trial.

An "approved cancer clinical trial" is an organized, systematic, scientific study of therapies, tests, or other clinical interventions for purposes of treatment, palliation, or prevention of cancer in human beings.

The approved trial must:

- seek to answer a credible and specific medical or scientific question for the purpose of advancing cancer care;

- enroll only those patients for whom there is no clearly superior, non-investigational treatment alternative;
- have available clinical or preclinical data that provides a reasonable expectation that the treatment obtained in the approved trial will be at least as effective as the non-investigational alternative;
- be conducted under the auspices of one of the following Vermont cancer care providers: Vermont Cancer Center at Fletcher Allen Health Care, the Norris Cotton Cancer Center at Dartmouth-Hitchcock Medical Center, or approved clinical trials being administered by a Vermont hospital and its affiliated, qualified Vermont cancer care providers;
- be conducted by a facility and personnel capable of conducting such a trial by virtue of experience, training and volume of patients treated to maintain such expertise;
- be conducted under the auspices of a peer-reviewed protocol that has been approved by one of the following entities: (a) one of the National Institutes of Health (NIH); (b) an NIH-affiliated cooperative group that is a formal network of facilities that collaborate on research projects and have an established NIH-approved peer-review program operating within the group; (c) the FDA in the form of an investigational new drug application or exemption; or (d) the federal department of Veterans Affairs or Defense.

"Routine patient care services" are any Covered Expenses under this plan, including any Medically Necessary health care service that is incurred as a result of the treatment being provided to the patient for the purposes of the approved cancer clinical trial. Routine patient care services do not include the following:

- the cost of investigational new drugs that have not been approved for market for any indication by the FDA, or the costs of any drug being studied under an FDA-approved investigational new drug exemption for the purpose of expanding the drug's labeled indications.
- the costs of non-health care services that may be required as a result of the treatment being provided for the purposes of the approved cancer clinical trial.
- the costs of the services that are clearly inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis and performed specifically to meet the requirements of the approved cancer clinical trial.

GM6000 INDEM194 V1 M

- the costs of any tests or services performed specifically to meet the needs of the approved cancer clinical trial protocol.
- the costs of running the approved cancer clinical trial and collecting and analyzing data.
- the costs associated with managing any research associated with the approved clinical trial.
- the costs for non-investigational treatments or services that would not otherwise be covered under the patient's health benefit plan.
- any product or service paid for by the trial sponsor.

GM6000 INDEM195 V1 M

Home Health Services

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

  Home Health Services are provided only if CG has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for non-skilled 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 non-skilled 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, with the exception of covered visits by a home health aide, which are defined as a period of 4 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 home or your Dependent's home, 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.

GM6000 05BPT108 V1 M

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, except that, for any day of confinement in a

private room, Covered Expenses will not include that portion of charges which is more than the Hospice Bed and Board Daily Limit shown in The Schedule;

- by a Hospice Facility for services provided on an outpatient basis;
- by a Physician for professional services;
- by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
- 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 M

  - 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 home or your Dependent's home;
- 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.

GM6000 CM35 FLX124V27 M

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.

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

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

Mental Health Residential Treatment services are exchanged with Inpatient Mental Health services. Two days of Mental Health Residential Treatment are equal to one day of Inpatient Mental Health Treatment.

GM6000 INDEM9 V68 M

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. Mental Health Intensive Outpatient Therapy Program services are exchanged with Outpatient Mental Health services. Each visit in conjunction with a Mental Health Intensive Outpatient Therapy Program will reduce the Outpatient Mental Health Services maximum shown in The Schedule by one.

GM6000 INDEM10 V58 M

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.

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

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

Substance Abuse Residential Treatment Services are exchanged with Inpatient Substance Abuse services. Two days of Substance Abuse Residential Treatment are equal to one day of Inpatient Substance Abuse Treatment.

Substance Abuse Residential Treatment Center means an institution which: (a) specializes in the treatment of psychological and social disturbances that are the result of Substance Abuse; (b) provides a subacute, structured, psychotherapeutic treatment program under the supervision of Physicians; (c) provides 24-hour care, in which a person lives in an open setting; and (d) 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, including outpatient rehabilitation in an program of individual therapy, or in 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 per week. Substance Abuse Intensive Outpatient Therapy Program services are exchanged with Outpatient Substance Abuse services. Each visit in conjunction with a Substance Abuse Intensive Outpatient Therapy Program will reduce the Outpatient Substance Abuse Rehabilitation Services maximum shown in The Schedule by one.

GM6000 INDEM11 V70 M

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.
- treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- developmental disorders, including, but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders, or developmental articulation disorders.
- counseling for activities of an educational nature.
- counseling for borderline intellectual functioning.
- counseling for occupational problems.
- counseling related to consciousness-raising.
- vocational or religious counseling.
- I.Q. testing.
- custodial care, including, but not limited to, geriatric day care.
- psychological testing on children requested by or for a school system.
- occupational/recreational therapy programs, even if combined with supportive therapy for age-related cognitive decline.

GM6000 INDEM12 V62 M

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: (a) are designed for, and able to withstand repeated use by, more than one person; (b) customarily serve a medical purpose; (c) generally are not useful in the absence of Injury or Sickness; (d) are appropriate for use in the home; and (e) are not disposable. Such equipment includes, but is not limited to, crutches, Hospital beds, respirators, wheel chairs, and dialysis machines.

Items that are not covered as Durable Medical Equipment under this plan include, but are not limited to, those listed below:

- **Bed-Related Items:** bed trays, over-the-bed tables, bed wedges, pillows, custom bedroom equipment, and mattresses (including non-power mattresses, custom mattresses, posturepedic mattresses)
- **Bath-Related Items:** bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand-held showers, paraffin baths, bath mats, 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), auto-tilt chairs
- **Fixtures to Real Property:** ceiling lifts, wheelchair ramps
- **Car/Van Modifications**
- **Air Quality Items:** room humidifiers, vaporizers, air purifiers, electrostatic machines
- **Blood/Injection Related Items:** blood pressure cuffs, centrifuges, nova pens, 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, diathermy machines

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External Prosthetic Appliances and Devices

- charges made for the initial purchase and fitting of external prosthetic appliances and devices ordered by a Physician, which available only by prescription and necessary for the alleviation or correction of Injury, Sickness, or congenital defect.

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

Prostheses/Prosthetic Appliances and Devices

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts.

Prostheses/prosthetic appliances and devices include, but are not limited to:

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

Orthoses and Orthotic Devices

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

- <u>Non-foot orthoses</u> – only the following non-foot orthoses are covered:
  - rigid and semi-rigid custom, fabricated orthoses,
  - semi-rigid, prefabricated, and flexible orthoses; and
  - rigid prefabricated orthoses, including preparation, fitting, and basic additions, such as bars and joints.
- <u>Custom foot orthoses</u> – 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 a replacement or substitute for missing parts of the foot (e.g., amputation), and is necessary for the alleviation or correction of Injury, Sickness, or congenital defect; and
  - for persons with a neurologic or neuromuscular condition (e.g., cerebral palsy, hemiplegia, spina bifida) producing spasticity, misalignment, or pathological positioning of the foot, and there is reasonable expectation of improvement.

GM6000 05BPT4 M

The following are specifically excluded from coverage as orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded, except when used post-operatively

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;

- orthotic shoes, shoe additions, procedures for 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 orthotic or orthopedic appliance that supports or holds in correct position any movable part of the body, and that allows for motion of that part.

Copes scoliosis braces are specifically excluded.

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.
- Replacement due to a surgical alteration or revision of the site.
- Coverage for replacement is additionally limited as follows:
- No more than once every 12 months for persons 18 years of age or younger; and
- No more than once every 24 months for persons 19 years of age or older

  The following are specifically excluded external prosthetic appliances and devices:

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

GM6000 05BPT5 M

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: (a) Medically Necessary massage therapy rendered by a licensed massage therapist or Other Health Care Provider practicing within the scope of his license; and (b) services provided by a chiropractic Physician when rendered in an outpatient setting. Services of a chiropractic Physician include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment that is rendered to restore motion, reduce pain and improve function.

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

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

Short-Term Rehabilitative Therapy and Chiropractic Care Services that are not covered include, but are not limited to:

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

  The following are specifically excluded from coverage as 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.

GM6000 05BPT8 V8 (2) M

Transplant Services

- charges made In-Network for human organ and tissue Transplant Services, which include solid organ and bone marrow/stem cell procedures. This coverage is subject to the following conditions and limitations.

  Transplant Services include the recipient's medical, surgical, and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant Services are covered only if they are

required to perform any of the following human-to-human organ or tissue transplants: allogeneic bone marrow/stem cell; autologous bone marrow/stem cell; corneal; heart; heart/lung; kidney; kidney/pancreas; liver; lung; pancreas or intestine (which includes small bowel); liver; or multiple viscera.

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

Transplant Services received from non-Participating Providers are not covered under this plan.

Transplant Travel Services

Charges made for reasonable travel expenses incurred in connection with a pre-approved organ/tissue transplant are covered, subject to the following conditions and limitations. Transplant Travel Services benefits are not available for corneal transplants. Benefits for transportation, lodging, and food are available only if the insured is the recipient of a pre-approved 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 recipient 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 consumed while at, or traveling to and from, the transplant site.

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

Travel costs incurred due to travel within 60 miles of the recipient's 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 V11 M

Breast Reconstruction and Breast Prostheses

- charges made for reconstructive surgery following a mastectomy; benefits include: (a) surgical services for reconstruction of the breast on which surgery was performed; (b) surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance; (c) postoperative breast prostheses; and (d) mastectomy bras and external prosthetics, limited to the most cost-effective 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 (a) abnormalities of the jaw or conditions related to TMJ disorder; or (b) for newborns; or (c) following a mastectomy, provided that: (1) the surgery or therapy restores or improves function; (2) reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or (3) the surgery or therapy 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 V14 M

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 (except that, in the case of a Dependent whose insurance would cease due to your death, a Converted Policy will be issued if the Dependent applies in writing and pays the required premium within 60 days after your death). Evidence of good health is not needed.

Members 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 (3) 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 CON13 M

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 M

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 for the Converted Policy 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, upon request, further details of the Converted Policy.

GM6000 CON29 M

Prescription Drug Benefits

The Schedule

For You and Your Dependents

This plan provides benefits for Prescription Drugs provided by Participating Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for Prescription Drugs and Related Supplies for each 90-day supply from a retail Participating Pharmacy or each 90-day supply from a mail-order Participating Pharmacy. That portion consists of the Coinsurance.

Coinsurance

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

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred due to charges made by a Participating Pharmacy (retail or mail-order) for Prescription Drugs for which no payment is provided because of the Coinsurance. Once the Out-of-Pocket maximum shown in The Schedule below has been met, you and your family need not satisfy any further Out-of-Pocket Expenses for the rest of that calendar year.

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
Out-of-Pocket Maximum		
Per Individual	$2,000 per calendar year	*Not Applicable*
Family Maximum	$4,000 per calendar year	*Not Applicable*

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
Retail Prescription Drugs		
Generic* drugs on the Prescription Drug List	50% (Plan pays 50%)	*In-network coverage only*
Brand-Name * drugs designated as preferred on the Prescription Drug List with no Generic equivalent	50% (Plan pays 50%)	*In-network coverage only*
Brand-Name * drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	50% (Plan pays 50%)	*In-network coverage only*
Mail-Order Drugs		
Generic * drugs on the Prescription Drug List	50% (Plan pays 50%)	*In-network coverage only*
Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	50% (Plan pays 50%)	*In-network coverage only*
Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	50% (Plan pays 50%)	*In-network coverage only*

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

Prescription Drug Benefits

For You and Your Dependents

Insuring Provisions

If you or any of your Dependents, while insured for Prescription Drug Benefits, incur expenses for charges made by a Participating 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 Prescription Drugs and Related Supplies 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 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 it had been filled by a Participating Pharmacy.

Limitations

Each Prescription Order shall be limited as follows:

- up to a consecutive, 90-day supply at a retail Participating Pharmacy, unless limited by the drug manufacturer's packaging;
- 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 limit as determined by the CG Provider Organization's Pharmacy and Therapeutics Committee (P & T Committee).

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GM6000 PHARM85

Coverage for certain Prescription Drugs and Related Supplies requires your Physician to obtain authorization prior to prescribing. If your Physician wishes to request coverage for a Prescription Drug or Related Supply for which prior authorization is required, he or she may call, or complete the appropriate form and fax it to CG, to request the necessary prior authorization. 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 CG's claim system to allow you to have coverage for the Prescription Drug or Related Supply. The length of the authorization will depend on: (a) the diagnosis; and (b) the specific Prescription Drug or Related Supply in question. When your Physician advises you that coverage for the Prescription Drug or Related Supply has been approved, you should contact the Pharmacy to fill the prescription.

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

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

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

All drugs newly approved by the Food and Drug Administration (FDA) are designated as either: (a) non-Preferred; or (b) 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 currently available therapy, according to the FDA, will be reviewed by the P&T Committee within 6 months after FDA approval. Prescription Drugs that, according to the FDA, appear to have therapeutic qualities similar to those of an already-marketed drug will not be reviewed by the P&T Committee for at least 6 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 Participating Pharmacy is subject to the Coinsurance. Please refer to The Schedule for the required Coinsurance and any applicable benefit maximums.

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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).
- any drug from a drug class in which at least one of the drugs is available over-the-counter, and the drugs in that class are deemed to be therapeutically equivalent (as determined by the P&T Committee).
- any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician-supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus); chemotherapy injectables; and endocrine and metabolic agents.

- any drugs that are experimental or investigational as described under the **Limitations and Exclusions** section of this certificate;
- Food and Drug Administration (FDA)-approved Prescription Drugs used for purposes other than those approved by the FDA, unless the drug is recognized for the treatment of the particular indication for which it was prescribed in one of the standard reference compendia (The United States Pharmacopeia Drug Information; The American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information); or in medical literature. Medical literature means scientific studies published in a peer-reviewed, national, professional medical journal;
- prescription and non-prescription supplies (such as ostomy supplies), devices, and appliances (other than Related Supplies);
- implantable contraceptive products;
- any oral or injectable infertility drug;
- prescription vitamins (other than prenatal), dietary supplements, and fluoride products;
- drugs used for cosmetic purposes, such as reducing wrinkles, promoting hair growth, or controlling perspiration, as well as fade cream products;
- diet pills or appetite suppressants (anorectics);
- immunization agents; biological products for allergy immunizations; biological sera; blood, blood plasma and other blood products or fractions; and medications used for travel prophylaxis;
- replacement of Prescription Drugs or Related Supplies due to loss or theft;
- medications used to enhance athletic performance;
- medications 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; and
- prescriptions more than one year from the original date of issue.

Other limitations are shown in the **Limitations and Exclusions** section.

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Reimbursement/Filing a Claim

When you or your Dependents purchase Prescription Drugs or Related Supplies from a retail Participating Pharmacy, you pay the applicable Coinsurance shown in The Schedule (after the Combined Medical/Pharmacy Plan Deductible has been satisfied) at the time of purchase. You do not need to file a claim form.

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

GM6000 PHARM94 V17 M

Vision Benefits

The Schedule

BENEFIT HIGHLIGHTS	
Vision Benefits **For You and Your Dependents**	**You or Your Dependent will Pay a Maximum of:**
Examinations	$30 per examination
Benefit Maximum: One complete eye examination every 24 months	
Lenses Per pair, one pair per 24 month period:	**This Plan will Pay a Maximum of:**
Single Vision	$15
Bifocal	$30
Trifocal	$42
Lenticular	$54
Contact Lenses	
Medically Necessary Contacts	$72
Elective Contacts	$30
Frames Per pair, one pair per 24 month period	$15
Benefit Maximum: Reimbursement toward purchase of one pair of eyeglasses (lenses and frames), or contact lenses, every 24 months	

Vision Benefits

Insuring Provisions

If you or any of your Dependents, while insured for Vision Benefits, incur expenses for:

- an eye examination by an Optometrist or an Ophthalmologist;
- lenses to correct vision; or
- eyeglass frames;

CG will pay you for such expenses, up to the Maximum Payment shown in The Schedule.

No payment will be made for any one person for more than:

- one examination and one pair of lenses during any 24-month period;
- or more than one pair of frames during any 24-month period.

Limitations

No payment will be made for expenses incurred for:

- medical or surgical treatment of the eye.
- lenses which are: (a) not Medically Necessary; and (b) not prescribed by an Optometrist or Ophthalmologist (or frames for such lenses).
- sunglasses, whether or not prescribed;
- replacement of lenses, unless an examination shows that, using the existing prescription, a visual defect equal to at least one-half of one diopter in strength exists; or a change of at least 10% in axis for astigmatism is required.
- services an supplies not listed in The Schedule.
- tinted lenses prescribed by the examiner when over Rose Tints No. 1 or No. 2; or
- charges for the excess cost of lenses over 65 millimeters in diameter.

Other limitations are shown in the **Limitations and Exclusions** section.

In addition, these benefits will be reduced so that the total payment under:

- this plan; and
- any medical expense plan or prepaid treatment program sponsored or made available by your Employer;
- will not be more than 100% of the charge made for the vision service.

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GM6000 VC2 VIS2V1 M

Limitations and Exclusions

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

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

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

  - not demonstrated, through existing, peer-reviewed, evidence-based, scientific literature, to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
  - the subject of review or approval by an Institutional Review Board for the proposed use, except as provided in the “Clinical Trials” section of this plan; or
  - the subject of an ongoing Phase I, II, or III clinical trial, except as provided in the “Clinical Trials” section of this plan.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem, or to treat psychological symptomatology or psychosocial complaints related to one’s appearance.
- regardless of clinical indication for macromastia, for gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty/panniculectomy; rhinoplasty; blepharoplasty; orthognathic surgeries; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- for or in connection with treatment of the teeth or periodontium, unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an Injury to sound natural teeth; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; (c) charges made by a Free-Standing Surgical Facility or the outpatient department of a Hospital in connection with surgery.
- for medical and surgical services, initial and repeat, intended for the treatment or control of obesity (other than clinically severe obesity), including: Medical and surgical services to alter appearance or physical changes resulting from any surgery performed for the management of obesity or clinically severe obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician, or under medical supervision.
- unless otherwise covered under 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 is specifically listed as a Covered Expense under this plan.
- infertility services, such as infertility drugs; surgical or medical treatment programs for infertility (including in vitro fertilization [IVF], gamete intrafallopian transfer [GIFT], zygote intrafallopian transfer [ZIFT], and any variations of these procedures); and any costs associated artificial insemination (including, but not limited to, the collection, washing, preparation, or storage of sperm, and donor fees). Cryopreservation of donor sperm and eggs is also excluded from coverage.
- reversal of male and female voluntary sterilization procedures.
- transsexual surgery, including medical or psychological counseling, and hormonal therapy in preparation for, or subsequent to, any such surgery.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.

- non-medical counseling or ancillary services, including, but not limited to: Custodial Services; education, training, vocational rehabilitation; behavioral training; biofeedback; neurofeedback; hypnosis; sleep therapy; employment counseling; back school; return-to-work services; work hardening programs; driving safety; services, training, educational therapy, or other non-medical ancillary services for learning disabilities, developmental delays, autism, or mental retardation.
- therapy or treatment intended primarily for the purpose of enhancing job, school, athletic, or recreational performance, including, but not limited to routine, long term, or non-Medically Necessary care.
- 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, unless Medically Necessary.
- 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 non-verbal communications, including, but not limited to: communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf, and memory books.
- 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 non-prescription and investigational/experimental drugs, except as otherwise specified under 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-implantation 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 opinion of the utilization review Physician, 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 aged 65 or older who is covered under this plan as a retiree (or as a Dependent thereof), when payment is denied by Medicare because treatment was received from a non-participating provider.
- medical treatment, when this plan is Secondary and payment is denied by a Primary Plan because treatment was received from a non-participating provider under that plan.
- 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, Internet consultations, and telemedicine.
- for charges which would not have been made if the person had no insurance.
- Covered Expenses incurred *Out-of-Network*, to the extent that the charges upon which they are based exceed 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 for business or 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 the Certification Requirements shown in this certificate.

GM6000 05BPT14V159 M 06BNRV78 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

12-month period during which a person is satisfying a waiting period and/or is insured for these benefits.

Pre-existing Condition

A Pre-existing Condition is an Injury or a Sickness for which a person receives treatment, incurs expenses, or receives a diagnosis from a Physician during the 6-month period before the earlier of the date: (a) a person begins an eligibility waiting period; or (b) 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.

The Pre-existing Condition Limitation is waived entirely for a person who provides proof of prior similar coverage, if that prior coverage existed within the previous 9 months and if the break in coverage between plans was no longer than 90 days.

Credit for Coverage Under Prior Plan

If a person was 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 that person had under a creditable health plan or policy, 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).

GM6000 CM10 INDEM82 V3 M

Coordination of Benefits

This section applies if you or any of your Dependents are 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 can neither be purchased by the general public, nor 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 benefits, primarily in the form of services, through a panel of employed or contracted providers, and that limits or excludes benefits for services rendered 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 provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines its benefits after the benefits provided or paid by the Primary Plan (and that may reduce its benefits accordingly). A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided.

GM6000 COB11 M

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 a person. 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 a person is confined to a private Hospital room and no Plan provides coverage for more than a semi-private room, the difference in cost between a private and semi-private room is not an Allowable Expense.
- If a person is 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 a person is 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 benefits for a person are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher

coinsurance percentage, a deductible, and/or a penalty) because he did not comply with Plan provisions, or because he did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and pre-certification of admissions or services.

Claim Determination Period

A calendar year, but does not include any part of such year during which a person is not insured under this plan; or any date before this section or any similar provision takes effect.

GM6000 COB12 M

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 a Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation will be utilized:

- The Plan that covers a person as an enrollee (or as a Member) shall be the Primary Plan, and the Plan that covers that person as a Dependent shall be the Secondary Plan;
- For a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee (or as a Member);
- For the Dependent child of divorced or separated parents, benefits shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's health care 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.

GM6000 COB13 M

- The Plan that covers a person as an active Member (or as a Dependent thereof) shall be the Primary Plan, and the Plan that covers that person as laid-off or retired Member (or as a Dependent thereof) 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 a person under a right of continuation which is provided by federal or state law shall be the Secondary Plan, and the Plan that covers that person as an active or retired Member (or as a Dependent thereof) 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 an insured is governed by the laws of the state whose laws govern this Plan; and that Plan determines the order of benefits based upon the gender of a parent; and, as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered an insured 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 the insured. CG will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

GM6000 COB14 M

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

- the extent of the Plan's obligation to provide services and supplies;
- whether a benefit reserve has been recorded for the person; and
- whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, the Plan will use the benefit reserve recorded for the claimant to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, the 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 benefits for charges that should have been paid by the Primary Plan; or if CG pays benefits for charges in excess of those for which it is obligated to provide, 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, health care plan, or other organization. If requested, the insured must execute and deliver to CG such instruments and documents as it determines are necessary to secure the right of recovery.

Right to Receive and Release Information

The Plan, without consent or notice, may obtain information from, and release information to, any other Plan in order to coordinate benefits pursuant to this section. The insured must provide the Plan with any information it requests in order to coordinate benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, the insured will be advised that "other coverage" information (including an Explanation of Benefits [EOB] 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 M

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 Member who is eligible for Medicare, and whose insurance is continued for any reason as provided in this Plan;

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

(c) a Member whose Employer (and each other Employer participating in the Plan) has fewer than 100 Members, and that Member is eligible for Medicare due to disability;

(d) the Dependent of a Member whose Employer (and each other Employer participating in the Plan) has fewer than 100 Members, and that Dependent is eligible for Medicare due to disability;

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

(f) an active or retired Member (or a Dependent thereof) 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 M

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 Member and his Dependent (or any former Member and his Dependent), unless he is listed under (a) through (f) above.

Domestic Partners

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

GM6000 MEL45 V3 M

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, Sickness, or condition. 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:

- the amount actually paid for such Covered Expenses by CG; or
- 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, award, or otherwise.

GM6000 CCP7 CCL7 M

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 incurred 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 or 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, at its discretion, will calculate Covered Expenses following evaluation/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 M

Termination of Insurance

Members

Your insurance will cease on the earliest date below:

- the date you cease to be in an Eligible Class or otherwise 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 benefits will be continued until the earlier of: (a) the date premium stops being paid for you; or (b) the Policyholder otherwise cancels your insurance.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, the benefits will not continue past the earlier of: (a) the date premium stops being paid for you; or (b) the Policyholder otherwise cancels your insurance.

GM6000 TRM15V44 M

Dependents

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 M

Special Continuation of Medical Insurance

If your insurance as a Member or a Dependent (including non-Employee civil union partners) ceases for any reason other than: (a) discontinuance of the Policy; (b) failure to make any required contributions; or (c) termination of your employment due to misconduct; and if you have been insured for at least 3 consecutive months and you are not eligible for Medicare; you may continue the insurance by paying the required contribution to the Policyholder. In no event will the insurance be continued beyond the earliest of the following dates:

- the expiration of 6 months from the date the insurance would otherwise have terminated;
- the last day of the period for which you have paid the required contribution;
- the date you become eligible for similar group coverage, or Medicare;
- the date you cease to qualify as a Dependent;
- the date the group policy cancels.

GM6000 TRM172V1 M

Additional Provisions for Continuation

The Policyholder will notify you or your Dependent of the right to elect continuation. Within 60 days after the earlier of: (a) the date the insurance would otherwise cease; or (b) the date notice of the right of continuation is given, you or your Dependent may then elect such continuation, in writing, contingent upon payment of the required contribution to the Policyholder.

The provisions of the section entitled, **Medical Conversion Privilege,** will apply following the termination of insurance.

The terms of this "Special Continuation of Medical Insurance" will not reduce any continuation of insurance otherwise provided.

If, on the day before the Effective Date of this Policy, medical insurance was being continued for a person under a group medical plan offered by the Policyholder, and was subsequently replaced by this Policy, that person's coverage will be continued for the remaining portion of his period of continuation under this Policy, subject to the terms of this section. However, the benefits payable under this Policy will be the benefits of the prior group medical plan, reduced by any benefits still payable under that prior plan.

GM6000 TRM173V1 M

Medical Benefits Extension

Upon Policy Cancellation

If the medical benefits under this plan cease for you or your Dependent due to cancellation of the Policy; and you or your Dependent is Totally Disabled on that date due to an Injury or a Sickness; medical benefits will be paid for Covered Expenses incurred for or in connection with that Injury or Sickness. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in The Schedule;
- the date you become covered for medical benefits under another group plan or policy;
- the date you are no longer Totally Disabled;
- 12 months from the date your Medical Benefits cease; or
- 12 months from the date the policy is canceled.

Totally Disabled

You will be considered Totally Disabled if, because of an Injury or a Sickness:

- you are unable to perform the basic duties of your occupation; and
- you are not performing any other work or engaging in any other occupation for wage or profit.

Your Dependent will be considered Totally Disabled if, because of an Injury or a Sickness:

- he is unable to engage in the normal activities of a person of the same age, sex and ability; or
- in the case of a Dependent who normally works for wage or profit, he is not performing such work.

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

GM6000 BEX183 V8 M

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 certificate, the provision which provides the better benefit will apply.

FDRL1V2 M

Notice of Provider Directory/Networks

You have access to a list of providers who participate in the network. Visit www.cigna.com; mycigna.com; or call the toll-free telephone number on your ID card.

Participating Provider/Pharmacy networks consist of groups 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.

FDRL32 M

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.

You must notify the Plan Administrator 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, 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 while satisfying 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.

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

C. Payment of Benefits

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

FDRL2V1 M

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

You or your eligible Dependent(s) may be entitled to enroll in the Plan outside of the designated Open 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): (a) Member only; (b) Dependent spouse only; (c) Member and Dependent spouse; (d) Dependent child(ren) only; (e) Member and Dependent child(ren); or (f) Member, Dependent spouse and Dependent child(ren).

  Enrollment of Dependent children is limited to newborn or adopted children, or children who became Dependent children of the Member due to marriage. Dependent children who are already Dependents of the Member, 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, coverage must have been declined in writing, with a statement that the reason for declining enrollment was due to other health coverage at the time enrollment in this Plan was previously declined. 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 Member;
  - 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 other coverage for the Member or Dependent(s) , 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 M

- **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 upon 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.

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

FDRL4V3 M

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 of the paragraph entitled, "Exception for Newborns" in the **Eligibility - Effective Date** section of this certificate will also apply to an adopted child or a child placed with you for adoption.

FDRL6 M

Federal Tax Implications for Dependent Coverage

Premium payments for Dependent health insurance are usually exempt from federal income tax. Generally, if you can claim an individual as a Dependent for purposes of federal income tax, then the premium for that Dependent's health insurance coverage will not be taxable to you as income. However, in the rare instance that you cover an individual under your health insurance who does not meet the federal definition of a Dependent, the premium may be taxable to you as income. If you have questions concerning your specific situation, you should consult your own tax consultant, attorney, or CPA.

FDRL7 M

Coverage for Maternity Hospital Stay

Group health plans and health insurance carriers 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 carrier 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 M

Women's Health and Cancer Rights Act (WHCRA)

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 telephone number shown on your benefit

identification card for more information.

FDRL51 M

Group Plan Coverage Instead of Medicaid

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

FDRL10 M

Pre-Existing Conditions Under the Health Insurance Portability & Accountability Act (HIPAA)

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

A. Pre-Existing Condition Limitation

Under HIPAA, a Pre-existing Condition Limitation (PCL) 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 ending on the enrollment date. Plan provisions may vary. Please refer to the section entitled, **Limitations and Exclusions**, for the specific Pre-existing Condition Limitation provisions which apply under this Plan.

B. Exceptions to Pre-existing Condition Limitation

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

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

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:

Vermont Association of Chamber Executives
P. O. Box 810
Montpelier, VT 05602

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: Self-insured employer group health plans; Individual or group health insurance indemnity or HMO plans; Part A or Part B of Medicare; Medicaid (except coverage solely for pediatric vaccines); Health plans 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; Medical care programs of the Indian Health Service or of a tribal organization; State health benefits risk pools; The Federal Employees Health Benefits Program; Public health plans established by a state, the U.S. government, or a foreign country; the Peace Corps Act; or a state Children's Health Insurance Program.

F. 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 (by whatever named called) 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 benefit identification card.

FDRL73 M

Requirements of the Family and Medical Leave Act of 1993 (FMLA)

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

A. Continuation of Health Insurance During Leave

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

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

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

B. Reinstatement of Canceled Insurance Following Leave

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

You will not be required to satisfy any eligibility or benefit waiting period to the extent that it had been satisfied prior to the start of such leave of absence.

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

FDRL13 M

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 with respect to a Member's military leaves of absence. These requirements apply to medical and dental coverage for you and your Dependents.

A. Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the section of the **Termination** provisions 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 cost 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 cost.

B. Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA and you are re-employed by your current Employer, coverage for you and your Dependents may be reinstated, if: (a) you gave your Employer advance written or verbal notice of your military service leave; and (b) the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of any Pre-Existing Condition Limitation (PCL) or eligibility 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.

FDRL58 M

Continuation Rights Under Federal Law (COBRA)

For You and Your Dependents

Note: COBRA Continuation benefits are administered by your Employer. Please direct any questions regarding COBRA Continuation to your Employer's Human Resources department.

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 "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:

(1) your death;

(2) your divorce or legal separation; or

(3) 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 under the Plan on the date 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); and 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, coverage for such individuals will terminate when your COBRA continuation coverage terminates. The sections entitled, "Secondary Qualifying Events" and "Medicare Extension For Your Dependents," are not applicable to these individuals.

FDRL67 M

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, both of the following requirements must be satisfied:

(a) The SSA must determine that the disability occurred prior to, or within, 60 days after the disabled individual elected COBRA continuation coverage; and

(b) 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 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.

FDRL21 M

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 Policy;
- 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: (a) the end of the applicable maximum period; (b)

the date the pre-existing condition provision is no longer applicable; or (c) the occurrence of (1), (2) or (3) above); or

- for any reason that the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

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

If you and/or your Dependents move out of the Plan's service area; or if the Plan eliminates the 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 Plan's service area. If the Policyholder offers another benefit option through CG (or another carrier) which can provide coverage in your new location, you may elect COBRA continuation coverage under that option.

FDRL22V1 M

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 coverage for you (or your Dependent spouse) 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 time frames:
  - (a) 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; or
  - (b) 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.

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 cost. 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 Dependent 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.

FDRL23 M

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 Member contributions) for coverage of a similarly-situated active Member or Dependent. The premium during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both Employer and Member contributions) for coverage of a similarly-situated active Member or Dependent. For example:

- If the Member alone elects COBRA continuation coverage, he or she will be charged 102% (or 150%) of the active Member cost.
- If the Dependent spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% (or 150%) of the active Member cost.
- If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%) of the applicable family cost.

When and How to Pay for COBRA

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 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.

FDRL24V2 M

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: (a) the date the qualifying event occurs; or (b) 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.

Notice must be made in writing and must include: the name of the Plan; name and address of the Member 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 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 will not be eligible for a secondary qualifying event.

FDRL25V1 M

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 persons 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 65% 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/2002act_index.asp.

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 specified under the “Termination of COBRA Continuation” provisions 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.

FDRL26 M

Notice of an Appeal or a Grievance

The appeal or grievance provisions in this certificate may be superseded by the laws of your state. Please see your explanation of benefits for the applicable appeal or grievance procedure.

GM6000 NOT90 M

<u>The Following Will Apply to Residents of Vermont</u>:

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 telephone 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 the 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 telephone number, or the address on your benefit identification card, explanation of benefits, or claim form.

GM6000 APL766 M

Level One Appeal For Mental Health/Substance Abuse Issues

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 10 calendar days.

You may request that the appeal process be expedited for an emergency. An "emergency" means a condition or illness which, if not treated immediately, presents a serious risk of harm to the individual, to others, or to property. When an appeal is expedited, we will respond orally with a decision within 24 hours followed up in writing.

Level One Appeal For Non-Mental Health/Substance Abuse Issues

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 post-service 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 the appeal is for urgently needed care. "Urgently needed care" means those health care services that are necessary to treat a condition or Sickness which, if not treated within 24 hours, presents serious risk of harm. When an appeal is expedited, we will respond orally with a decision within 72 hours followed up in writing.

GM6000 APL767 M

Voluntary Level Two Appeal For Mental Health/Substance Abuse Issues

If you are dissatisfied with our Level One appeal decision, you may request a voluntary second review. To start a Level Two appeal, follow the same process required for a Level One appeal.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Physician reviewer in the same (or a 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. The Committee review will be completed within 10 calendar days. You will be notified in writing of the Committee's decision within five (5) 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 for an emergency. An "emergency" means a condition or Sickness which, if not treated immediately, presents a serious risk of harm to the person, to others, or to property. When an appeal is expedited, we will respond orally with a decision within 24 hours followed up in writing.

Level Two Appeal For Non-Mental Health/Substance Abuse Issues

If you are dissatisfied with our Level One appeal decision, you may request a second review. To start a Level Two appeal, follow the same process required for a Level One appeal.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Physician reviewer in the same (or a 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 pre-service and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For post-service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days, and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five (5) 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 the appeal is for urgently needed care. "Urgently needed care" means those health care services that are necessary to treat a condition or Sickness which, if not treated within 24 hours, presents serious risk of harm. When an appeal is expedited, we will respond orally with a decision within 48 hours, followed up in writing.

GM6000 APL768 M

External Review Procedure For Mental Health/Substance Abuse Issues

If you are dissatisfied with either a Level One Appeal decision or a voluntary Level Two Appeal decision related to Medical Necessity or clinical appropriateness, you may request an External Review of your issue by an Independent Panel of Mental Health Care Providers (IP). To start the External Review by an IP, you (or a representative, on your behalf) or your mental health care provider must file a written request with CG and the IP. You must include your consent for CG to release confidential patient files to the IP. The IP address is:

Independent Panel of Mental Health Care Providers
Department of Banking, Insurance and Securities
89 Main Street, Drawer 20
Montpelier, VT 05620-3101
802.828.3301

When CG receives your request for an External Review, it will send the file supporting the initial decision and the appeal decision(s) to the IP within: (a) 24 hours of receiving the request in emergency situations; and (b) within five (5) working days of receiving the request in all other situations.

The IP may address inquiries to any of the parties (you or your authorized representative, your mental health care provider, or CG) and may set a reasonable time period for a response. If CG does not provide all necessary information in the required time periods, the delay will result in a presumption in your favor and will not delay the IP's review of the issue. The IP also has the authority to request any or all of the parties to meet with it. The IP will make its review decision within: (a) 24 hours of receiving all necessary information in emergency situations; and (b) within 15 working days in all other situations, and will communicate that decision by mail or facsimile to CG and to the person who filed the request for External Review. Emergency decisions will be communicated by telephone, facsimile, or delivered by express mail, as appropriate. CG is required to abide by IP's decision. If you have a complaint about a matter that is not related to Medical Necessity or clinical appropriateness, you may file a consumer complaint with the Insurance Consumer Services Division at the following address:

Insurance Consumer Services Division
Department of Banking, Insurance and Securities
89 Main Street, Drawer 20
Montpelier, VT 05620-3101
802.828.3302

External Appeal Procedure For Non-Mental Health/Substance Abuse Issues

If you have exhausted CG's internal appeal process, you may request an External Review of your issue by an Independent Review Organization (IRO). You (or your authorized representative or provider on your behalf) may file a written request for External Review within 90 days from the date you receive CG's final, written appeal decision. The written request for External Review must be filed with the Division of Health Care Administration at the following address:

Division of Health Care Administration
External Appeals Program
89 Main Street, Drawer 20
Montpelier, VT 05620-3601

The insured must file on a form provided by the Division and include: (a) a $25 fee (or a request for a waiver or reduction of the fee); (b) general release of medical records relevant to the appeal; (c) identification of insurer; and (d) a statement that all internal appeals have been exhausted. An oral request will also be accepted if made within the 90-day period, provided that the request is confirmed in writing on the state-approved request form within 10 calendar days. The External Appeal program is a voluntary program.

Once notified by the Division that the External Appeal has been accepted for review by an IRO, CG must submit all information relevant to the appeal, including: (a) the review criteria used in making the decision; (b) copies of any applicable policies or procedures; and (c) copies of all medical records considered in making the decision in the appeal process. CG may request an extension of up to 10 days to submit information and documentation, granted by the Division for good cause.

CG must pay the costs of the External Appeal to the Division within 30 days of notification of the reasonable and necessary costs of the review by the IRO.

The Division will provide the request form for an External Appeal, and will assist you in filing a written request. An oral request will also be accepted if made within the 90-day period, provided that the request is confirmed in writing on the state-approved request form within 10 calendar days. Within five (5) working days of

receiving the External Appeal request, the Division will process the form and materials, and accept the appeal for review by an IRO after determining that: (a) you are or were insured; (b) the service is a covered service under the plan; (c) the External Appeal involves an appealable decision; (d) you have exhausted the internal processes; and (e) all information has been provided.

GM6000 APL769 M

External Appeal Procedure for Non-Mental Health/Substance Abuse Issues

The Vermont Division of Health Care Administration (referred to herein as the "Division") will notify you when the External Appeal submission is complete, and whether the External Appeal has been accepted for review by an IRO. CG must submit any required documentation within 10 calendar days from the date CG receives the request notice. CG may request a 10-calendar day extension for good cause. You may have an extension for any reason.

The Division shall provide copies of documentation (and follow-up information) to you and to CG; each will have 3 working days to file responsive documentation with the Division.

The Division will assign the External Appeal on a rotating basis to an IRO for clinical review.

The Division will review the determination of the IRO and then issue the determination to you and to CG, which will be binding on CG but not on you.

The IRO will conduct a full review, and may request any additional information it requires from you, CG, or the Division. The IRO will complete the review, and forward its written determination to the Division within: (a) five (5) calendar days from receipt, if the External Appeal involves emergency or urgently needed care; and (b) 30 calendar days from receipt for all other External Appeal requests. The IRO's written determination will include the clinical rationale for the determination. The IRO may request an extension from the Commissioner.

Appeal to the State of Vermont

You have the right to contact the Vermont Department of Banking, Insurance, Securities, and Health Care Administration for assistance at any time. The Department may be contacted at the following address and telephone number:

Vermont Department of Banking, Insurance,
Securities and Health Care Administration
89 Main Street - Drawer 20
Montpelier, Vermont 05620-3601
1-802-828-2900
1-800-631-7788

Other Consumer Assistance Organizations:

Office of Health Care Ombudsman: 1-800-917-7787
[A free statewide program to help Vermonters resolve problems and complaints with their health insurance]

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Notice of Benefit Determination on Appeal (Applies to All Issues)

Every notice of a determination of 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; (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 (6) an explanation of the scientific or clinical judgment for a determination that is based on Medical Necessity, experimental treatment, or other similar exclusions or limitations.

You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to determine what options may be available is to contact your local U.S. Department of Labor office, or your state insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

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

Legal Action

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 APL771 M

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 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, 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 a provider has contracted, directly or indirectly, with CG for a different amount.

DFS940

Custodial Services

The term Custodial Services refers to 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 primarily 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 unmarried child of yours who is
  - less than 19 years old;
  - 19 years old or older, but less than 25 years old, enrolled in school as a full-time student and primarily supported by you;
  - 19 years old or older, but less than 25 years old, enrolled in school as a full-time student and primarily supported by you, but on a Medically Necessary leave of absence from school. Coverage will continue for a period not to exceed: (a) 24 months; or until the date the child's coverage would otherwise end upon reaching age 25; whichever occurs first. Documentation and certification by the student's treating Physician of the Medical Necessity of the leave of absence must be submitted to CG. CG may also require reasonable periodic proof from the student's treating Physician that the leave of absence continues to be Medically Necessary.
  - 19 years old or older, primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CG within 31 days after the date the child ceases to qualify above. During the next two years CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

The term "child" includes: (a) a child born to you; (b) a child legally adopted by you; (c) a grandchild who is considered your Dependent for federal income tax purposes; and (d) a stepchild who lives with you.

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 insured as a Member will not be insured as a Dependent.

No one may be insured as a Dependent of more than one Member.

DFS57 V1

Emergency Services

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

DFS1533

Employer

The term Employer refers to an employer group that elects to participate in the Vermont Association of Chamber Executives benefit program.

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: (a) it has a medical staff of Physicians, Nurses, and licensed anesthesiologists; (b) it maintains at least two operating rooms and one recovery room; (c) it maintains diagnostic laboratory and x-ray facilities; (d) it has equipment for emergency care; (e) it has a blood supply; (f) it maintains medical records; (g) it has agreements with Hospitals for immediate acceptance of patients who require Hospital Confinement; and (h) 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 designed 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 Sickness;
- a program for persons who have a Terminal Illness and for the families of those persons.

DFS70

Hospice Care Services

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

DFS599

Hospice Facility

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

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

DFS72

Hospital

The term Hospital means:

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

DFS1836

Injury

The term Injury means an accidental bodily injury.

DFS147

Maximum Reimbursable Charge

The Maximum Reimbursable Charge for a covered service is the lesser of:

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

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

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

GM6000 DFS1997V5

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

The term Medically Necessary refers to services and supplies that are determined by CG to: (a) be consistent with generally accepted practice parameters as recognized by health care providers in the

same (or a similar) general specialty as typically treats or manages the diagnosis or condition; (b) be helpful in restoring or maintaining the person's health; (c) prevent deterioration of, or palliate, the person's condition; or (d) prevent the reasonably likely onset of a health problem or detect an incipient problem. Health care services shall also include diagnostic testing, preventive services, and aftercare appropriate, in terms of type, amount, frequency, level, setting, and duration, to the person's diagnosis or condition.

DFS1913

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

Member

The term Member refers to a member in good standing of the Vermont Association of Chamber Executives who is: (a) working on a regularly-scheduled basis; and (b) currently in Active Service. The term does not include such persons who are temporary, or who normally work less than 17.5 hours per week.

DFS1427

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 due to special nursing, dental, or medical fees.

DFS151

Nurse

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

DFS155

Ophthalmologist

The term Ophthalmologist means a person practicing ophthalmology within the scope of his license. It also includes a Physician operating within the scope of his license when he performs any of the vision care services described in the plan.

DFS156

Optometrist

The term Optometrist means a person practicing optometry within the scope of his license. It also includes a Physician operating within the scope of his license when he performs any of the vision care services described in the plan.

DFS157

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 Care Professional

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

DFS1685

Participating Pharmacy

The term Participating Pharmacy means a retail pharmacy or mail-order pharmacy with which CG has contracted to provide prescription services to insureds.

DFS1937

Participating Provider

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

DFS1910

Pharmacy

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

DFS1934

Pharmacy & Therapeutics (P & T) Committee

The Pharmacy & Therapeutics (P & T) Committee is comprised of 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

The term 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, which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

DFS1708

Prescription Drug List

The term Prescription Drug List refers to 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

The term Prescription Order means the lawful authorization of a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of his or her 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, and authorized by CG, 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

The term Related Supplies includes, but is not limited to: diabetic supplies (insulin needles and syringes, lancets, and glucose test strips); needles and syringes for injectables covered under the pharmacy plan; and spacers for use with oral inhalers.

DFS1710

Review Organization

The term Review Organization refers to an affiliate of 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

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses 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 and certified by a Physician.

DFS197

Urgent Care

Urgent Care refers to 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 be 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, including, but 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