

**Welfare Fund of Local 1
IATSE**

OPEN ACCESS PLUS MEDICAL BENEFITS
PRESCRIPTION DRUG BENEFITS

(OAP3 – Tier III)

EFFECTIVE DATE: July 1, 2008

CN008
3319944

This document printed in May, 2006 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.



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

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

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

POLICYHOLDER: Welfare Fund of Local 1 IATSE

GROUP POLICY(S) - COVERAGE

3319944-OAP3 OPEN ACCESS PLUS MEDICAL BENEFITS

EFFECTIVE DATE July 1, 2008

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.

Susan L. Cooper

Corporate Secretary

GM6000 C2

CER7V21



Explanation of Terms

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

THE SCHEDULE

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



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Open Access Plus Medical Benefits

The Schedule

For You and Your Dependents

This plan provides medical benefits for services and supplies provided by Participating Providers and Non-Participating Providers, unless otherwise noted. To receive Open Access Plus Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.

You or your Dependent can obtain the names of Participating Providers in your area by consulting your Physician Guide, or calling the toll-free number shown on the back of your I.D. card.

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

Coinsurance

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

Copayments/Deductibles

Copayments are expenses to be paid by you or your Dependent for the services received. Deductibles are also expenses to be paid by you or your Dependent. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance.

Plan Maximum Benefits	This Plan will Pay:	
	Participating Provider	Non-Participating Provider
Maximum Benefit	Lifetime Maximum: Unlimited	Annual Maximum: \$1,500,000



<p>Maximum Reimbursable Charge</p> <p>Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or</p> <p>A percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database we have selected.</p> <p>Note: The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles, copayments and coinsurance.</p>	<p>Not Applicable</p>	<p>70th Percentile</p>
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<p>Plan Deductibles</p>	<p>You Pay:</p>	
	<p>Participating Provider</p>	<p>Non-Participating Provider</p>
<p>Individual Deductible</p> <p>Regardless of the Individual Deductible amount stated above, that Deductible will not be more than \$50 for expenses incurred for charges made by a Home Health Care Agency. Any expenses incurred in excess of \$50 for such charges will not reduce the Individual Deductible.</p>	<p>None</p>	<p>\$400 per person per calendar year</p>



<p>Family Deductible</p>	<p>None</p>	<p>\$1,000 per family per calendar year</p> <p>After Non-Participating Provider Deductibles totaling \$1,000 have been applied in a Calendar Year for either (a) you and your Dependents or (b) your Dependents, your family need not satisfy any further Medical Deductible for the rest of that year.</p>
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Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for Participating Provider and Non-Participating Provider charges for which no payment is provided because of the coinsurance factor. In addition, benefits for Covered Expenses incurred for or in connection with Mental Health and Substance Abuse will accumulate toward the Out-of-Pocket Maximums and benefits for such expenses will be increased. However, charges for Covered Expenses incurred for or in connection with non-compliance penalties or in excess of Reasonable & Customary levels will not accumulate toward the Out-of-Pocket Maximums and benefits for such expenses will not be increased.

<p>Out-of-Pocket Maximums</p>	<p>You Pay:</p>	
	<p>Participating Provider</p>	<p>Non-Participating Provider</p>
<p>Individual Out-of-Pocket Maximum</p>	<p>None</p>	<p>\$1,200 per person per calendar year</p> <p>When a person has incurred Out-of-Pocket Expenses totaling \$1,200 for Covered Medical expenses in a Calendar Year for which no payment is made, Covered Medical Benefits for that person for the remainder of that Calendar Year will be payable at 100%</p>

<p>Family Out-of-Pocket Maximum</p>	<p>None</p>	<p>None</p>
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Benefits for care other than for Mental Health and Substance Abuse	How this Plan Works:	
	Participating Provider	Non-Participating Provider
	You and your Dependent pay the Participating Provider Copayments and any benefit deductible shown below plus the Coinsurance, then the Plan pays the Benefit Percentage shown	You and your Dependent pay the Non-Participating Provider Deductibles or Copayments and any benefit deductible shown below plus the Coinsurance, then the Plan pays the Benefit Percentage shown

Physician Services		
Physician Office Visit	\$25 per visit, then 100%	80% after plan deductible
Specialist Office Visit	\$25 per visit, then 100%	80% after plan deductible
Surgery Performed in the Physician's Office	\$25 per visit, then 100%	80% after plan deductible
Surgery Performed in the Specialist's Office	\$25 per visit, then 100%	80% after plan deductible
Allergy Treatment/Injections	The lesser of: (a) the Physician or Specialist office visit copay; or (b) the actual charge	80% after plan deductible
Allergy Serum (dispensed by the Physician in the office)	No Charge	80% after plan deductible

Hearing Aids	No Charge	100% no deductible
Maximum: \$1,500 per ear up to a \$3,000 maximum every 3 years		



Benefits for care other than for Mental Health and Substance Abuse	How this Plan Works	
	Participating Provider	Non-Participating Provider

Preventive Care		
Well-Child Care for children to age 19		
New York and Non-New York residents	No Charge	80% after plan deductible
Child Immunizations birth to age 19		
Office Visit	No Charge	80% after plan deductible

Annual Routine Physicals age 19 and above		
Office Visit	\$25 per visit, then 100%	80% after plan deductible
Immunizations for age 19 and above		
Office Visit	No Charge	80% after plan deductible

Mammogram	No Charge	80% after plan deductible
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Pap Test	No Charge	80% after plan deductible
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Prostate Specific Antigen (PSA)	No Charge	80% after plan deductible
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Benefits for care other than for Mental Health and Substance Abuse	How this Plan Works	
	Participating Provider	Non-Participating Provider
Pre-Admission Testing		
Physician Office Visit	\$25 per visit, then 100%	80% after plan deductible
Specialist Office Visit	\$25 per visit, then 100%	80% after plan deductible
Outpatient Hospital Facility	No Charge	80% after plan deductible
Independent Lab and X-Ray Facility	No Charge	80% after plan deductible
Inpatient Hospital Facility Services	No Charge	80% after plan deductible
Semi Private Room and Board	The Hospital's negotiated rate for a semi-private room	The Hospital's most common daily rate for a semi-private room
Private Room and Board	The Hospital's negotiated rate for a semi-private room	The Hospital's most common daily rate for a semi-private room
Special Care Units (ICU/CCU) and Board	The Hospital's negotiated rate	The Hospital's most common daily rate for an ICU/CCU room
Outpatient Hospital Facility Services	No Charge	80% after plan deductible
Operating Room, Recovery Room, Procedure Room, and Treatment		



Benefits for care other than for Mental Health and Substance Abuse	How this Plan Works	
	Participating Provider	Non-Participating Provider

Inpatient Hospital Doctor's Visits/Consultations	No Charge	80% after plan deductible
Inpatient Hospital Professional Services: Surgeon Radiologist Pathologist Anesthesiologist	No Charge	80% after plan deductible
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	No Charge	80% after plan deductible

<p>Multiple Surgical Reduction</p> <p>Multiple surgeries performed during one operating session result in a payment reduction of 50% to the surgery of the lesser charge. The most expensive procedure is paid as any other surgery.</p> <p>Cosurgeon</p> <p>Charges made by an assistant surgeon in excess of 20 percent of the surgeon's allowable charge; or for charges made by a cosurgeon in excess of the surgeon's allowable charge plus 20 percent. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)</p>		
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<p>Second Opinions (Services will be provided on a voluntary basis)</p> <p>Office Visit</p>	\$25 per visit, then 100%	\$25 per visit, then 100%
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Benefits for care other than for Mental Health and Substance Abuse	How this Plan Works	
	Participating Provider	Non-Participating Provider
<p>Emergency and Urgent Care Services</p> <p>Office Visit</p> <p>Hospital Emergency Room</p> <p>Urgent Care Facility or Outpatient Facility</p> <p>Ambulance</p>	<p>\$25 per visit, then 100%</p> <p>\$25 per visit*, then 100%</p> <p>\$25 per visit*, then 100%</p> <p>No Charge</p> <p>* Copayment Waived if Admitted</p>	<p>\$25 per visit, then 100% **</p> <p>\$25 per visit*, then 100% **</p> <p>\$25 per visit*, then 100% **</p> <p>No Charge **</p> <p>* Copayment Waived if Admitted</p> <p>** <i>Except if not a true emergency, then 80% after plan deductible</i></p>
<p>Inpatient Services at Other Health Care Facilities</p> <p>Includes: Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</p> <p>Inpatient Facility Room and Board</p> <p>Calendar Year Maximum: 60 days</p>	<p>No Charge</p> <p>The Facility's negotiated rate</p>	<p>80% after plan deductible</p> <p>The Facility's most common daily rate for a semi-private room</p>



Benefits for care other than for Mental Health and Substance Abuse	How this Plan Works	
	Participating Provider	Non-Participating Provider
<p>Laboratory and Radiology Services</p> <p>Advanced Radiological Imaging</p> <p>MRIs, MRAs, CAT Scans and PET Scans</p> <p>Outpatient Hospital Facility</p> <p>Other Laboratory and Radiology Services (All charges billed by an independent facility)</p>	<p>No Charge</p> <p>No Charge</p> <p>No Charge</p>	<p>80% after plan deductible</p> <p>80% after plan deductible</p> <p>80% after plan deductible</p>
<p>Home Health Care</p> <p>Calendar Year Maximum: 120 days</p> <p>Expenses incurred for either Participating Provider or Non-Participating Provider charges will be used to satisfy the maximum</p>	<p>No Charge</p>	<p>\$50 per Calendar Year deductible, then 80%</p>
<p>Hospice</p> <p>Inpatient Facility</p> <p>Outpatient Services</p> <p>Hospice Room and Board</p>	<p>No Charge</p> <p>No Charge</p> <p>The Hospice Facility's negotiated rate</p>	<p>80% after plan deductible</p> <p>\$50 per Calendar Year deductible, then 80%</p> <p>The Hospice Facility's most common daily rate for a semi-private room</p>



Benefits for care other than for Mental Health and Substance Abuse	How this Plan Works	
	Participating Provider	Non-Participating Provider
<p>Bereavement Counseling</p> <p>Inpatient (Same as Inpatient Hospice Facility)</p> <p>Outpatient (Same as Outpatient Hospice)</p> <p>Maximum: Unlimited</p> <p>NOTE: Services provided by a Mental Health Professional will reduce the number of outpatient visits available under the plan's Mental Health benefit</p>	<p>No charge for services provided as part of the Hospice Care Program</p> <p>No charge for services provided as part of the Hospice Care Program</p>	<p>80% after plan deductible, for services provided as part of the Hospice Care Program</p> <p>80% after plan deductible, for services provided as part of the Hospice Care Program</p>
<p>Outpatient Short-Term Rehabilitative Therapy</p> <p>Calendar Year Maximum: 60 days for all therapies combined</p> <p>Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy</p> <p>Chiropractic Care</p> <p>Calendar Year Maximum: Unlimited</p>	<p>\$25 per visit, then 100%</p> <p>\$25 per visit, then 100%</p>	<p>80% after plan deductible</p> <p>80% after plan deductible</p>



Benefits for care other than for Mental Health and Substance Abuse	How this Plan Works	
	Participating Provider	Non-Participating Provider
<p>Acupuncture</p> <p>Calendar Year Maximum: 20 visits</p>	\$25 per visit, then 100%	80% after plan deductible
<p>Maternity</p> <p>Initial Visit to Confirm Pregnancy</p> <p>Office Visit</p> <p>All Subsequent Physician's charges for Prenatal Visits, Postnatal Visits, and Delivery</p> <p>Delivery (Inpatient Hospital, Birthing Center)</p>	<p>\$25 per visit, then 100%</p> <p>No Charge</p> <p>Same as plan's Inpatient Hospital Facility Benefit</p>	<p>80% after plan deductible</p> <p>80% after plan deductible</p> <p>Same as plan's Inpatient Hospital Facility Benefit</p>
<p>Abortion (Limited to non-elective procedures)</p> <p>Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p>	<p>\$25 per visit, then 100%</p> <p>Same as plan's Inpatient Hospital Facility Benefit</p> <p>Same as plan's Outpatient Hospital Facility Benefit</p> <p>No Charge</p>	<p>80% after plan deductible</p> <p>Same as plan's Inpatient Hospital Facility Benefit</p> <p>Same as plan's Outpatient Hospital Facility Benefit</p> <p>80% after plan deductible</p>



Benefits for care other than for Mental Health and Substance Abuse	How this Plan Works	
	Participating Provider	Non-Participating Provider
<p>Family Planning</p> <p>Office Visits including Tests and Counseling</p> <p>Office Visit</p> <p>Surgical Sterilization Procedures for Vasectomy/Tubal Ligations (excluding reversals)</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p>	<p>\$25 per visit, then 100%</p> <p>Same as plan's Inpatient Hospital Facility Benefit</p> <p>Same as plan's Outpatient Hospital Facility Benefit</p> <p>No Charge</p>	<p>80% after plan deductible</p> <p>Same as plan's Inpatient Hospital Facility Benefit</p> <p>Same as plan's Outpatient Hospital Facility Benefit</p> <p>80% after plan deductible</p>
<p>Infertility Treatment</p> <p>Office Visit (Tests, Counseling)</p> <p>Surgical Treatment: Limited to Procedures for Correction of Infertility, Artificial Insemination (excludes In Vitro Fertilization, GIFT, ZIFT, and similar procedures)</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p>	<p>\$25 per visit, then 100%</p> <p>Same as plan's Inpatient Hospital Facility Benefit</p> <p>Same as plan's Outpatient Hospital Facility Benefit</p> <p>No Charge</p>	<p>80% after plan deductible</p> <p>Same as plan's Inpatient Hospital Facility Benefit</p> <p>Same as plan's Outpatient Hospital Facility Benefit</p> <p>80% after plan deductible</p>



Benefits for care other than for Mental Health and Substance Abuse	How this Plan Works	
	Participating Provider	Non-Participating Provider
<p>Transplants Includes all medically appropriate non-experimental transplants</p> <p>Lifesource Facility</p> <p>Other Inpatient Hospital Facility</p> <p>Physician's Services Lifesource Physician</p> <p>Non-Lifesource Physician</p>	<p>No Charge</p> <p>Same as plan's Inpatient Hospital Facility benefit</p> <p>No Charge</p> <p>No Charge</p>	<p>Not Covered</p> <p>Not Covered</p> <p>Not Covered</p> <p>Not Covered</p>
<p>Transplant Travel Services Maximum (Covered only when transplant procedure is performed at a Lifesource Facility)</p>	<p>\$10,000 per transplant</p>	<p>Not Covered</p>
<p>Durable Medical Equipment</p> <p>Calendar Year Maximum: Unlimited</p>	<p>No Charge</p>	<p>80% after plan deductible</p>
<p>External Prosthetic Appliances</p> <p>Calendar Year Maximum: Participating Provider: Unlimited</p> <p>Non-Participating Provider: \$1,000</p>	<p>\$200 per Calendar Year deductible, then 100%</p>	<p>\$200 per Calendar Year deductible, then 80% after plan deductible</p>



Benefits for care other than for Mental Health and Substance Abuse	How this Plan Works	
	Participating Provider	Non-Participating Provider
<p>Wigs</p> <p>Calendar Year Maximum: \$1,000</p>	Not Covered	\$200 per Calendar Year deductible, then 80%
<p>Nutritional Evaluation</p> <p>Calendar Year Maximum: 3 visits per person, however the three visit limit will not apply to treatment of diabetes</p>	No Charge, if performed by the PCP or Specialist then no charge after the PCP or Specialist per visit copay.	80% after plan deductible
<p>Dental Care (Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth)</p> <p>Doctor's Office</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p>	<p>\$25 per visit, then 100%</p> <p>Same as plan's Inpatient Hospital Facility benefit</p> <p>Same as plan's Outpatient Hospital Facility benefit</p> <p>No Charge</p>	<p>80% after plan deductible</p> <p>Same as plan's Inpatient Hospital Facility benefit</p> <p>Same as plan's Outpatient Hospital Facility benefit</p> <p>80% after plan deductible</p>



Benefits for care other than for Mental Health and Substance Abuse	How this Plan Works	
	Participating Provider	Non-Participating Provider
Temporomandibular Joint Disorder (Surgical & Non-Surgical Treatment)		
Office Visit	\$25 per visit, then 100%	80% after plan deductible
Inpatient Facility	Same as plan's Inpatient Hospital Facility Benefit	80% after plan deductible
Outpatient Facility	Same as plan's Outpatient Hospital Facility Benefit	80% after plan deductible
Physician Services	No Charge	80% after plan deductible
Calendar Year Maximum: Unlimited		
All Other Covered Expenses	No Charge	80% after plan deductible



Mental Health and Substance Abuse	How this Plan Works:	
	Participating Provider	Non-Participating Provider
	<p>You and your Dependent pay any Participating Provider Copayment and benefit deductible shown below plus any Coinsurance, then the Plan pays the Benefit Percentage shown</p>	<p>You and your Dependent pay the Non-Participating Provider Deductible, any Copayment and benefit deductible shown below plus any Coinsurance, then the Plan pays the Benefit Percentage shown</p>

<p>Mental Health</p> <p>Inpatient</p> <p>Calendar Year Maximum: Thirty (30) days per calendar year, while confined in a Hospital. Two days of partial confinement are equivalent to one day of full confinement.</p>	<p>No Charge</p>	<p>80% after plan deductible</p>
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Benefits for Mental Health and Substance Abuse	How this Plan Works	
	Participating Provider	Non-Participating Provider
<p>Outpatient</p> <p>Calendar Year Maximum: Unlimited</p> <p>Intensive Outpatient Program</p> <p>Calendar Year Maximum: Not to exceed 3 programs, or the plan's Outpatient Visit Maximum (Visits used reduce the number of Mental Health Outpatient visits available).</p> <p>Benefit levels are managed in accordance with clinical guidelines. "Current guidelines recommend up to 3 Intensive Outpatient Programs per calendar year." Thereafter, a different mode of treatment is recommended and may include inpatient or outpatient services for additional rehabilitation.</p>	<p>\$25 per visit, then 100%</p> <p>\$50 per program, then 100%</p>	<p>80% after plan deductible</p> <p>\$50 per program, then 80% no deductible</p>
<p>Group Therapy</p> <p>Calendar Year Maximum: Subject to the plan's Outpatient Mental Health benefit maximum.</p>	<p>\$25 per visit, then 100%</p>	<p>80% after plan deductible</p>



Benefits for Mental Health and Substance Abuse	How this Plan Works	
	Participating Provider	Non-Participating Provider
<p>Substance Abuse</p> <p>Inpatient</p> <p>Calendar Year Maximum: 30 Days</p> <p>Outpatient</p> <p>Calendar Year Maximum: 60 visits per calendar year, including up to 20 visits for counseling and education for insured family Participants, even if the person in need of treatment is not being treated.</p> <p>Intensive Outpatient Program</p> <p>Calendar Year Maximum: Not to exceed 3 programs, or the plan's Outpatient Visit Maximum (Visits used reduce the number of Substance Abuse Outpatient visits available).</p> <p>Benefit levels are managed in accordance with clinical guidelines. "Current guidelines recommend up to 3 Intensive Outpatient Programs per calendar year." Thereafter, a different mode of treatment is recommended and may include inpatient or outpatient services for additional rehabilitation.</p>	<p>No Charge</p> <p>\$25 per visit, then 100%</p> <p>\$50 per program, then 100%</p>	<p>80% after plan deductible</p> <p>80% after plan deductible</p> <p>\$50 per program, then 80% no deductible</p>



Prescription Drug Benefits

The Schedule

For You and Your Dependents

Pharmacy Benefits	How this Plan Works:
	Prescription Drugs purchased at a Participating Pharmacy are considered Covered Prescription Drugs under this benefit. You or your Dependent must pay a portion of Covered Prescription Drugs, then the plan will pay the percentage shown below for each 30-day supply at a retail pharmacy or each 90-day supply from a mail order pharmacy
<p>Retail Prescription Drugs</p> <p>Generic - Formulary*</p> <p>Name Brand - Formulary*</p>	<p>Copays Effective July 1, 2005</p> <p>\$5 per prescription order or refill, then 100%</p> <p>\$20 per prescription order or refill, then 100%</p>
* Designated as per generally-accepted industry sources and adopted by CG	
<p>Mail-Order Drugs</p> <p>Generic - Formulary*</p> <p>Name Brand - Formulary*</p>	<p>Copays Effective July 1, 2005</p> <p>\$10 per prescription order or refill, then 100%</p> <p>\$40 per prescription order or refill, then 100%</p>
* Designated as per generally-accepted industry sources and adopted by CG	



Pharmacy Benefits	How this Plan Works:
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Retail Prescription Drugs Generic - Formulary* Name Brand - Formulary* Generic or Name-Brand - Non-Formulary*	Copays Effective January 1, 2006 \$5 per prescription order or refill, then 100% \$20 per prescription order or refill, then 100% \$30 per prescription order or refill, then 100%
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* Designated as per generally-accepted industry sources and adopted by CG

Mail-Order Drugs Generic - Formulary* Name Brand - Formulary* Generic or Name-Brand - Non-Formulary*	Copays Effective January 1, 2006 \$10 per prescription order or refill, then 100% \$40 per prescription order or refill, then 100% \$60 per prescription order or refill, then 100%
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* Designated as per generally-accepted industry sources and adopted by CG



Special Plan Provisions

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

Services Available in Conjunction With Your Medical Plan

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

FPINTRO4V1

CIGNA'S Toll-Free Care Line

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

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

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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 number** shown on your ID card during normal business hours, Monday through Friday. In addition, your Fund, a claim office or a utilization review program (see the PAC/CSR section of your certificate) may refer an individual for Case Management.
2. The Review Organization assesses each case to determine whether Case Management is appropriate.
3. You or your dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.
4. Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available for example, in-home medical care in lieu of an extended Hospital convalescence. You are not penalized if the alternate treatment program is not followed.
5. The Case Manager arranges for alternate treatment services and supplies, as needed, for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home.
6. The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed, for example, by helping you to understand a complex medical diagnosis or treatment plan.
7. Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

FPCM6 M



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

FPCM2

Additional Programs

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

GM6000 PRM1

Notice of Federal Requirements

Coverage for Reconstructive Surgery Following Mastectomy

When a person insured for benefits under this certificate who has had a mastectomy at any time, decides to have breast reconstruction, based on consultation between the attending Physician and the patient, the following benefits will be subject to the same coinsurance and deductibles which apply to other plan benefits:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- treatment of physical complications in all stages of mastectomy, including lymphedema; and
- mastectomy bras and external prostheses limited to the lowest cost alternative available that meets the patient's physical needs.

If you have any questions about your benefits under this plan, please call the number on your ID card or contact your Fund.

Coverage for Maternity Hospital Stay

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

discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

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

NOT101

Notice Regarding Provider/Pharmacy Directories and Provider/Pharmacy Networks

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

You may also have access to a list of Providers who participate in the network by visiting www.cigna.com; mycigna.com or by calling the toll-free telephone number on your ID card.

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

NOT88

Notice of Federal Requirements Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and reemployment in regard to military leaves of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage.

Continuation of Coverage

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

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

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

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

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



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

NOT141

Reinstatement of Benefits (applicable to all coverages)

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

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

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

NOT142 M

Notice of an Appeal or a Grievance

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

NOT90

Notice of Federal Requirements

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

NOT99

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:

When you elect Medical Insurance, you may select a Primary Care Physician for yourself and your Dependents from a list provided by CG. 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.

Primary Care Physician's Role/Direct Access to Participating Physicians:

The Primary Care Physician's role is to provide or arrange for medical care for you and any of your Dependents.

However, you and your Dependents are allowed direct access to Participating Physicians for covered services. Even if you select a Primary Care Physician, there is no requirement to obtain an authorization of care from your Primary Care Physician for visits to the Participating Physician of your choice, including Participating Specialist Physicians, for covered services.

Changing Primary Care Physicians:

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

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

GM6000 NOT123

Notice

Health Care Services

A denial of claim or a clinical decision regarding health care services will be made by qualified clinical personnel. Notice of denial or determination will include information regarding the basis for denial or determination and any further appeal rights.

Authorization

No authorization will be required prior to receiving Emergency Services.

Non-English Assistance

For non-English assistance in speaking to Participant Services, please use the translation service provided by AT&T. For a translated document, please contact your Participant Services Representative.

NOT19



New York Disclosure and Synopsis Statement

The insurance evidenced by this certificate meets the minimum standards for major medical insurance as defined by the New York State Insurance Department.

This Schedule highlights the benefits of the plan. The benefits shown may not always be payable because the plan contains certain limitations and exclusions. Medical Expense Benefits, for instance, are not payable for such things as work-related injuries or unnecessary care or treatment. These limitations and others can be found in their entirety on subsequent pages of the certificate.

Eligibility, Termination, COBRA Continuation and ERISA Information

Refer to the Fund's Summary Plan Description for information relevant to Eligibility, Termination, COBRA Continuation and ERISA.



Effective Date of Insurance for Newborns and Newly Acquired Dependents

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

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption, you may enroll your eligible Dependents and yourself, if you are not already enrolled, within 30 days of such event. Coverage will be effective on the date of marriage, birth, adoption, or placement for adoption. Any applicable Pre-existing Condition limitation will apply to you and your Dependents upon enrollment, reduced by prior Creditable Coverage.

GM6000 EF 3

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Requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93)

These health coverage requirements do not apply to any benefits for loss of life, dismemberment or loss of income.

Any other provisions in this certificate that provide for: (a) the definition of an adopted child and the effective date of eligibility for coverage of that child; and (b) eligibility requirements for a child for whom a court order for medical support is issued; are superseded by these provisions required by the federal Omnibus Budget Reconciliation Act of 1993, where applicable.

A. Eligibility for Coverage Under a Qualified Medical Child Support Order

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

You must notify your Fund and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the Qualified Medical Child Support Order being issued.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child

and relates to benefits under the group health plan, and satisfies all of the following:

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

OBRA1

The Qualified Medical Child Support Order may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except an order may require a plan to comply with States laws regarding child health care coverage.

Payment of Benefits

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

B. Eligibility for Coverage for Adopted Children

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

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

The provisions in the "Exceptions for Newborns" section of this certificate that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.



Any "Pre-existing Condition Limitation" in this certificate will be waived for an adopted child or a child placed for adoption.

OBRA2



Open Access Plus Medical Benefits

For You and Your Dependents

Inpatient Certification Requirements for Non-Preferred Provider Benefits (Preferred Provider Inpatient Certification is the Responsibility of the Physician)

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 DG

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

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Prior Authorization/Pre-Authorized

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

Services that require Prior Authorization:

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

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V9 DG

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below if they are incurred after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by CG. **Any applicable Copayments, Deductibles or limits are shown in The Schedule.**

Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.



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

GM6000 CM5

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

GM6000 CM6

FLX108V748 DG

- charges for appropriate counseling, medical services connected with surgical therapies, including vasectomy and tubal ligation.
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives approved by the Federal Food and Drug Administration or generic-equivalents approved by the Food and Drug Administration.
- charges made for Routine Preventive Care from age 19 including immunizations. Routine Preventive Care means health care assessments, wellness visits and any related services.
- charges made for hearing aid not to exceed the maximum shown in the Schedule.
- charges made for treatment of acupuncture not to exceed the maximum shown in the Schedule.

- charges made for surgical and non-surgical care of Temporomandibular Joint Dysfunction (TMJ) when medically necessary, excluding appliances and orthodontic treatment.
- charges made for wigs Non-Participating Provider when medically necessary not to exceed the maximum shown in the Schedule.

GM6000 CM6

FLX108V776 DG M

- charges made for or in connection with a baseline mammogram for women ages 35 through 39, a mammogram every two years or more frequently if recommended by her Physician for women ages 40 through 49, an annual mammogram for women ages 50 and over, and a mammogram for women at any age if there is a history of cancer present for her, her mother, or her sister provided the test is ordered by her Physician;
- charges made for cervical cytology screening including a Pap smear and a pelvic exam each year for women age 18 or older;
- charges made for diagnostic screening for prostate cancer for: (a) standard diagnostic testing, including but not limited to, a digital rectal exam and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and (b) an annual standard diagnostic exam, including but not limited to, a digital rectal exam and a prostate-specific antigen test for men age 50 and older who are asymptomatic, and for men age 40 and older with a family history of prostate cancer or other prostate cancer risk factors.

GM6000 CM92

INDEM100V22 M

- charges for inpatient coverage with respect to the treatment of breast cancer, for a period of time determined by you and the attending Physician to be appropriate following a mastectomy, lumpectomy or lymph node dissection, for the treatment of breast cancer.
- charges for bone mineral density measurements or tests as covered under the federal Medicare program and in accordance with the criteria of the National Institutes of Health, including dual-energy X-ray absorptiometry, for persons: (a) previously diagnosed as having osteoporosis or having a family history of osteoporosis; (b) with symptoms or conditions indicative of the presence or the significant risk of osteoporosis; (c) on a prescribed drug regimen posing a significant risk of osteoporosis; or (d) with lifestyle factors posing a significant risk of osteoporosis; or (e) with age gender and/or other physiological characteristics posing a significant risk for osteoporosis.
- charges made by a Hospital for inpatient care for a mother and newborn for at least 48 hours following a vaginal delivery, or at least 96 hours following a cesarean section.



The mother has the option of being discharged early. Services may be rendered by a certified nurse-midwife, a licensed facility, or a Physician. These services include parent education, assistance in feeding the newborn, and maternal and newborn clinical assessments. If discharge is prior to 48 or 96 hours, at least one home health care visit will be covered in full if made within 24 hours of discharge from the Hospital or the mother's request, whichever is later. The home health care visit will not be subject to deductibles, copays, or coinsurance.

GM6000 CM92

INDEM101V22

- charges for a drug that has been prescribed for the treatment of a type of cancer for which it has not been approved by the Food and Drug Administration (FDA) only if such drug is recognized for the treatment of the specific type of cancer for which the drug has been prescribed in one of the established reference compendia: (i) the American Medical Association Drug Evaluations; (ii) the American Hospital Formulary Service Drug Information; (iii) the United States Pharmacopeia Drug Information; or (iv) recommended by a review article or editorial comment in a major peer-reviewed professional journal.
- charges made by a Physician, or Participant of his office staff, a certified diabetes nurse-educator, certified nutritionist, or licensed dietitian for a program which provides instruction for a person with diabetes, for the purpose of instructing such person about the disease and its control. Training will be provided in group sessions, where practicable. If medically necessary, training will be provided in the person's home.
- charges for glucometers, blood glucose monitors, monitors for the visually impaired, insulin pumps, infusion devices and related accessories.

GM6000 CM92

INDEM101V19

- charges for enteral formulas for home use for the treatment of: (a) inherited diseases of amino acid or organic acid metabolism; (b) Crohn's disease; (c) gastroesophageal reflux with failure to thrive; (d) disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and (e) multiple, severe food allergies. The Physician must issue a written order stating that the enteral formula is medically necessary and has been proven effective as a disease-specific treatment regimen for individuals who are or will become malnourished or suffer from disorders which, if left untreated, cause chronic physical disability, mental retardation or death. Covered expenses will also include modified solid food products that are low protein or which contain modified protein, which are medically

necessary. Such coverage for any calendar year or continuous 12-month period will be limited to \$2,500.

GM6000 CM92

INDEM102V7

- charges made due to Advanced Cancer for the following Acute Care Services provided for insureds using NY facilities or programs when the attending Physician, in consultation with the medical director of the facility or program, determines care would be appropriately provided there:
 - by an Acute Care 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 Limit shown in The Schedule;
 - by an Acute Care 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 or family bereavement counseling within one year after the person's death;
 - for pain relief treatment, including drugs, medicines and medical supplies;
 - by an Acute Care Facility for:
 - part-time or intermittent nursing care by or under the supervision of a nurse;
 - part-time or intermittent services of a Home Health Aide.

Advanced Cancer

The term "Advanced Cancer" means cancer with no hope of reversal of the primary disease as diagnosed by a person's attending Physician and as a result of which the person has fewer than 60 days to live.

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INDEM102V4

Acute Care Services

The term "Acute Care Services" means any services provided by: (a) a Hospital; (b) a Skilled Nursing Facility or a similar institution, (c) an Acute Care Facility; or (d) any other licensed facility or agency under an Acute Care Program.

Acute Care Facility

The term "Acute Care Facility" means a Hospital or a nonprofit or public home health care agency which:

- primarily provides care for Terminally Ill patients;



- is run according to rules established by a group of professional persons;
- meets standards established by CG;
- does not primarily provide custodial care or care and treatment of the mentally ill; and
- fulfills any licensing requirements of the state or locality in which it operates.

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INDEM102V5

In addition, Covered Expenses will include expenses incurred at any of the Approximate Age Intervals shown below for a Dependent child from birth to age 19 for charges made for Preventive Care for children consisting of the following services delivered or supervised by a Physician, in keeping with prevailing medical standards as determined by the American Academy of Pediatrics:

- (a) one postnatal Hospital visit by a Physician, while the Dependent Child is an inpatient;
- (b) well-child visits to a Physician which will include:
 - a medical history;
 - a complete physical examination;
 - developmental assessment;
 - anticipatory guidance;
 - appropriate immunizations; and
 - laboratory tests when ordered at the time of a visit and performed in the practitioner's office or in a clinical laboratory;

excluding any charges for:

- services for which benefits are otherwise provided under this Medical Benefits section;
- services for which benefits are not payable according to the Expenses Not Covered section.

Approximate Age Intervals are: Birth, 2 or 3 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, one visit every 2 years from age 6 to age 12, and one visit every 3 years from age 12 to age 19.

GM6000 CM6

INDEM103V4

Clinical Trials

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

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

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

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

Genetic Testing

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

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



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

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

Nutritional Evaluation

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

Internal Prosthetic/Medical Appliances

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

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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 mean the home care and treatment of a covered person who is under the care of a Physician and the plan covering the home health service is established and approved in writing by that Physician. Home care will only be provided if hospitalization or confinement in a nursing facility would otherwise have been required if home care was not provided.

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

Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Professionals. A visit by a home health aide is defined as a period of 4 hours. Necessary consumable medical supplies and home infusion therapy administered or used

by Other Health Care Professionals in providing Home Health Services are covered. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions, and benefit limitations. Physical, occupational, and other Short-Term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Short-term Rehabilitative Therapy Maximum shown in The Schedule.

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Hospice Care Services

- charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
 - by a Hospice Facility for Bed and Board and Services and Supplies, 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;

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

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



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

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Mental Health and Substance Abuse Services

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

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

Inpatient Mental Health Services

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

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

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

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

GM6000 INDEM9

V51

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 at a rate of one visit of Mental Health Intensive Outpatient Therapy being equal to one visit of Outpatient Mental Health Services.

GM6000 INDEM10

V46

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 of 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. The exchange for services will be two Partial Hospitalization sessions are equal to one day of inpatient care.

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

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

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

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

Outpatient Substance Abuse Rehabilitation Services

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

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week. Substance Abuse Intensive Outpatient Therapy Program services are exchanged with Outpatient Substance Abuse services at a rate of one visit of Substance Abuse Intensive Outpatient Therapy being equal to one visit of Outpatient Substance Abuse Rehabilitation Services.

GM6000 INDEM11

V62

Substance Abuse Detoxification Services

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

Exclusions

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

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.
- Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- Counseling for activities of an educational nature.
- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness raising.
- Vocational or religious counseling.
- I.Q. testing.
- Custodial care, including but not limited to geriatric day care.
- Psychological testing on children requested by or for a school system.
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

GM6000 INDEM12

V48 DG

Durable Medical Equipment

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



responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

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

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

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

GM6000 05BPT3

External Prosthetic Appliances and Devices

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

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

Prostheses/Prosthetic Appliances and Devices

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

- Basic limb prostheses;
- Terminal devices such as hands or hooks; and
- Speech prostheses.

Orthoses and Orthotic Devices

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

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

GM6000 05BPT4

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;



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

Braces

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

The following braces are specifically excluded: Copes scoliosis braces.

Splints

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

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

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

Repairs and necessary maintenance of purchased equipment not otherwise provided under a manufacturer's warranty or purchase agreement are also covered

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

V2

Infertility Services

- charges made for services related to diagnosis of infertility and treatment of infertility. Services include, but are not limited to: infertility drugs; procedures to induce pregnancy, including such procedures as artificial insemination; surgical and medical procedures which would correct malformation, disease or dysfunction resulting in infertility; and diagnostic tests and procedures that are necessary to determine infertility or that are necessary in connection with any surgical or medical treatments or prescription drugs covered under the plan, including but not limited to such diagnostic tests and procedures as: (a) hysterosalpingogram; (b) hysteroscopy; (c) endometrial biopsy; (d) laparoscopy; (e) sonohysterogram; (f) post-coital tests; (g) testis biopsy; (h) semen analysis; (i) blood tests; or (j) ultrasound.

Infertility is defined as the inability of opposite sex partners to achieve conception after one year of unprotected intercourse; or the inability of a woman to achieve conception after six trials of artificial insemination over a one-year period.

Diagnosis and treatment must be prescribed by a Physician in accordance with standards no less favorable than those established by the American Society of Reproductive Medicine (ASRM). Any requests for coverage of storage of sperm for artificial insemination (including donor fees) and cryopreservation of donor sperm and eggs will be subject to Medical Necessity review.

To be covered for infertility diagnosis and treatment, a person must be at least 21 years old and no older than 44 years old.

The following are specifically excluded infertility diagnostic and treatment services:

- in vitro fertilization (IVF); gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT);
- reversal of male and female elective sterilization;
- sex change procedures;
- cloning; and
- any medical or surgical services or procedures which are determined to be experimental in accordance with standards no less favorable than those established and adopted by the ASRM.

Services will not be excluded or subject to age limits for any hospital, surgical or medical care for diagnosis and treatment of correctable medical conditions covered under the plan solely because the medical condition results in infertility.

GM6000 05BPT18

V1



Short-Term Rehabilitative Therapy

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

The following limitations apply to Short-term Rehabilitative Therapy:

- To be covered all therapy services must be restorative in nature. Restorative Therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of Injury or Sickness. Restorative Therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the Injury or Sickness.
- Services are not covered if they are custodial, training, educational or developmental in nature. (Custodial care services means help in transferring, eating, dressing, bathing, toileting, and other such related activities.)
- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Illness or Injury.

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

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

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

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

For purposes of this section, custodial care services means help in transferring, eating, dressing, bathing, toileting, and other such related activities.

Chiropractic Care Services

Charges made for Medically Necessary diagnostic and treatment services utilized in an office setting by chiropractic

Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function.

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

GM6000 05BPT9

V4 DG

The following limitations apply to Chiropractic Care Services:

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

The following are specifically excluded from Chiropractic Care Services:

- Services of a chiropractor which are not within his scope of practice, as defined by state law;
- Charges for care not provided in an office setting;
- Maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status;
- Vitamin therapy, unless Medically Necessary;
- Massage therapy in the absence of other modalities.

GM6000 05BPT10

V3

Transplant Services

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

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



kidney/pancreas, liver, lung, pancreas or intestinal which includes small bowel, liver or multivisceral.

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

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

Transplant Travel Services

Charges made for reasonable travel expenses incurred by you in connection with a pre-approved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for transportation, lodging and food are available to you only if you are the recipient of a 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 person receiving the transplant will include charges for: transportation to and from the transplants site (including charges for a rental car used during a period of care at the transplant facility); lodging while at, or traveling to and from the transplant site; and food while at, or traveling to and from the transplant site.

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

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

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

GM6000 05BPT7

V1 DG

Breast Reconstruction and Breast Prostheses

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

Reconstructive Surgery

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder that are not medical in nature) provided that: (a) the surgery or therapy restores or improves function; (b) reconstruction is required as a result of Medically Necessary, noncosmetic surgery; or (c) the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

GM6000 05BPT2

V9



Prescription Drug Benefits

For You and Your Dependents

Covered Expenses

If you or any one of your Dependents, while insured for prescription drug benefits, incurs expenses for charges made by a Participating Pharmacy, for Medically Necessary Prescription Drugs ordered by a Physician, CG will pay that portion of the expenses remaining after you or your Dependents have paid the required Copayment and Deductible shown in the Schedule. Coverage also includes Prescription Drugs dispensed by a Participating Pharmacy for a prescription issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with an invasive dental procedure.

When you or a Dependent is issued a prescription for a prescription drug as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by CG, as if filled by a Participating Pharmacy. Oral fertility drugs, Periostat, Periodex, Periogard, insulin pens and cartridges are covered without prior authorization.

Benefits include coverage of both oral and injectable insulin, insulin needles and syringes, glucose test strips and lancets.

Limitations

Each prescription order or refill shall be limited as follows:

- to up to a consecutive thirty 30-day supply at a retail Participating Pharmacy, unless limited by the drug manufacturer's packaging; or
- to up to a consecutive ninety 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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Your Payments

Coverage for Prescription Drugs purchased at a Participating Pharmacy is subject to the Copayment and Deductible shown in the Schedule, if applicable.

If two or more prescriptions or refills are dispensed at the same time a Copayment must be paid for each prescription order or refill.

When a treatment regimen contains more than one type of drug and the drugs are packaged together for your or your

Dependent's convenience, a Copayment will apply to each type of drug.

Please refer to the Schedule for the required Copayment and Deductible.

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Exclusions

No payment will be made for the following expenses:

- drugs or medications available over-the-counter that do not require a prescription by federal or state law, and any drug or medication that is equivalent (in strength, regardless of form) to an over-the-counter drug or medication other than insulin;
- any drugs that are labeled as experimental or investigational;
- Food and Drug Administration (FDA) approved prescription drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia; (The United States Pharmacopeia Drug Information, The American Medical Association Drug Evaluations; or The Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
- all newly FDA approved drugs, prior to review by the Pharmacy and Therapeutics committee;
- prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than syringes used in conjunction with injectable medications and glucose test strips;
- implantable contraceptive products;
- injectable infertility drugs;
- prescription drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
- prescription vitamins, (other than prenatal vitamins), fluoride products and dietary supplements, except charges for enteral formulas for home use for the treatment of: (a) inherited diseases of amino acid or organic acid metabolism; (b) Crohn's disease; (c) gastroesophageal reflux with failure to thrive; (d) disorders of gastrointestinal motility such as chronic intestinal pseudo-obstruction; and (e) multiple, severe food allergies. The Physician must issue a written order stating that the

GM6000 PHARM41

V18 M



enteral formula is medically necessary and has been proven effective as a disease-specific treatment regimen for individuals who are or will become malnourished or suffer from disorders which, if left untreated, cause chronic physical disability, mental retardation or death. Covered expenses will also include modified solid food products that are low protein or which contain modified protein, which are medically necessary. Such coverage for any calendar year or continuous 12-month period will be limited to \$2,500.

GM6000 PHARM44

- prescription smoking cessation products;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- replacement of prescription drugs 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;
- prescriptions more than one year from the original date of issue; and
- for prescriptions obtained from a Non-Participating Pharmacy.

Other limitations are shown in the "General Limitations" section.

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V18

Reimbursement/Filing a Claim

When you or your Dependents purchase your Prescription Drugs through a Participating Pharmacy, you pay only the copayment amount shown in the Schedule at the time of purchase. You do not need to file a claim form.

If you or your Dependents purchase your Prescription Drugs through a Non-Participating Pharmacy as part of the rendering of Emergency Services, you pay the full cost at the time of purchase. You must submit a claim form to be reimbursed.

To purchase Prescription Drugs from a Mail-Order Pharmacy, see your Mail-Order Drug Introductory Kit for details, or contact Participant Services for assistance.

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

GM6000 PHARM40

V2

Medical Conversion Privilege

For You and Your Dependents

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy). A Converted Policy will be issued by CG only to a person who is Entitled to Convert, and only if he applies in writing and pays the first premium for the Converted Policy to CG within 45 days after the date his insurance ceases. Evidence of good health is not needed.

Participants Entitled To Convert

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

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

If you retire you may apply for a Converted Policy within 45 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.

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The following Dependents of reservists who are serving on active military duty are also Entitled to Convert, regardless of



whether or not the reserivist has elected continuation of Medical Insurance: (1) a child whose insurance under this plan ceases because of your death or because he no longer qualifies as a Dependent due to age; and (2) a spouse whose insurance under this plan ceases due to divorce, annulment of marriage or your death.

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 45 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 need not provide major medical coverage unless it is required by the laws of the jurisdiction in which the Converted Policy is issued.

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

The Converted Policy may not exclude any pre-existing condition not excluded by this plan. During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable under the

Converted Policy and the Medical Benefits Extension of this plan will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan.

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

GM6000 CP4

CON29

Exclusions, Expenses Not Covered and General Limitations

Covered Expenses will not include, and no payment will be made, for the following expenses incurred, unless those expenses are considered Medically Necessary.

- expenses for charges that are not Medically Necessary, except as specified in any certification requirement shown in this plan.
- 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: (a) unless there is a legal obligation to pay such charges whether or not there is insurance; or (b) 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, toileting or other non-Medically Necessary self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services. However, CG will cover an experimental or investigational treatment approved by an external appeal agent. If the external appeal agent approved coverage of an experimental or investigational treatment that is part of a clinical trial, CG will only cover the costs of services required to provide treatment to you according to the design of the trial. CG shall not be responsible for the costs of investigational drugs or devices, the costs of non-



health care services, the costs of managing research, or the costs which would not be covered under this plan for nonexperimental or noninvestigational treatments provided in such clinical trial.

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 and determined not to be Medically Necessary. However, reconstructive surgery is covered as provided under **Covered Expenses**, and for the purposes of this exclusion, the term cosmetic surgery or therapy shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part.
- regardless of clinical indication for macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty/panniculectomy; rhinoplasty; blepharoplasty; orthognathic surgeries; redundant skin surgery; removal of skin tags; acupressure; craniocervical/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 services or supplies provided for or in connection with an accidental injury to sound natural teeth, provided a continuous course of dental treatment started within 12 months of the accident; (b) charges made by a Hospital for Bed and Board or Necessary

Services and Supplies; (c) charges made by a Free-Standing Surgical Facility or the outpatient department of a Hospital in connection with surgery,.

- for medical and surgical services intended for the treatment or control of obesity, unless Medically Necessary. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute (NHLBI) guidelines to be covered only at approved centers if the services are demonstrated, through existing peer-reviewed, evidence-based, scientific literature and scientifically based guidelines, to be safe and effective for treatment of the condition. Clinically severe obesity is defined by the NHLBI as a BMI of 40 or greater without comorbidities, or 35-39 with comorbidities. The following are specifically excluded: (a) medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and (b) weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- any services or supplies for the treatment of female sexual dysfunction and male impotence, such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation, except as specifically provided in the "Infertility Services" provision under **Covered Expenses**.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation.



- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the “Home Health Services” or “Breast Reconstruction and Breast Prostheses” sections of this plan.
- abortion, but only when the life of the mother is endangered if the fetus were carried to term.
- private Hospital rooms and/or private duty nursing except as provided under the Home Health services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs (except as shown under **Covered Expenses**).
- 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 (except as shown under **Covered Expenses**).
- aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- medical benefits for eyeglasses, contact lenses or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery.
- charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.
- all noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- Participant ship costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician’s opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids and nutritional formulae (except as described in **Covered Expenses**).
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- telephone, e-mail, and Internet consultations, and telemedicine.
- massage therapy.
- for charges which would not have been made if the person had no insurance.
- to the extent that they are more than Maximum Reimbursable Charges.
- expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure.



- to the extent of the exclusions imposed by any certification requirement shown in this plan.

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Coordination of Benefits

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

Definitions

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

Plan

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

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

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

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

GM6000 COB11V2

Allowable Expense

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

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

- (1) An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- (2) If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense, unless the patient's stay in a private Hospital room is medically necessary in terms of generally accepted medical practice.
- (3) If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- (4) If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- (5) If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

A calendar year, or that part of a calendar year in which the person has been covered under this Plan.

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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 rendered under similar or comparable circumstances by other health care providers located within the immediate geographic area.

Order of Benefit Determination Rules

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



- (1) The Plan that covers that person as an enrollee or an Participant shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- (2) For a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent as an enrollee or Participant whose birthday falls first in the calendar year;
- (3) For the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
 - (a) first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
 - (b) then, the Plan of the parent with custody of the child;
 - (c) then, the Plan of the spouse of the parent with custody of the child;
 - (d) then, the Plan of the noncustodial parent of the child.

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

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

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

Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

Effect on the Benefits of this Plan

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

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

GM6000 COB14

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

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

If there is a benefit reserve, the Plan will use the benefit reserve recorded for you to pay up to one hundred percent (100%) of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero (0) and a new benefit reserve shall be calculated for each new Claim Determination Period.

Right of Recovery

If the amount of payments made by an insurer is more than it should have paid under its COB provision, it may recover the excess from one or more of:

- (1) the persons it has paid or for whom it has paid;
- (2) insurance companies; or
- (3) other organizations

Right to Receive and Release Information

The Plan, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits.

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Medicare Eligibles

If you are eligible for Medicare and no longer an active employee, please refer to the special Medicare Eligible Retiree Booklets, for more information on your coverage. Under the Medicare Eligible Retiree program of the Plan, CG will pay as the Secondary Plan as permitted by the Social Security Act of 1965 as amended for the following:

- (a) any Participant in the Plan who is eligible for Medicare and who does not have “current employment status” under the Medicare Secondary Payor Statute;
- (b) a Participant’s Dependent, or a Dependent Spouse who is covered under this Plan, eligible for Medicare and who does not have “current employment status” under the Medicare Secondary Payor Statute;
- (c) a Participant, Dependent or Spouse who is covered under this Plan and eligible for Medicare due to disability;
- (d) a Participant, Dependent or Spouse who is eligible for Medicare due to End State Renal Disease after that person has been eligible for Medicare for 30 months;

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Whether you have or you have not enrolled in Medicare, if you are eligible for Medicare coverage, and are a retiree, CG will pay benefits on the basis of the assumption that you have done so on the earliest date that you could. CG will pre-suppose 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 Participant and his Spouse or Dependent unless he is listed under (a) through (d) above.

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Expenses For Which A Third Party May Be Liable

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

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

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



CG will only exercise its subrogation rights if the amount received by you is specifically identified in the settlement or judgment as amounts paid for medical expenses.

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Payment of Benefits

To Whom Payable

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

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

If you die while any of these benefits remain unpaid, CG may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; to a beneficiary if one is designated; 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 not more than 60 days after it receives due proof of loss.

Recovery of Overpayment

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

Calculation of Covered Expenses

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

- The methodologies in the most recent edition of the Current Procedural terminology.

- The methodologies as reported by generally recognized professionals or publications.

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Continuation Required by New York State Law For You and Your Dependents

This Continuation does not apply to any benefits for loss of life, dismemberment or loss of income.

New York State law enables you or your Dependent to continue health insurance if coverage would cease due to a reduction of your work hours or your termination of employment. New York State law also enables your Dependents to continue health insurance if their coverage ceases due to your death or entitlement to Medicare, divorce or legal separation, or with respect to a Dependent child, failure to continue to qualify as a Dependent. Continuation must be elected in accordance with the rules of your Fund's group health plan(s) and is subject to New York state law, regulations and interpretations.

A. Participants and Dependents Continuation Provision

If you and your Dependent's insurance would otherwise cease because of a reduction in the number of hours you work or your termination of employment for any reason, you or your Dependent may continue health insurance upon payment of the required premium to the Fund. You and your Dependents must elect to continue insurance within 60 days from the later of: (a) the date of a reduction of your work hours or your termination of employment; or (b) the date notice of the right to continue insurance is sent via first class mail. Such insurance will not be continued by CG for you and/or your Dependents, as applicable, beyond the earliest of the following dates:

- 18 months from the date your work hours are reduced or your employment terminates, whichever may occur first;
- the date the policy cancels;
- the date coverage ends due to your failure to pay the required subsequent premium within 30 days of the due date;
- the date your Dependent ceases to qualify as an eligible Dependent;
- the date you become entitled to Medicare, following your enrollment in Medicare; or
- the effective date of coverage under another group health plan, unless you have a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

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B. Dependents Continuation Provision

If health insurance for your Dependents would otherwise cease because of:

- (1) your death;
- (2) your entitlement to Medicare;
- (3) divorce or legal separation; or
- (4) with respect to a Dependent child, failure to continue to qualify as a Dependent,

such insurance may be continued upon payment of the required premium to the Fund. In the case of (3) or (4) above, you or your Dependent must notify your Fund within 60 days of such event. In addition, a Dependent must elect to continue insurance within 60 days from the later of: (a) the date the insurance would otherwise cease; or (b) the date notice of right to continue insurance is sent via first class mail.

CG will not continue the health insurance of a Dependent beyond the earliest of the following dates:

- 36 months from the date of (1), (3) or (4) above, whichever may occur first;
- the date coverage ends due to failure to pay the required subsequent premium within 30 days of the due date;
- the date the Dependent becomes entitled to Medicare, following his/her enrollment in Medicare;
- the date the policy cancels; or
- the date the Dependent becomes covered under another group health plan, unless the Dependent has a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

If your Dependent would lose coverage because of an event described in (1), (3) or (4) of Section B after you have continued your Dependent's coverage due to your employment termination or reduction in work hours, your Dependent may continue coverage for up to 36 months from the date of loss of employment or reduction in work hours.

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If, after you have continued your Dependent's coverage due to your loss of employment or reduction in work hours, your Dependent would lose coverage because you became entitled to (enrolled in) Medicare, your Dependent may continue coverage for up to 36 months from the date you become entitled to Medicare.

Disabled Individuals Continuation Provisions

If you or your Dependent is disabled on the date of termination of employment or a reduction in work hours you

may continue health insurance for up to an additional 11 months beyond the 18-month period.

To be eligible you or your Dependent must:

- a) be declared disabled under Title II or XVI by the Social Security Administration; and
- b) notify the Plan Administrator of the Social Security Administration's determination within 60 days following the determination and within the initial 18-month continuation period, and provide the Plan Administrator with a copy of the determination.

Termination of coverage during the 29-month period will occur if you or your Dependent is found by the Social Security Administration to be no longer disabled. Termination will occur on the first day of the month beginning more than 30 days after the date of the final determination. All reasons for termination which apply to the initial 18 months will also apply for any additional months of coverage.

GM6000 TER5

TRM140V14

Conversion Available Following Continuation

If you or your Dependent's Continuation ends due to the expiration of the maximum 18- or 36-month continuation period, whichever applies, you or your Dependent will be entitled to convert to the insurance in accordance with the Medical Conversion benefit then available to Participants and their Dependents.

Interaction with Other Continuation Benefits

A person who is eligible to continue insurance under both (1) and (2) below may continue the insurance, upon payment of any required premium, for a period of time not to exceed the longer of: (1) continuation required by New York state law; or (2) any other continuation of insurance provided in this Certificate.

Newly Acquired Dependents

If your insurance is being continued under New York state law provisions, and you acquire a new Dependent, such Dependent will be eligible for this Continuation provided:

- the required premium is paid; and
- CG is notified of your newly acquired Dependent in accordance with the terms of the policy.

However, such newly acquired Dependents will not be entitled to continue their insurance if items (1), (2), (3) or (4) listed in Section B should subsequently occur.

GM6000 TER5

TRM141V11



Special Continuation of Medical Insurance for Military Reservists and Their Dependents

If you are a reservist whose Medical Insurance would otherwise cease because you are called to active military duty, you may continue Medical Insurance for yourself and your Dependents, upon payment of the required premium to your Fund. You may continue the insurance for up to four years, but not beyond the earliest of the following dates:

- the last day for which the required premium has been paid;
- the date you or your Dependent becomes eligible for insurance under another group policy, other than the Civilian Health and Medical Program of the Uniformed Services;
- the date you become eligible for Medicare.

The continuation of Medical Insurance will provide the same benefits as those provided to any similarly situated person insured under the policy who has not been called to active duty.

Provisions Regarding Notification and Election of Special Continuation

You or your Dependent must request continuation, in writing, within 60 days of being called to active duty. You must also pay the required premium to the Fund.

Conversion Available Following Continuation

The provisions of the "Medical Conversion Privilege" section will apply following the termination of insurance.

GM6000 TER1

TRM186V5

Reinstatement of Medical Insurance For Military Reservists and Their Dependents

If you return to employment when your active military duty as a reservist ends, you are entitled to the reinstatement of medical insurance for yourself and your Dependents. Such reinstatement will be without the application of:

- a new waiting period. However, the remainder of a waiting period not satisfied before active military duty began may still be applied.
- the Pre-existing Condition Limitation to any new condition that you or your Dependent may have developed while coverage was interrupted due to active military duty. However, the Pre-existing Condition Limitation may still be applied to conditions resulting directly from military duty.

"Reservist" means a Participant of a reserve component of the armed forces of the United States. "Reservist" includes a

Participant of the National Guard whose active duty is extended at a time when the president is authorized to order: a) units of the ready reserve; or b) Participants of a reserve component, to active duty. Such additional active duty must be at the request and for the convenience of the federal government. It does not include: a) reservists entering active duty for the purpose of training or determining physical fitness; or b) reservists who have served more than four years of active duty.

Provisions Applicable to Reinstatement

If you return to employment after your discharge, you may reinstate your medical insurance. You must notify your Fund that you elect reinstatement within 90 days from your date of discharge. Such reinstatement will be retroactive to your date of discharge.

GM6000 TER1

TRM186V6

Requirements of Family and Medical Leave Act of 1993

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

A. Continuation of Health Insurance During Leave

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

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

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

B. Reinstatement of Canceled Insurance Following Leave

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

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

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

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Benefits Extension

Medical Benefits Extension

Any expense incurred within one year after a person's Medical Expense Insurance ceases will be deemed to be incurred while he is insured if such expense is for an Injury or Sickness which causes him to be Totally Disabled from the day his insurance ceases until that expense is incurred.

The terms of this Medical Benefits Extension will not apply to (a) a child born as a result of a pregnancy which exists when a person's benefits cease; or (b) any person when he becomes insured under another group policy for medical benefits.

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.

GM6000 BE3

BEX156

External Appeal for End of Life Care

If CG disagrees with the admission, provision, or continuation of care for the terminally ill insured by the facility, CG shall initiate an expedited external appeal. Until a decision is rendered from the appeal, CG will not deny coverage for care and during this time will reimburse the facility for services provided, subject to the limitations of the insured's policy. The decision of the external appeal agent shall be binding on all parties.

If CG does not initiate an expedited external appeal, CG will reimburse the facility for all services provided according to the terms and limitations of the insured's policy.

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Claims and Appeals Generally

The following sections of this booklet provide important information about filing a claim or appeal with CG. However, you should also refer to the Summary Plan Description of the Welfare Fund of Local One IATSE, which has been

distributed with this booklet, for important information about claims and appeals under the Fund generally.

How to File Your Claim

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

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

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

Hospital Confinement

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

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

Doctor's Bills and Other Medical Expenses

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

CLAIM REMINDERS

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

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

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

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

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

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CLA9V41



Accident and Health Provisions

Claims

Notice of Claim

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

Claim Forms

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

Proof of Loss

Written proof of loss must be given to CG within 90 days after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated nor 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.

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When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "you," "your" or "Participant" 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 Participant Services

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

Customer Services Toll-Free Number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate a complaint about: (1) a denial of, or failure to pay for, a referral; or (2) a determination as to whether a benefit is covered under the Policy, we will get back to you on the same day we receive your complaint, or use the "Grievances and Appeals of Administrative and Other Matters" process described in the following section to provide a Grievance resolution if we cannot resolve your complaint on the same day.

If you have a concern which requires an expedited review as described in the following section, or if you submit a written concern about any matter in writing, we will use the "Grievances and Appeals of Administrative and Other Matters" process described in the following section to provide a Grievance resolution.

Concerns regarding the quality of care, choice of or access to providers, or provider network adequacy, will be forwarded to CG's Quality Management Staff for review, and CG will provide written acknowledgment of your concern within 15 days with appropriate resolution information to follow in a timely manner.

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Grievance and Appeals of Administrative and Other Matters

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



We will acknowledge your appeal in writing within five working days after we receive the appeal. Acknowledgments include the name, address, and telephone of the person designated to respond to your appeal, and indicate what additional information, if any, must be provided.

Level One Administrative Appeal/Grievance

You or your representative, with your acknowledgment and consent, must submit your Level One Administrative Appeal in writing or by telephone:

Customer Services Toll-Free Number or Address that appears on your Benefit Identification card, explanation of benefits or claim form.

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving clinical appropriateness will be considered by a health care professional of the same or similar specialty as the care under consideration.

For level one appeals, we will respond in writing with a decision within 30 calendar days after we receive the appeal; or within 15 calendar days if the appeal is related to coverage that requires preservice review.

GM6000 APL686

This notification will include the reasons for the decision, including clinical rationale if applicable, as well as additional appeal rights, if any. You may request that the review process be expedited if, the time frames under this process would increase risk to your health or seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician, would cause you severe pain which cannot be managed without the requested services. CG's Physician reviewer, in consultation with the treating Physician, will decide if an expedited review is necessary. When an appeal is expedited, we will respond orally with a decision within 48 hours after receiving all the necessary information, but in no event later than 72 hours after receiving the appeal. A written notice of the decision will be transmitted within two working days after rendering the decision.

GM6000 APL748

Level Two Administrative Appeal

Most requests for a second review will be conducted by the Administrative Appeal Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving clinical appropriateness, the Committee will consult with at least one Physician or Dentist reviewer in the same or similar specialty as the care under consideration, as determined by CG's Physician or Dentist 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 30 calendar days; or within 15 calendar days if the appeal is related to coverage that requires preservice review. 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 are not obligated to grant the Committee an extension or to provide the requested information. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the review process be expedited if, the time frames under this process would increase risk to your health or seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services. CG's Physician reviewer, in consultation with the treating Physician will decide if an expedited review is necessary. When a review is expedited, we will respond orally with a decision within two working days after receiving all the necessary information, but no later than 72 hours after receiving the appeal. A written notice of the decision will be transmitted within two working days after rendering the decision.

GM6000 APL687

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II. Appeals of Utilization Review Decisions

CG has a two-step appeals procedure to review any dispute you may have regarding a CG utilization review determination. 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 or ask for information about utilization review decisions by calling the toll-free number on your Benefit Identification card, explanation of benefits or claim form, Monday through Friday, during regular business hours. If calling after hours, follow the recorded instructions if you wish to leave a message.

We will acknowledge your appeal in writing within five working days after we receive the appeal. Acknowledgments include the name, address, and telephone of the person designated to respond to your appeal, and indicate what additional information, if any, must be provided.

If no decision is made within the applicable time frames described below regarding your appeal of an adverse



utilization review determination, the adverse determination will be deemed to be reversed.

Level One Appeal (Final Adverse Determination)

You or your representative with your acknowledgment and consent must submit your Level One appeal in writing or by telephone to:

Customer Services Toll-Free Number or Address that appears on your Benefit Identification card, explanation of benefits or claim form

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 of the same or similar specialty as the care under consideration.

GM6000 APL688

We will respond in writing with a decision within 15 calendar days after we receive an appeal. If more information is needed to make the determination, we will notify you in writing or request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. You are not obligated to grant CG an extension or to provide the requested information.

You may request that the appeal process be expedited if, (1) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (2) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay; or (3) your appeal involves (a) continued or extended health care services, procedures or treatments or additional services for you or an insured undergoing a course of continued treatment prescribed by a health care provider or (b) an adverse determination in which the health care provider believes an immediate appeal is warranted except any retrospective determination. CG's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an expedited appeal is requested, CG will provide reasonable access to its clinical peer reviewer within one working day after receiving the appeal. When an appeal is expedited, CG will respond orally with a decision within two working days after receiving all the necessary information, but no later than 72 hours after receiving the appeal.

GM6000 APL747

A written notice of the decision will be transmitted within two working days after rendering the decision. If you are not satisfied with the result of the expedited appeal review, you may further appeal under the time frames above, or through the external appeal process described in the following paragraph.

If you remain dissatisfied with the Level One or Expedited Appeal decision of CG, you have the right to request an External Appeal as well as a Level Two Appeal as described in the following paragraphs. You may also request an External Appeal application from the New York Insurance Department toll-free at 800-400-8882, or its website (www.ins.state.ny.us); or the New York Department of Health at its website (www.health.state.us).

Level Two Appeal

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

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

For level two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For required 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 are not obligated to grant the Committee an extension, or to provide the requested information. You will be notified in writing of the Committee's decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

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You may request that the appeal process be expedited if, (1) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain, which cannot be managed without, the requested services; (2) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay; or (3) your appeal involves (a) continued or extended health care services, procedures or treatments or additional services for you or an insured undergoing a course of continued treatment prescribed by a health care provider or (b) an adverse determination in which the health care provider believes an immediate appeal is warranted except any retrospective determination. CG's



Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

External Appeal

1. Your right to an external appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if CG has denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you or your representative, with your acknowledgment and consent, may appeal that decision to an External Appeal Agent, an independent entity certified by the State to conduct such appeals.

2. Your right to appeal a determination that a service is not medically necessary

If CG has denied coverage on the basis that the service is not medically necessary, you may appeal to an External Appeal Agent if you satisfy the following criteria:

- The service, procedure or treatment must otherwise be a Covered Expenses under this Certificate; and
- You must have received a final adverse determination through the first level of the Plan's internal appeal process and CG must have upheld the denial or you and CG must agree in writing to waive any internal appeal.

GM6000 APL690

3. Your rights to appeal a determination that a service is experimental or Investigational

If you have been denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following criteria:

- The service must otherwise be a Covered Expenses under this Certificate; and
- You must have received a final adverse determination through the first level of CG's internal appeal process and CG must have upheld the denial or you and CG must agree in writing to waive any internal appeal.

In addition, your attending Physician must certify that you have a life threatening or disabling condition or disease. A life-threatening condition or disease is one which according to the current diagnosis of your attending Physician has a high probability of death. A disabling condition or disease is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders you unable to engage in any substantial

gainful activities. In the case of a child under the age of 18, a disabling condition or disease is any medically determinable physical or mental impairment of comparable severity.

Your attending Physician must also certify that your life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure covered by CG or one for which there exists a clinical trial (as defined by law).

In addition, your attending Physician must have recommended one of the following:

- A service, procedure or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Expenses (only certain documents will be considered in support of this recommendation - your attending Physician should contact the State in order to obtain current information as to what documents will be considered acceptable); or
- A clinical trial for which you are eligible (only certain clinical trials can be considered).

GM6000 APL691

For the purposes of this section, your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

4. The External Appeal Process

If, through the first level of CG's internal appeal process, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you have 45 days from receipt of such notice to file a written request for an external appeal. If you and CG have agreed in writing to waive any internal appeal, you have 45 days from receipt of such waiver to file a written request for an external appeal. CG will provide an external appeal application with the final adverse determination issued through the first level of CG's internal appeal process or its written waiver of an internal appeal.

You will lose your right to an external appeal if you do not file an application for an external appeal within 45 days from your receipt of the final adverse determination from the first level plan appeal regardless of whether you choose to pursue a second level internal appeal with CG.

The External Appeal Program is a voluntary program.

You may also request an external appeal application from New York State at toll-free at 800-400-8882, or its website (www.ins.state.ny.us); or our Participant Services department at the toll-free number on your Benefit ID card. Submit the



completed application to State Department of Insurance at the address indicated on the application. If you satisfy the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You will have an opportunity to submit additional documentation with your request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which CG based its denial, the External Appeal Agent will share this information with CG in order for it to exercise its right to reconsider its decision. If CG chooses to exercise this right, CG will have three working days to amend or confirm its decision. In the case of an expedited appeal as described in the following section, CG does not have a right to reconsider its decision.

GM6000 APL692

External Appeals

In general, the External Appeal Agent must make a decision within 30 days of receipt of your completed application. The External Appeal Agent may request additional information from you, your Physician or CG. If the External Appeal Agent requests additional information, it will have five additional working days to make its decision. The External Appeal Agent must notify you in writing of its decision within two working days.

If your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request expedited external appeal. In that case, the External Appeal Agent must make a decision within three days of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify you and CG by telephone or facsimile of the decision. The External Appeal Agent must also notify you in writing of its decision.

If the External Appeal Agent overturns CG's decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, CG will provide coverage subject to the other terms and conditions of this document. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, CG will only cover the costs of services required to provide treatment to you according to the design of the trial. CG shall not be responsible for the costs of investigational drugs or devices, the costs of nonhealth care services, the costs of managing research, or costs which would not be covered under this certificate for nonexperimental or noninvestigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both you and CG. The External Appeal Agent's decision is admissible in any court proceeding.

CG will charge you a fee of \$50 for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. CG will also waive the fee if CG determines that paying the fee would pose a hardship to you. If the External Appeal Agent overturns the denial of coverage, the fee shall be refunded to you.

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5. Your Responsibilities

It is your responsibility to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If utilization review was initiated after health care services have been provided, your Physician may file an external appeal by completing and submitting the "New York State External Appeal Application For Health Care Providers To Request An External Appeal Of A Retrospective Final Adverse Determination," which will require your signed acknowledgment of the provider's request and consent to release the medical records.

Under New York State law, your completed request for appeal must be filed within 45 days of either the date upon which you receive written notification from CG that it has upheld a first level denial of coverage or the date upon which you receive a written waiver of any internal appeal. CG has no authority to grant an extension of this deadline.

Complaints/Appeals to the State of New York

At any time in the Grievance/Appeals process you may contact the Department of Health (for medically related issues) or the Department of Insurance (for billing/contract related Issues) at the following address and telephone number to register your complaint.

New York Department of Health
Metropolitan Regional Area Office
5 Penn Plaza, 2nd Floor
New York, NY 10001
212-268-6306 or 800-206-8125

or

New Rochelle Area Office
145 Huguenot Street, 6th Floor
New Rochelle, NY 10810
914-654-7199 or 800-206-8125

or

New York State Insurance Department
One Commerce Plaza
Albany, NY 12257
800-342-3736

GM6000 APL704



Notice of Benefit Determination on Grievance or Appeal

Every notice of a determination on grievance or 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 including clinical rationale; (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: (a) the procedures to initiate the next level of appeal; (b) any voluntary appeal procedures offered by the plan, and (c) the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

In addition, every notice of a utilization review final adverse determination must include: (a) a clear statement describing the basis and clinical rationale for the denial as applicable to the insured; (b) a clear statement that the notice constitutes the final adverse determination; (c) CG's contact person and his or her telephone number; (d) the insured's coverage type; (e) the name and full address of CG's utilization review agent, if any; (f) the utilization review agent's contact person and his or her telephone number; (g) a description of the health care service that was denied, including, as applicable and available, the dates of service, the name of the facility and/or Physician proposed to provide the treatment and the developer/manufacturer of the health care service; (h) a statement that the insured may be eligible for an external appeal and the time frames for requesting an appeal; and (i) a clear statement written in bolded text that the 45-day time frame for requesting an external appeal begins upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing the request a second level internal appeal, the time may expire for the insured to request an external appeal.

GM6000 APL693

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

Relevant Information

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

Legal Action

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

GM6000 APL746

Definitions

Bed and Board

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

DFS14

Charges

The term "charges" means the actual billed charges. It also means an amount negotiated by a provider, directly or indirectly, with CG if that amount is different from the actual billed charges.

DFS989

Custodial Services

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



they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking, (b) grooming, (c) bathing, (d) dressing, (e) getting in or out of bed, (f) toileting, (g) eating, (h) preparing foods, or (i) taking medications that can usually 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 but less than 23 years old, enrolled in school as a full-time student and primarily supported by you. Proof of the child's age, status as a student and dependence must be submitted to CG as of the later of his 19th birthday or the date he is enrolled for Dependent Insurance. After that, CG may require such proof at least once each year until he attains age 23.
 - 19 years but less than 23 years old, enrolled in school as a full-time student and on leave of absence certified as medically necessary by the student's Physician. Coverage will continue for up to 12 months from the last day of school attendance or attainment of age 23.
 - 19 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CG within 31 days after the date the child ceases to qualify above. During the next two years CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

A child includes a legally adopted child from the start of any waiting period prior to the finalization of the child's adoption. It also includes a newborn infant who is adopted by you from the moment you take physical custody of the child upon the child's release from the hospital prior to the finalization of the

child's adoption. It also includes a stepchild who lives with you.

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

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

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

DFS1697 DG

Emergency Services

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

DFS1533

Expense Incurred

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

DFS60

Formulary

Formulary means a listing of approved drug products. The drugs and medications included have been approved in accordance with parameters established by the Provider Organization. This list is subject to periodic review and is amended as required.

DFS1499



Free-Standing Surgical Facility

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

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

DFS682

Fund

The term Fund means a Fund participating in the fund which is established under the agreement of Trust for the purpose of providing insurance.

DFS274

Hospice Care Program

The term Hospice Care Program means:

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

DFS70

Hospice Care Services

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

DFS599

Hospice Facility

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

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

DFS72

Hospital

The term Hospital means:

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

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

DFS1693

Hospital Confinement or Confined in a Hospital

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

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

DFS1815



Injury

The term Injury means an accidental bodily injury.

DFS147

Maximum Reimbursable Charge - Medical

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

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

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

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

GM6000 DFS1997

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Medicaid

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

DFS192

Medically Necessary/Medical Necessity

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

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

effectiveness of alternative services, settings or supplies when determining least intensive setting.

DFS1813

Medicare

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

DFS149

Necessary Services and Supplies

The term Necessary Services and Supplies includes:

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

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

DFS151

Nurse

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

DFS155

Other Health Care Facility

The term Other Health Care Facility means a facility other than a Hospital or a 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

- 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

Participating Pharmacy

The term Participating Pharmacy means a retail pharmacy or mail-order pharmacy with which Connecticut General Life Insurance Company has contracted, either directly or indirectly, to provide prescription services to its insureds.

DFS1497

Prescription Drug

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

DFS1498

Participating Provider

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

DFS1910

Primary Care Physician

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

DFS622

Participant

The term Participant means a Participant of the Fund.

DFS1427 DG M

Participation Date

The term Participation Date means the later of:

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

DFS245

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

Pharmacy & Therapeutics (P&T) Committee

A committee of Provider Organization Participants comprised of Medical providers, Pharmacists, Medical Directors and Pharmacy Directors, which reviews medications for safety, efficacy, cost effectiveness and value. The P & T Committee evaluates medications for addition to or deletion from the Formulary and may also set dispensing limits on medications.

DFS1500

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 Participants who perform utilization review services.

DFS1688

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:



Sickness - For Medical Insurance

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

DFS531

Skilled Nursing Facility

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

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

DFS193

Specialist

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

DFS1429

Terminal Illness

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

DFS197

Urgent Care

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

DFS1534

DEF



CIGNA HealthCare

Welfare Fund of Local 1 IATSE

EXTRATERRITORIAL LEGISLATION

EFFECTIVE DATE: July 1, 2008

ETALLMF05A
3319944

This document printed in July, 2008 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)

Certificate Rider

Policyholder: Welfare Fund of Local 1 IATSE
Rider Eligibility: Each Employee
Policy No. or Nos. 3319944
Effective Date: 07/01/2008

This certificate rider forms a part of the certificate issued to you by CG describing the benefits provided under the policy(ies) specified above.

This certificate rider takes the place of any other issued to you on a prior date.

**Important Information for Residents of States
Other Than the State of New York**

For residents of states other than the State of New York, there is a state-specific certificate rider that contains provisions which add to or which change your certificate provisions.

Note: The provisions identified in your state-specific rider, incorporated herein, are applicable only to Employees located in that state. The specific state for which the rider is applicable is identified at the beginning of each individual rider as part of the "Rider Eligibility" heading.

Read the following

Note: The provisions identified in each state-specific rider incorporated herein are specifically applicable only for:

- (a) Benefit plans which have been made available by your Employer to you and/or your Dependents;
- (b) Benefit plans for which you and/or your Dependents are eligible;
- (c) Benefit plans which you have elected for you and/or your Dependents;
- (d) Benefit plans which are currently effective for you and/or your Dependents.

Please refer to the Table of Contents for the individual state-specific rider that is applicable for your residence state.

Susan L. Cooper
Corporate Secretary



**Connecticut General Life Insurance Company
a CIGNA Company (called CG)**

Certificate Rider - Alabama Residents

Rider Eligibility: Each Employee who is located in Alabama

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

This certificate rider forms a part of the certificate issued to you by CG.

The provisions set forth in this certificate rider comply with legislative requirements of the state of Alabama regarding group insurance plans covering insureds located in Alabama. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

The following is added to the Exclusive Provider or Designated Provider Medical Benefits section of the certificate entitled, "Important Information":

Primary Care Physician

A woman may designate her OB/GYN as a Primary Care Physician providing the ob/gyn is willing to accept such designation and meets the plan's credentialing criteria.

Direct Access to OB/GYN:

If a woman does not choose her OB/GYN as a Primary Care Physician, she may receive services for all visits to the OB/GYN without an authorization of care from her Primary Care Physician.

GM6000 R7

CEPV458M

- charges made by a Hospital for the inpatient care of a mother and her newborn for 48 hours following a vaginal delivery and 96 hours following a cesarean section when requested by the perinatal care Physician, OB/GYN, certified nurse-midwife, or the child's attending Physician. (No authorization of care will be required for these timeframes.) Shorter stays will be permitted if the mother and Physician agree, in writing, that early discharge is acceptable. A longer stay will be covered if it is determined to be Medically Necessary and is in accordance with the "Guidance for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

GM6000 R7

CEPV796

**Connecticut General Life Insurance
Company a CIGNA Company (called CG)**

Certificate Rider - Arizona Residents

Rider Eligibility: Each Employee who is located in Arizona

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

This certificate rider forms a part of the certificate issued to you by CG.

The provisions set forth in this certificate rider comply with legislative requirements of the state of Arizona regarding group insurance plans covering insureds located in Arizona. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

The following is added to your certificate:

This Certificate Of Insurance May Not Provide All Benefits And Protections Provided By Law In Arizona. Please Read This Certificate Carefully.

The following is added to the section of your certificate entitled "Termination of Insurance":

Reinstatement of Insurance

If your Insurance ceases because you are called to active duty from status as a reservist on or after August 22, 1990, the insurance for you and your Dependents, including those born during your time of active duty, will be reinstated after your deactivation, provided you apply for reinstatement within 90 days of discharge or within one year of continuous hospitalization from the date of discharge.

Such reinstatement will be without the application of: (a) a new waiting period, or (b) a new Pre-existing Condition Limitation to a condition that you or your Dependent may have developed while coverage was interrupted. However, no payment will be made for a condition that was the direct result of active military duty.

GM6000 R7

CEPV113 M

Arizona Important Notice

This notice is to advise you that you can obtain a replacement Appeals Process Information Packet by calling the Customer Service Department at the telephone number listed on your identification card for "Claim Questions/Eligibility Verification" or for "Member Services," or by calling 1-800-244-6224.



The Information Packet includes a description and explanation of the appeal process for CG.

Provider Lien Notice

Arizona law entitles health care providers to assert a lien for their customary charges for the care and treatment of an injured person upon any and all claims of liability or indemnity, except health insurance. If you are injured and have a claim against a non-health liability insurer (such as automobile or homeowner insurance) or any other payor source for injuries sustained, your health care provider may assert a lien against available proceeds from any such insurer or payor in an amount equal to the difference between the sum, if any, payable to the health care provider under this Plan and the health care provider's full billed charges.

GM6000 R7

CEPV1101

The following definition of Late Entrant is added to the section of the certificate entitled "**Definitions**":

Late Entrant

You are a Late Entrant for Employee or Dependent Insurance if:

- (a) you have not been continuously covered for one year under a group medical insurance policy or a self-insured group medical plan, other than a policy issued by a state high-risk insurance pool; and
- (b) you have declined for yourself or your Dependents medical coverage through your Employer during the initial enrollment period, or have ended your coverage at any time; and
- (c) you later request coverage for yourself or your Dependents.

The initial enrollment period must have been at least 30 days. An individual is not considered a Late Entrant if one of the following applies:

- 1. The person, at the time of the initial enrollment period, was covered under a prior plan. "Prior plan" means a public or private group medical insurance policy or self-insured group medical plan.
- 2. The person lost coverage under the prior plan due to the Employee's termination of employment or eligibility, the termination of the prior plan's coverage, the death of the spouse, or divorce.
- 3. The person requests enrollment within 30 days after the termination of coverage provided under the prior plan.
- 4. The person is employed by an Employer that offers multiple medical plans and the person elects a different plan during an open enrollment period.

- 5. A court orders that coverage be provided for a spouse or minor child under a covered Employee's medical plan and the Employee requests enrollment within 30 days after the court order is issued.

"Continuously covered" means the person is covered at the beginning and the end of the period and has not had any breaks in coverage during the period totaling more than 31 days.

GM6000 R7

CEPV154

The following is added to the Exclusive Provider or Designated Provider Medical Benefits section of the certificate entitled "For You and Your Dependent," which show a percentage of benefits payable:

Regarding Emergency Services, services for an initial screening exam, immediately necessary stabilization and ambulance service when provided by an Arizona provider not contracted or employed by CIGNA, are payable at the Out-of-Network level without authorization.

The following is added to the medical benefits section of the certificate entitled "**Expenses Not Covered**":

Late Entrant - A Late Entrant will be excluded from coverage for a Pre-existing Condition until that person has been continuously insured for these benefits for a period of 18 months.

Pre-Existing Condition

A Pre-existing Condition is an Injury or a Sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a Physician during the 90 days prior to the date that person becomes insured for these benefits. The term Pre-existing Condition will also include any condition which is related to any such Injury or Sickness. The Pre-existing Condition Limitation will not apply to a newborn who was otherwise covered from the time of birth.

Credit for Coverage Under Prior Policy

If a person was previously covered under another group medical policy or self-insured group medical plan, a credit of one month shall be given for each month of continuous coverage under the prior plan. Continuous coverage means that no more than 60 days has elapsed between coverage under a prior group medical plan and coverage under this plan, exclusive of any waiting period.

GM6000 R7

CEPV856 M



The following definitions are added to the section of the certificate entitled "**Definitions**":

Emergency Services/Emergency Medical Condition

Emergency Services are a health care item or service furnished or required to evaluate and treat an Emergency Medical Condition, which may include, but shall not be limited to health care services that are provided in a licensed Hospital's emergency facility by an appropriate provider. An Emergency Medical Condition is the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

- (a) Placing the person's health in significant jeopardy;
- (b) Serious impairment to a bodily function;
- (c) Serious dysfunction of any bodily organ or part;
- (d) Inadequately controlled pain; or
- (e) With respect to a pregnant woman who is having contractions:
 - (1) That there is inadequate time to effect a safe transfer to another hospital before delivery; or
 - (2) That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

Urgent Care

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

GM6000 R7

CEPV857 M

The following is added to the Comprehensive Medical Benefits section of the certificate entitled "**Expenses Not Covered**":

- for or in connection with an Injury or a Sickness which is a Pre-existing Condition after benefits equal to \$750 have become payable, unless those expenses are incurred after a twelve-month period during which a person is continuously insured for these benefits.

Late Entrant - A Late Entrant will be excluded from coverage for a Pre-existing Condition until that person has been continuously insured for these benefits for a period of 18 months.

Pre-Existing Condition

A Pre-existing Condition is an Injury or a Sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a Physician during the 90 days prior to the date that person becomes insured for these benefits. The term Pre-existing Condition will also include any condition which is related to any such Injury or Sickness. The Pre-existing Condition Limitation will not apply to a newborn who was otherwise covered from the time of birth.

Credit for Coverage Under Prior Policy

If a person was previously covered under another group medical policy or self-insured group medical plan, a credit of one month shall be given for each month of continuous coverage under the prior plan. Continuous coverage means that no more than 60 days has elapsed between coverage under a prior group medical plan and coverage under this plan, exclusive of any waiting period.

GM6000 R7

CEPV155 M

**Connecticut General Life Insurance Company
a CIGNA Company (called CG)**

Certificate Rider - California Residents

Rider Eligibility: Each Employee who is located in California

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

This certificate rider forms a part of the certificate issued to you by CG.

The provisions set forth in this certificate rider comply with legislative requirements of the state of California regarding group insurance plans covering insureds located in California. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

Late Entrants - Eligibility

The following provision is added to the "Eligibility - Effective Date" section of your certificate:

A person will not be considered a Late Entrant if his initial enrollment period was less than 30 days; if he is a Dependent



spouse or minor child enrolled due to a court order within 30 days after the order is issued; or if he did not decline coverage during his initial enrollment period by signing a Declination of Medical Coverage form, provided by your Employer.

GM6000 R7

CEPV743 M

The following is added to the medical benefits section of the certificate entitled "Covered Expenses":

- charges made by a psychologist; a respiratory care practitioner; a licensed social worker; a registered nurse licensed in psychiatric-mental health; or a licensed marriage, family or child counselor, for professional services in connection with mental illness when such services are recommended by a Physician.
- charges made for or in connection with an annual Papanicolaou screening test.

GM6000 R7

CEPV744

The following is added to the Expenses Not Covered Section of your Certificate:

Expenses Not Covered (Continued)

- for or in connection with an Injury or a Sickness which is a Pre-existing Condition after benefits equal to \$750 have become payable, unless those expenses are incurred after the earlier of: (a) a consecutive 90-day period, which begins on or after the date a person begins an eligibility waiting period or becomes insured for these benefits, during which he receives no treatment, incurs no expenses and receives no diagnosis from a Physician in connection with that Injury or Sickness; or (b) a continuous, 6-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 90 days before the earlier of the date a person; begins an eligibility waiting period, or becomes insured for these benefits.

Exceptions to Pre-existing Condition Limitation

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

A newborn child, an adopted child, or a child placed for adoption before age 18 will not be subject to any Pre-existing Condition limitation if such child was covered within 31 days of birth, adoption or placement for adoption. Such waiver will apply only if fewer than 63 (or 180, as applicable) days elapse

between coverage during a prior period of Creditable Coverage and coverage under this plan.

Late Entrant

A Late Entrant will be excluded from coverage for a Pre-existing Condition until that person has been continuously insured for these benefits for a period of 12 months.

GM6000 R7

CEPV917

To contact the Department of Insurance, write or call:

Consumer Affairs Division
 California Department of Insurance
 Ronald Reagan Building
 300 South Spring Street
 Los Angeles, CA 90013

Calling within California: 1-800-927-4537

Los Angeles Area and Outside California: 1-213-897-8921

The Department of Insurance should be contacted only after discussions with the insurer have failed to produce a satisfactory resolution to the problem.

GM6000 R7

CEPV991

**Connecticut General Life Insurance Company
a CIGNA Company (called CG)**

Certificate Rider - Colorado Residents

Rider Eligibility: Each Employee who is located in Colorado

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

This certificate rider forms a part of the certificate issued to you by CG.



The provisions set forth in this certificate rider comply with legislative requirements of the state of Colorado regarding group insurance plans covering insureds located in Colorado. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

The following is added to the "Eligibility-Effective Date" section of your certificate:

A Dependent spouse or minor child of yours will not be considered a Late Entrant if enrolled due to a court order within 30 days after such order is issued.

GM6000 R7

CEPV772 M

Important Information About Your Medical Plan

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

Primary Care Physician

Choice of Primary Care Physician:

When you elect Medical Insurance, you will select from a list provided by the Provider Organization, a Primary Care Physician for yourself and your Dependents. The Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

Primary Care Physician's Role/Your Responsibility:

The Primary Care Physician's role is to provide or arrange for medical care for you and any of your Dependents.

You and your Dependents are responsible for contacting and obtaining the authorization of the Primary Care Physician, as required, prior to seeking medical care. (You are responsible for obtaining such authorization on behalf of a Dependent who is a minor.)

Changing Primary Care Physicians:

You may request a transfer from one Primary Care Physician to another through the Provider Organization. Any such transfer will be effective on the first day of the month following the month in which the Provider Organization completes the processing of the change request.

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.

Direct Access for OB/GYN Services:

Female insureds covered by this plan are allowed direct access to licensed/certified participating practitioners for covered

ob/gyn services. There is no requirement to obtain an authorization of care from your Primary Care Physician for visits to the participating practitioner of your choice for pregnancy, well-woman gynecological exams, primary and preventive gynecological care, and acute gynecological conditions.

GM6000 R7

CEPV724

The following is added to the medical section of your certificate entitled "**Covered Expenses**":

- charges up to a maximum of \$76, made for or in connection with mammograms for breast cancer screening for diagnostic purposes, including, but not limited to: (a) a baseline mammogram for women ages 35 through 39; (b) a mammogram every 2 years for women ages 40 through 49, but at least once a year for a woman with risk factors based on the attending Physician's recommendation; and (c) a mammogram every year for women ages 50 to 65. Such coverage will not be subject to deductible.
- charges made for or in connection with an annual screening for prostate cancer in men over age 50, or over age 40 if the Physician determines there is a high risk factor. There will be no deductible. The annual amount for screening (PSA blood test and a digital rectal exam) will not exceed \$65.
- charges made for or in connection with management of pain for which a cause or cure can not be found through reasonable efforts made by a Physician or specialist.

GM6000 R7

CEPV944

The following is added to the medical section of your certificate entitled "**Covered Expenses**":

Covered Expenses

- charges made for treatment of Biologically Based Mental Illness. Such Covered Expenses will be payable the same as for other illnesses. Any Mental Illness Maximums in the Schedule and any Full Payment Area exceptions for Mental Illness will not apply to Biologically-Based Mental Illnesses. A Biologically-Based Mental Illness is defined as: schizophrenia; schizo affective disorder; bipolar affective disorder; panic disorder; specific obsessive-compulsive disorder; or major depressive disorder.

GM6000 R7

CEPV839

The following is added to the medical section of your certificate entitled "**Covered Expenses**":



Covered Expenses

- charges by a Hospital for a mother and newborn made for inpatient care for 48 hours following a vaginal delivery and 96 hours of care following a cesarean section. No authorization of care will be required for these time-frames. For longer stays, guidelines prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists will be used. A shorter length of stay is acceptable if the decision for early discharge is made by the mother and the Physician.

In addition, Covered Expenses will include charges made for Preventive Child Health Supervision Services for a Dependent child on or before that child's 13th birthday, at any of the Approximate Age Intervals shown below. Charges made for Preventive Child Health Supervision Services consist of the following services, provided in keeping with prevailing medical standards by a Physician or a Physician's Assistant, or by a Registered Nurse with additional training in child health assessment and who is working in collaboration with a Physician:

- a history;
- an age-appropriate physical examination;
- anticipatory guidance; and
- appropriate immunizations and laboratory tests;

excluding any charges for:

- more than one visit to one provider for Preventive Child Health Supervision Services at each of the Approximate Age Intervals up to a total of 16 visits for each child;
- services for which benefits are otherwise provided under this Comprehensive Medical Benefits plan; and
- services for which benefits are not payable according to the Expenses Not Covered section.

It is provided that any Deductible that would otherwise apply will be waived for those Covered Expenses incurred for Preventive Child Health Supervision Services.

Approximate Age Intervals are: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years and 12 years.

GM6000 R7

CEPV771

The following replaces language regarding Pre-existing Conditions in the "Expenses Not Covered" section of your certificate:

A continuous 6-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 90 days before the earlier of the date a person; begins an eligibility waiting period, or becomes insured for these benefits.

Exceptions to Pre-existing Condition Limitation

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

A newborn child, an adopted child, or a child placed for adoption before age 18 will not be subject to any Pre-existing Condition limitation if such child was covered within 30 days of birth, adoption or placement for adoption. Such waiver will apply only if fewer than 90 days elapse between coverage during a prior period of Creditable Coverage and coverage under this plan.

Credit for Coverage Under Prior Plan

If a person was previously covered under a plan which qualifies as Creditable Coverage, the following will apply, provided he notifies the Employer of such prior coverage, and fewer than 90 days elapse between coverage under the prior plan and coverage under this plan, exclusive of any waiting period.

CG will reduce any Pre-existing Condition limitation period under this policy by the number of days of prior Creditable Coverage you had under a creditable health plan or policy for up to 6 months.

GM6000 R7

CEPV773

**Connecticut General Life Insurance Company
a CIGNA Company (called CG)**

Certificate Rider - Connecticut Residents

Rider Eligibility: Each Employee who is located in Connecticut

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

This certificate rider forms a part of the certificate issued to you by CG.

The provisions set forth in this certificate rider comply with legislative requirements of the state of Connecticut regarding group insurance plans covering insureds located in Connecticut. These provisions supersede any provisions in



your certificate to the contrary unless the provisions in your certificate result in greater benefits.

The following is added to the section of the certificate entitled "Covered Expenses":

- for treatment of Lyme disease to include 30 days of intravenous antibiotic therapy and 60 days of oral antibiotic therapy. Further treatment will be covered if recommended by a board certified rheumatologist, infectious disease specialist or neurologist.

GM6000 R7

CEPV919

The following is added to the section of the certificate entitled "Termination of Insurance":

Notice of Cancellation or Substitution

Your Employer will give you written notice at least 15 days before the date:

- the life Insurance or Medical Insurance policy is canceled; or
- another policy, providing similar benefits, is substituted for the policy with no interruption of benefits.

GM6000 R7

CEPV920

**Connecticut General Life Insurance Company
a CIGNA Company (called CG)**

Certificate Rider - Delaware Residents

Rider Eligibility: Each Employee who is located in Delaware

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

This certificate rider forms a part of the certificate issued to you by CG.

The provisions set forth in this certificate rider comply with legislative requirements of the state of Delaware regarding group insurance plans covering insureds located in Delaware. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

The following is added to the medical benefits section of your certificate entitled, "**Eligibility/Effective Date**":

A person will not be considered a Late Entrant and will not be subject to a Pre-existing Condition limitation if his initial enrollment period was shorter than 30 days.

A Dependent spouse or a minor child enrolled within 30 days following a court order of such coverage will not be considered a Late Entrant.

Any Pre-existing Condition limitation which applies for a Late Entrant, will begin as of the date the Late Entrant applies for coverage.

For Plans with Mail Order Drug Benefits:

Any copayment amount for a prescription filled at a Participating Mail-Order Pharmacy will be three times the copayment for a prescription filled at a Participating Retail Pharmacy.

GM6000 R7

CEPV741M

The following is added to the medical benefits section of your certificate entitled "Covered Expenses":

- charges made for or in connection with an annual Papanicolaou screening test.
- charges made for or in connection with prostate cancer screening (commonly known as a prostate-specific antigen (PSA) test for males age 50 or older.
- charges made for or in connection with mammograms including; (a) a baseline mammogram for asymptomatic women at least age 35; (b) a mammogram every one or two years for asymptomatic women age 40-49, but no sooner than two years after a woman's baseline mammogram; (c) an annual mammogram for women age 50 and over; and (d) a mammogram, anytime when prescribed by a Physician, regardless of the woman's age;
- charges made for or in connection with one baseline lead poison screening test for Dependent children at or around 12 months of age;
- charges made for or in connection with lead poison screening and diagnostic evaluations for Dependent children under the age of 6 years who are at high risk for lead poisoning according to guidelines set by the Division of Public Health.

GM6000 R7

CEPV872

**Connecticut General Life Insurance Company
a CIGNA Company (called CG)**

Certificate Rider – Georgia Residents

Rider Eligibility: Each Employee who is located in Georgia

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status. However, you will not be insured for any



loss of life, dismemberment or loss of income coverage until you are in Active Service.

This certificate rider forms a part of the certificate issued to you by CG.

The provisions set forth in this certificate rider comply with legislative requirements of the state of Georgia regarding group insurance plans covering insureds located in Georgia. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

The following applies to the section of the certificate titled "The Schedule.":

Payment for Emergency Services will not be subject to prospective or retrospective denial. Emergency Service provided by a non-Participating Provider will be covered at the In-Network level.

NOTICE: Any provision in your certificate that refers to integration with no-fault insurance will not apply in Georgia.

GM6000 R7

CEPV966M

The following relates to your Primary Care Physician's role, and your responsibility:

Authorization by a Primary Care Physician will not be required if you or your Dependent obtains care from an OB/GYN.

The following relates to drugs and medicines which are covered only if listed on the Provider Organization's Formulary, as described under "Covered Expenses."*

*If a formulary drug is ineffective in treating a person's condition, or if a drug causes or may cause an adverse reaction, the Physician may ask the Provider Organization to substitute a nonformulary drug.

The following is added to the "Covered Expenses" section of your certificate:

- charges for general anesthesia, Hospital and Physician expenses for inpatient or outpatient dental procedures when performed: (1) on a child who is seven years of age or younger, or who is developmentally disabled; (2) when a successful result cannot be expected under local anesthesia because of a neurological or other medically compromising condition of the individual; or (3) on a person who has sustained extensive facial or dental trauma.

GM6000 R7

CEPV786

**Connecticut General Life Insurance Company
a CIGNA Company (called CG)**

Certificate Rider - Indiana Residents

Rider Eligibility: Each Employee who is located in Indiana

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

This certificate rider forms a part of the certificate issued to you by CG describing the benefits provided under the policy(ies) specified above.

The provisions set forth in this certificate rider comply with legislative requirements of the state of Indiana regarding group insurance plans covering insureds located in Indiana. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

The following is added to the definition of "Dependent" with respect to medical benefits for a Dependent child:

A child includes a legally adopted child including: (a) a child who has been placed with you for adoption provided the child is not removed from placement prior to legal adoption; or (b) a child for whom entry of an order granting custody to you has been made.

The following is added to the medical section of the certificate entitled "Covered Expenses":

Coverage for or in connection with expenses arising from medical and dental care (including orthodontic and oral surgery treatment) involved with the management of cleft lip and cleft palate.

Charges for reimbursement payments made to the Indiana First Steps program, not to exceed \$3,500 annually for Early Intervention Services incurred by a Dependent child enrolled in the program, from birth through age two. Payments may not apply toward any annual or lifetime limit. Payments made directly by the program will be credited toward deductibles or copayments.

GM6000 R 7

CEPV878 M

Indiana Notice

Connecticut General Claim Offices Serving Indiana

We are here to serve you...

As our certificate holder, your satisfaction is very important to us. If you have a question about your certificate, if you need



assistance with a problem, or if you have a claim, you should first contact your Benefits Administrator or us at the numbers and addresses listed below. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion.

Medical Questions

Connecticut General Life Insurance Company
Midwest Claim Service Center
P.O. Box 2100
Bourbonnais, IL 60914 Tel. (815) 939-4566

OR

Connecticut General Life Insurance Company
Columbus Claim Service Center
1000 Polaris Parkway
Columbus, OH 43240-2005 Tel. (614) 785-1310

Should you feel you are not being treated fairly with respect to a claim, you may contact the Indiana Department of Insurance with your complaint.

To contact the Department, write or call:

Consumer Services Division
Indiana Department of Insurance
311 West Washington Street, Suite 300
Indianapolis, IN 46204-2787

1-800-622-4461 or 1-317-232-2395

GM6000

R7CEPV324

The following is added to the section of your certificate entitled "Definitions".

Early Intervention Services

Early Intervention Services are defined as developmental services that are:

- 1) provided under public supervision, at no cost, except where federal or state law allows for a system of payments by families, which may include a sliding scale of fees;
- 2) designed to meet the developmental needs of infants and toddlers with disabilities in any one or more of the following areas: physical, cognitive, or communication development; or social, emotional or adaptive development;
- 3) in compliance with all required state and federal standards;
- 4) provided by qualified personnel, including: early childhood special educators, early childhood educators,

special educators, speech and language pathologists, audiologists, occupational or physical therapists, psychologists, social workers, nurses, nutritionists, family therapists, orientation and mobility specialists, pediatricians and other physicians;

- 5) provided in natural environments, including the home and community settings in which children without disabilities participate; and
- 6) provided in conformity with an individualized family service plan.

Early Intervention Services include: family training, counseling, and home visits; special instruction; speech and language pathology and audiology, occupational and physical therapy; psychological services; service coordination services; medical services only for diagnostic, evaluation, or consultation purposes; early identification, screening and assessment services; other health services necessary for the infant or toddler to benefit from their services; vision services; assistive technology devices and supportive technology services; and transportation and related costs that are necessary to enable an infant or a toddler and the infant or toddler's family to receive early intervention services.

GM6000 R7

CEPV879

**Connecticut General Life Insurance Company
a CIGNA Company (called CG)**

Certificate Rider - Kansas Residents

Rider Eligibility: Each Employee who is located in Kansas

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

This certificate rider forms a part of the certificate issued to you by CG.

The provisions set forth in this certificate rider comply with legislative requirements of the state of Kansas regarding group insurance plans covering insureds located in Kansas. Mental illness and substance abuse benefits supersede any shown in the certificate. All other Rider provisions supersede benefits in the certificate, unless exceeded by certificate benefits.

The following is added to the section of your certificate entitled "Eligibility Effective Date":

A Dependent spouse or minor child of yours will not be considered a Late Entrant if enrolled due to a court order within 30 days after such order is issued. A Late Entrant may not be required to wait to enroll any later than the beginning of the next annual enrollment period.



The following is added to the medical benefits section of the certificate entitled "Covered Expenses":

Covered Expenses will also include charges made for diagnostic mammograms and Papanicolaou screening tests.

Covered Expenses will also include charges incurred at birth for the delivery and obstetrical expenses for the birth mother of a child legally adopted by you within 90 days of his date of birth, subject to all other terms of these Medical Benefits. This benefit is at the option of the insured and is in excess of the birth mother's coverage.

GM6000 R 7

CEPV756 M

The following is added to the Exclusive Provider or Designated Provider Medical Benefits section entitled "Important Information":

Important Notice

This notice is to advise you that CG will, upon request, provide you with the following:

a complete description of health care services; a description of limitations and exclusions; prior authorization policies; restricted drug formularies; other provisions restricting access; a copy of the participating provider directory; notice of plan changes that affect benefits or cost; a description of the available grievance and appeal procedures; and description of your rights regarding termination, disenrollment, nonrenewal, or cancelation of coverage.

GM6000 R7

CEPV641 M

Covered Expenses

The following is added to the "Covered Expenses" section of the certificate:

- charges for a drug that has been prescribed for the treatment of cancer for which use of the drug has not been approved by the U.S. Food and Drug Administration if that drug has been recognized as a treatment for cancer in one of the standard reference compendia or supported by articles in accepted, peer-reviewed medical literature. Coverage will also be provided for any medical services necessary to administer the drug.
- charges for a prostate-specific antigen (PSA) blood test and a digital rectal examination for: (a) a man age 50 and over regardless of whether or not symptoms are present; and (b) a man age 40 and over who is symptomatic or who is considered a high risk for prostate cancer.

In addition, Covered Expenses will include expenses incurred for a Dependent child from birth to age 6, for charges made for Child Preventive Care Services without application of any deductible, copayment or coinsurance, as follows:

- no less than 5 doses of vaccine for protection from diphtheria, pertussis, and tetanus;
- no less than 4 doses of vaccine for protection from polio and Hemophilus influenza type B (Hib);
- 3 doses of vaccine for protection from Hepatitis B;
- 2 doses of vaccine for protection from measles, mumps, and rubella;
- 1 dose of vaccine for protection from varicella (chicken pox); and
- any other vaccines that are prescribed by the Kansas Secretary of Health and Environment.

GM6000 R7

CEPV993 M

- charges for emergency services if symptoms presented by the insured and recorded by the Physician indicate an emergency. This term means a sudden and unexpected onset of a health condition that requires immediate medical attention and failure to receive such attention would result in serious impairment to bodily functions. Follow-up care after the emergency will also be covered.

GM6000 R7

CEPV566 M

The following is added to the Exclusive Provider or Designated Provider Medical Benefits section entitled "Covered Expenses":

The following alcoholism, drug abuse, and mental illness benefits apply:

Inpatient Alcoholism, Drug Abuse and Mental Illness

Payment will be made for Covered Expenses incurred for treatment of: (a) alcoholism, (b) drug abuse, and (c) mental illness while a person is Confined in a Hospital on the same basis as payment for any other illness with regard to coinsurance, deductible, copayment and maximum provisions, up to 30 days each for (a)-(c) per contract year.

Outpatient Alcoholism, Drug Abuse, and Mental Illness

Payment will be made for Covered Expenses incurred for treatment of alcoholism, drug abuse, or mental illness while a person is not Confined in a Hospital, without application of any deductible or copayment, at a rate of 100% for the first \$100 of charges, 80% of the next \$100 of charges, 50% thereafter for mental illness; and 50% of the next \$1,640 of charges to a separate maximum of \$1,000 each for alcoholism and drug abuse; per contract year.



A Lifetime Alcohol and Drug Abuse Outpatient Maximum will equal \$7,500.

The following is added to the section of the certificate entitled "**Expenses not Covered**" with regard to the pre-existing condition limitation.

The following is added to the section of the certificate entitled "**Expenses not Covered**":

- for Out-of-Network benefits, for or in connection with an Injury or Sickness which is a Pre-existing Condition, after benefits equal to \$750 have become payable, unless those expenses are incurred after a continuous 90-day period during which a person is satisfying a waiting period and/or is insured for these benefits. Any credit for prior coverage will reduce any Pre-existing Condition limitation up to 90 days.

The following is added to the "**Medical Conversion**" section of the certificate entitled "Employees Entitled to Convert":

To allow for timely conversions, persons whose insurance is being continued under any "Continuation" provision **must** submit Conversion Information Request Form #311084 to CG no later than 31 days after the date that continued coverage would cease or not later than 31 days after receipt of notification that coverage has ceased. This form and further details are available from the Policyholder.

GM6000 R 7

CEPV804 M

The following language is added to the certificate:

Effect of Group Medical Replacement Insurance

You and your Dependents who would have become insured under the replaced policy had you satisfied the waiting period under that policy will become insured under this policy, subject to the "Eligibility for Employee Insurance," "Eligibility for Dependent Insurance," "Effective Date of Employee Insurance," and "Effective Date of Dependent Insurance" sections. Credit will be given for time accrued toward the waiting period of the replaced policy.

The terms below apply to you if you:

- are in a Class of Eligible Employees under this policy;
- were insured on the day before the Effective Date of this policy under the replaced policy in an eligible class of employees; and
- were insured under the replaced policy which was sponsored by the Employer and is replaced by this policy.

Credit will be given toward any deductibles under this policy to the extent that all or part of any deductible amount was satisfied under the replaced policy.

The Pre-existing Condition Limitation, if any, for this policy, will not apply.

GM6000 R 7

CEPV759

The following is added to the section of the certificate entitled "Definitions":

The term child in the definition of Dependent will also include a child legally adopted by you. For a newborn adopted child, medical coverage begins from the moment of birth if a petition of adoption is filed within 31 days of the newborn's birth; otherwise, coverage for an adopted child begins from the date of placement in the insured's home.

GM6000 R 7

CEPV760

The following is added to the Important Notice page in your Certificate:

Insured persons have the right to request an independent external review of an adverse decision by the plan when (1) the covered person has exhausted all internal review procedures for non-emergency medical conditions, (2) the covered person has not received a final decision within 60 days of seeking the internal review and did not request the delay, or (3) there is an emergency medical condition. Within 90 days receipt of the adverse decision, the request for external review must be sent in writing to the Commissioner from the covered person, his treating Physician with written authorization, or a legally authorized designee of the covered person. The covered person must provide (1) all pertinent information, (2) an appeal form, and (3) a fully executed release form pertaining to medical records. Upon request from the Commissioner, the covered person or insurer/HMO must provide pertinent information within 5 business days. The Commissioner will (1) negotiate contracts with external review organizations, (2) allow the participants to provide additional written information, (3) make a decision on the request within 10 business days of receiving all necessary information, and (4) notify the covered person, provider or designee in writing if the request for external review was granted. The external review organization chosen by the Commissioner will issue a binding written decision to the covered person, insurer and Commissioner within 30 business days, expedited resolution when an emergency condition exists within 7 business days.

GM6000 R 7

CEPV858

**Connecticut General Life Insurance Company
a CIGNA Company (called CG)**

Certificate Rider - Kentucky Residents

Rider Eligibility: Each Employee who is located in Kentucky



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

This certificate rider forms a part of the certificate issued to you by CG.

The provisions set forth in this certificate rider comply with legislative requirements of the Commonwealth of Kentucky regarding group insurance plans covering insureds located in Kentucky. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

The following is added to the medical benefits section of your certificate entitled "Eligibility."

Exception of Newborns

Any newborn child born while you are insured for Medical Insurance will be covered from his date of birth for the first 31 days. If you elect to insure your newborn beyond the 31-day period, notification of the birth and payment of any premium must be received within 31 days after the date of birth.

GM6000 R 7

CEPV677 M

The following is added to the section of the certificate entitled "Important Information":

Continuity of Care

When a provider's contract is terminated for reasons other than quality of care or fraud, coverage will continue until the insured is discharged from an inpatient facility or the active course of treatment is completed, whichever time period is greater. If the insured is in her fourth month of pregnancy or later, coverage will be provided through the end of the postpartum period.

GM6000 R7

CEPV906

The following is added to the section of the certificate entitled "Covered Expenses":

- charges for cochlear implants for person's age 2 and over with the diagnosis of profound sensorineural deafness or postlingual deafness in adults. Cochlear implants for children under age 2 will be covered when, upon review, they are determined to be medically necessary.
- charges for therapeutic, respite and rehabilitative care for treatment of Autism for your Dependent child. This benefit will be limited to a \$500 maximum per month, per child.

- charges for bone density testing for women age 35 and older, as indicated by a Physician, for the purpose of early detection of osteoporosis.
- charges for the diagnosis and treatment of endometriosis and endometritis.
- charges for amino acid modified preparations and low protein modified food products for the treatment of inherited metabolic diseases provided the amino acid products are prescribed as medically necessary for the therapeutic treatment of inherited metabolic diseases and administered under the direction of a Physician. Coverage will be limited to an annual maximum of \$4,000 on both individual medical food prescription expenditures and medical formulas. An amino acid modified preparation is a product intended for the dietary treatment of an inherited metabolic disease under the direction of a Physician. A low protein modified food product is a product formulated to have less than one 1 gram of protein per serving and intended for the dietary treatment of an inherited metabolic disease.

GM6000 R7

CEPV909

The following is added to the "Definition" section of your certificate:

Autism

- A. A total of six or more items from subparagraphs 1, 2, and 3 of this paragraph, with at least two from subparagraph 1 and one each from subparagraphs 2 and 3 will be used to define Autism:
 1. Qualitative impairment in social interaction, as manifested by at least two of the following:
 - a. Marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;
 - b. Failure to develop peer relationships appropriate to developmental level;
 - c. A lack of spontaneous seeking to share enjoyment, interests or achievement with other people; or
 - d. Lack of social or emotional reciprocity.
 2. Qualitative impairments in communication as manifested by at least one of the following:
 - a. Delay in, or total lack of, the development of spoken language;



- b. In individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others;
- c. Stereotyped and repetitive use of language or idiosyncratic language; or
- d. Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental levels.

GM6000R7

CEPV660 M

3. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

- a. Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus;
- b. Apparently inflexible adherence to specific, nonfunctional routines or rituals;
- c. Stereotyped and repetitive motor mannerism; or
- d. Persistent preoccupation with parts or objects;

B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age three years:

- 1. Social interaction;
- 2. Language as used in social communication; or
- 3. Symbolic or imaginative play; and

C. The disturbance is not better accounted for by Rett Syndrome or Childhood Disintegrative Disorder.

GM6000 R 7

CEPV661 M

The attached is added to the medical benefits section of your certificate entitled "Termination of Insurance."

Special Continuation of Medical Insurance For Employees and Dependents

If your Medical Insurance would cease and if you have been insured for at least three consecutive months under the policy or a policy it replaced, upon your payment of the required premium to your Employer, your Medical Insurance will be continued, until the earliest of:

- 18 months from the date Medical Insurance would otherwise cease;
- the last day for which you have paid the required premium;
- the date you become eligible for insurance for medical benefits under another group policy or under Medicare;

- for a Dependent, the date that Dependent no longer qualifies as a Dependent;
- the date the policy cancels.

Your Employer will notify you in writing of your right to elect such continuation by sending you an "election of continuation of coverage" form, samples of which have been provided by the Insurance Company.

Within 31 days after the date notice is sent, you may elect such continuation in writing by returning the "election of continuation of coverage" form and paying the required premium.

GM6000 R 7

CEPV755

The following is added to the Pre-Existing Condition section, under "Expenses Not Covered" in the Medical benefits section of your certificate.

Credit for Coverage Under Prior Plan

If a person was previously covered under a prior medical benefits plan, and his coverage under that plan ended no more than 60 days before his coverage under this plan started, the following will apply:

- If a person had partially satisfied a waiting period for the Pre-existing Condition under the prior plan, he will be given credit under this plan's Pre-existing Condition limitation for that period of time.

Prior plans include any group or individual health insurance policies, self-insured plans, health maintenance organization or health service corporation contracts, and Medicare or Medicaid coverage.

Please notify the Employer of any prior coverage.

GM6000 R 7

CEPV479

Connecticut General Life Insurance Company a CIGNA Company (called CG)

Certificate Rider - Louisiana Residents

Rider Eligibility: Each Employee who is located in Louisiana

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

This certificate rider forms a part of the certificate issued to you by CG.

The provisions set forth in this certificate rider comply with the legislative requirements of the state of Louisiana



regarding group insurance plans covering insureds located in Louisiana. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

The following is added to the medical section of your certificate entitled "**Expenses Not Covered**":

Credit for Coverage Under Prior Policy

If a person was previously covered under another substantially similar group or individual insurance policy or self-insured plan, including a policy providing any state or federally required continuation of coverage, the following will apply provided no more than 60 days have elapsed between coverage under the prior plan and coverage under this plan exclusive of any waiting period:

- If the person was covered for the Pre-existing Condition under the prior plan, the Pre-existing Condition limitation under this policy will be waived for that condition.
- If the person had partially satisfied a waiting period for the Pre-existing Condition under the prior plan, he will be given credit under this policy's Pre-existing Condition limitation for that period of time.

GM6000 R 7

CEPV197 M

The following is added to the section of your certificate entitled "**Termination of Insurance**":

Medical Insurance for Surviving Spouse

For purposes of this section, the term Surviving Spouse means your legal spouse, who at the time of your death is:

- 50 or more years old; and
- insured as your Dependent for Medical Insurance.

If you die while insured for Medical Insurance, your Surviving Spouse may continue to be insured for such benefits, subject to the terms set forth below.

Your Employer will notify your Surviving Spouse of his right to elect continuation of his Medical Insurance. Your Surviving Spouse, within 90 days of the date the insurance would otherwise cease, may elect such continuation in writing and by paying the required premium to your Employer. If your Surviving Spouse elects this option, his insurance will be continued until he:

- becomes eligible for another group medical plan;
- becomes eligible for Medicare;
- remarries; or
- discontinues premium payments to your Employer;

whichever occurs first.

This option will not operate to reduce any continuation of insurance otherwise provided.

GM6000

R7CEPV198

Continuation of Insurance During Active Military Duty

If your coverage would otherwise cease because you are a reservist in the United States Armed Forces and are called to active duty, the insurance for you and your Dependents will be continued during your active duty only if you elect it in writing, and will continue until the earliest of the following dates:

- 90 days from the date your military service ends;
- the last day for which you made any required contribution for the insurance; or
- the date the group policy is canceled.

Reinstatement of Insurance

If your Insurance ceases because of active duty in: (a) the United States Armed Forces; (b) the Reserves of the United States Armed Forces; or (c) the National Guard, the insurance for you and your Dependents will be reinstated after your deactivation provided you apply for reinstatement and you are otherwise eligible.

Such reinstatement will be without the application of: (a) a new waiting period, or (b) a new Pre-existing Condition Limitation. A new Pre-existing Condition Limitation will not be applied to a condition that you or your Dependent may have developed while coverage was interrupted. The remainder of a Pre-existing Condition Limitation which existed prior to interruption of coverage may still be applied.

GM6000 R7

CEPV28

The following is added to the medical section of your certificate entitled "**Covered Expenses**":

Covered Expenses will include:

- charges for electronic imaging/telemedicine health care services, including, but not limited to, diagnostic testing and treatment. The Physician must be physically present with the patient and communicating with a Physician at the facility receiving the transmission. Payment shall not be less than 75% of the Reasonable and Customary payment received for an intermediate office visit. These electronic/telemedicine benefits are subject to utilization review requirements.



The following is added to the definition of "Dependent" in the section of your certificate entitled "Definitions":

A child includes a legally adopted child, including: (a) an unmarried child who is placed in your home according to an adoption placement agreement executed with a licensed adoption agency effective from the date of placement in your home, or (b) any unmarried child, following execution of an act of voluntary surrender in favor of you or your legal representative effective from the date on which the act of voluntary surrender becomes irrevocable.

GM6000 R 7

CEPV461 M

Covered Expenses will include:

- charges for an insured's costs for treatment in a clinical trial for cancer including investigational treatments and associated protocol related patient care if:
 - (a) treatment is provided with a therapeutic or palliative intent for patients with cancer or for the prevention or early detection of cancer;
 - (b) treatment is being provided for, or the studies are being conducted in, a Phase II, Phase III, or Phase IV clinical trial for cancer;
 - (c) treatment is being provided in accordance with a clinical trial approved by one of the United States National Institutes of Health (NIH), a cooperative group founded by one of the NIH, the FDA in the form of an investigational new drug application, the US Department of Veterans Affairs, the US Department of Defense, a federally funded general clinical research center or The Coalition of National Cancer Cooperative Groups;
 - (d) the proposed protocol has been reviewed and approved by a qualified institutional review board operating in Louisiana with a multiple project assurance contract approved by the Office of Protection from Research Risks;
 - (e) the facility and personnel are providing the treatment within the scope of their practice, experience and training and are capable of doing so by virtue of their experience, training and volume of patients treated to maintain expertise;
 - (f) there is no clearly superior, noninvestigational approach;
 - (g) the available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative; and

- (h) the patient has signed an institutional review board approved consent form.

Insured's cost means the cost of any health care services, treatments or testing that are incurred as part of the protocol treatment being provided to the patient for purposes of the clinical trial. Insured's cost does not include the cost of nonhealth care services that a patient may be required to receive as a result of the treatment being provided in accordance with the clinical trial, the costs associated with managing the research data associated with the clinical trial, the costs of such investigational devices or drugs not required to be covered in Louisiana, or the costs not otherwise covered under the insured's plan for noninvestigational treatments.

GM6000 R 7

CEPV880

**Connecticut General Life Insurance Company
a CIGNA Company (called CG)**

Certificate Rider - Maine Residents

Rider Eligibility: Each Employee who is located in Maine

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

This certificate rider forms a part of the certificate issued to you by CG.

The provisions set forth in this certificate rider comply with legislative requirements of the state of Maine regarding group insurance plans covering insureds located in Maine. These provisions supersede any provisions in your certificate to the contrary unless the provisions in the certificate result in greater benefits.

The following is added to the medical benefits section of the certificate entitled "Covered Expenses":

- charges made for or in connection with mammograms for breast cancer screening or diagnostic purposes, not to exceed: (a) one mammogram every two years for women age 40 but less than 50; and (b) one annual mammogram for women age 50 and over.
- charges made on its own behalf, by a facility licensed to furnish mental health services, for care and treatment of mental illness provided on an outpatient basis.



- charges made on its own behalf, by a facility licensed to furnish treatment of alcohol or drug abuse, for care and treatment provided on an outpatient basis.
- charges made for or in connection with Pap tests when recommended by a Physician.

GM6000 R 7

CEPV456 M

- charges for metabolic formulas and special modified low-protein food products, when prescribed by a Physician, for a person with an inborn error of metabolism. Low-protein food products do not include foods naturally low in protein and are covered to a limit of \$3,000 per calendar year.
- charges for all stages and revisions of reconstructive breast surgery performed on nondiseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. Coverage includes; (a) reconstruction of the mastectomy site; (b) creation of a new breast mound, and of a new nipple/areola complex without regard to the lapse of time between the mastectomy and the reconstruction, upon the treating Physician's approval.
- charges for inpatient coverage with respect to the treatment of breast cancer, for a period of time determined by the attending Physician, in consultation with you, to be medically appropriate following a mastectomy, lumpectomy or lymph node dissection for the treatment of breast cancer.

GM6000

R7CEPV612

- charges for a digital rectal examination and a prostate-specific antigen test for the early detection of prostate cancer, if recommended by a Physician, at least once a year for a man 50 years of age and older until the man reaches age 72.

GM6000 R7

CEP813

The following mental illness benefits apply:

Inpatient Mental Illness Benefits

Payment will be made for Covered Expenses incurred for or in connection with inpatient treatment of mental illness while Confined in a Hospital, on the same basis as payment for any other illness with regard to coinsurance and deductible provisions, up to 30 days confinement in a calendar year. Benefits will not exceed the Inpatient and Outpatient Mental Illness Lifetime Maximum.

Outpatient Mental Illness Benefit

Payment will be made for Covered Expenses, for or in connection with outpatient treatment of mental illness while not Confined in a Hospital, at 50% of charges incurred, up to \$1,500 in a calendar year. Benefits will not exceed the Inpatient and Outpatient Mental Illness Lifetime Maximum.

Inpatient and Outpatient Serious Mental Illness Benefit

For inpatient Day Treatment and outpatient treatment of schizophrenia, bipolar disorder; pervasive developmental disorder; autism; paranoia; panic disorder; obsessive-compulsive disorder; or major depressive disorder, payment for Covered Expenses incurred will be made on the same basis as payment for any other illness, including increasing the rate of payment by CG when the Full Payment Area conditions are met.

Inpatient and Outpatient Mental Illness Lifetime Maximums

Payment for inpatient and outpatient mental illness benefits combined will not exceed \$50,000 in a person's lifetime.

Payment for inpatient, including Day Treatment and outpatient Serious Mental Illness benefits will not be subject to a lifetime maximum.

Day Treatment

Day Treatment for Serious Mental Illness will include psycho-educational, physiological, psychological and psychosocial concepts, techniques and processes to maintain or develop functional skills, provided on an individual or group basis for more than 2 hours, but less than 24 hours per day.

GM6000 R 7

CEPV394

The following alcohol and drug abuse benefits apply:

Inpatient Alcohol and Drug Abuse Benefit

Payment will be made for Covered Expenses incurred for or in connection with inpatient treatment of alcohol and drug abuse while Confined in a Hospital on the same basis as payment for any other illness with regard to coinsurance and deductible provisions, up to 30 days confinement in a calendar year. Benefits will not exceed the Inpatient and Outpatient Alcohol and Drug Abuse Lifetime Maximum.

Outpatient Alcohol and Drug Abuse Benefits

Payment will be made for Covered Expenses incurred for or in connection with treatment of alcohol and drug abuse while not Confined in a Hospital on the same basis as payment for any other illness with regard to coinsurance and deductible provisions, up to \$1,500 in a calendar year. Benefits will not



exceed the Inpatient and Outpatient Alcohol and Drug Abuse Lifetime Maximum.

Inpatient and Outpatient Alcohol and Drug Abuse Lifetime Maximum

Payment for inpatient and outpatient alcohol and drug abuse benefits combined will not exceed \$25,000 in a person's lifetime. However, in no event will the payment for inpatient treatment of alcohol and drug abuse be less than 60 days confinement in a person's lifetime.

GM6000 R7

CEPV135

**Connecticut General Life Insurance Company
a CIGNA Company (called CG)**

Certificate Rider - Maryland Residents

Rider Eligibility: Each Employee who is located in Maryland

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

This certificate rider forms a part of the certificate issued to you by CG.

The provisions set forth in this certificate rider comply with legislative requirements of the state of Maryland regarding group insurance plans covering insureds located in Maryland. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

Notices:

The benefits of the policy providing your coverage are governed primarily by the law of a state other than Maryland. It may not contain all the benefits required for a policy issued in Maryland.

This plan provides Hospital coverage for at least 48 hours following a vaginal birth and at least 96 hours following a cesarean section. Four additional days are covered for a newborn when the mother remains hospitalized due to medical necessity. One postpartum visit is covered, with an additional visit covered for early discharge, when medically necessary.

GM6000 R 7

CEPV507 M

The following is added to the Exclusive Provider or Designated Provider section of your certificate entitled "Important Information":

Direct Access to an OB/GYN

A woman who is covered under this plan may receive services, including routine care, by an ob/gyn without an authorization of care. The care must be medically necessary; the ob/gyn must communicate (via telephone, mail or fax) the diagnosis or treatment to the PCP after the visit; and the ob/gyn must confer with the PCP before performing any diagnostic procedures which are not considered routine care during an annual visit.

GM6000 R7

CEPV890 M

- charges made by a Hospital for inpatient Hospital services. Covered Expenses will include charges for Hospital Confinement of a mother and her newborn child for 48 hours following a vaginal delivery, or for 96 hours following a cesarean delivery. The mother may request an earlier discharge, if after consulting with her care provider, it is determined that less time is needed for recovery. If medical necessity requires the mother or newborn to remain confined for longer than 48 or 96 hours, the additional confinement will be covered. If the mother is required to remain confined due to medical necessity, and if she requests that the newborn also remain in the Hospital, charges for up to four days of confinement for the newborn are covered in full.
- charges made for one postpartum home care visit following discharge from the Hospital of the mother and newborn. If the mother is discharged prior to the 48 or 96 hours described above, an additional postpartum home care visit will be covered, if ordered by the attending Physician. The first such visit must be made within 24 hours of the discharge, but will be covered if made later. No Copayment, Coinsurance or Deductible will apply to postpartum home care services. Postpartum home care services include such services which are provided to a mother and newborn child in accordance with generally accepted standards of nursing practice, including any services required by the attending provider. Such services must be provided by a registered Nurse with at least one year of experience in maternal and child health nursing, or in community health nursing with emphasis on maternal and child health.

GM6000R7

CEPV485

The following is added to the medical benefits section of your certificate entitled "Covered Expenses":



- charges for orthodontics; oral surgery; and otologic, audiological and speech/language treatment necessary to manage cleft lip or cleft palate or both.
- charges made for testing of bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis when requested by a Physician.

GM6000 R 7CEPV721

**Connecticut General Life Insurance Company
a CIGNA Company (called CG)**

Certificate Rider - Massachusetts Residents

Rider Eligibility: Each Employee who is located in Massachusetts

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

This certificate rider forms a part of the certificate issued to you by CG.

The provisions set forth in this certificate rider comply with legislative requirements of the Commonwealth of Massachusetts regarding group insurance plans covering insureds located in Massachusetts. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

GM6000 R 7

CEPV776 M

The mental illness and alcoholism benefits shown in The Schedule for medical benefits are changed to read as follows:

Inpatient Alcoholism Treatment

Treatment is covered on the same basis as treatment for any other illness, up to 30 days per year. However, benefits do not increase as described in the Full Payment Area provision.

Outpatient Alcoholism Treatment

The plan will pay 50% of the Covered Expenses, after the applicable medical deductible in The Schedule has been satisfied. However, benefits do not increase as described in the Full Payment Area provision.

Outpatient Mental Illness

Treatment is covered on the same basis as treatment for any other illness, for up to 24 visits per year. Benefits will increase as described in the Full Payment Area provision.

Inpatient Mental Illness

Treatment received in a Hospital is covered on the same basis as treatment for any other illness for 60 days per year. Benefits will increase as described in the Full Payment Area provision.

Partial Confinement

Partial Confinement for treatment of mental illness or alcoholism will be payable for two days of Partial Confinement equaling one day of being Confined in a Hospital. The term Partially Confined means continually treated for at least 3 hours, but not more than 12 hours, in any 24-hour period.

GM6000 R7CEPV870

The following is added to the Covered Expenses section of the certificate:

- coverage for biologically-based mental illness which includes schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia, psychotic disorders, obsessive-compulsive disorder, affective disorders, panic disorder, delirium, dementia, or any other biologically-based mental disorders appearing in the DSM that are scientifically recognized and approved by the Commissioner of the Department of Mental Health in consultation with the Commissioner of Insurance. Covered Expenses will be payable the same as for other illnesses. Any Mental Illness Maximums in the Schedule will not apply for biologically-based mental illness. Alcoholism and drug dependency when treated with biologically-based mental illness will not be subject to limits normally applied to alcohol/drug abuse. Services may only be denied by a licensed mental health care professional for all Covered Mental Illness.
- coverage for medically necessary treatment of mental disorders that are not biologically-based. The insured person must be referred for treatment by the Primary Care Physician, Primary Pediatrician or a licensed mental health professional. Any limits applicable to treatment of alcoholism and chemical dependency are not applicable when the treatment is given in conjunction with treatment of mental disorders.
- coverage for medically necessary treatment of all other mental disorders will be covered. Any limits applicable to treatment of alcoholism and chemical dependency are not applicable when the treatment is given in conjunction with treatment of mental disorders. Coverage will be for at least 60 days of inpatient treatment and 24 outpatient visits.
- coverage for rape-related mental or emotional disorders for rape victims or victims of an assault with intent to commit rape, will be paid the same as any other illness.



Any Mental Illness maximum in the Schedule will not apply to rape-related Mental Illness.

- coverage for psychopharmacological services and neuropsychological assessment services will be treated as medical benefits and covered the same as all other medical services.

GM6000 R7CEPV948

The following is added to the Covered Expenses section of the certificate:

- Children and adolescents under age 19 will receive all mental health benefits with the same terms as other medical conditions. The diagnosis and treatment of nonbiologically-based mental, behavioral, or emotional disorders, as described in the most recent addition of the DSM, which substantially interfere with or substantially limit the function and social interaction of such child or adolescent provided that said interference or limitation is documented by, and the referral of said diagnosis and treatment is made by the Primary Care Physician, Primary Pediatrician or a licensed mental health professional of such a child or adolescent, or is evidenced by conduct, including but not limited to: (1) an inability to attend school as a result of the disorders; (2) the need to hospitalize the child or adolescent as a result of the disorder; or (3) a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others. Ongoing treatment for children over 19 will continue until the course of treatment is completed as long as the plan is in effect. The Mental Illness Maximum in the Schedule will not apply to child and adolescent Mental Illness.
- Medication management is treated the same as a regular office visit. Inpatient services may be provided at a general Hospital licensed to provide such services, a facility under the direction and supervision of the Department of Mental Health or in a substance abuse facility, licensed by the Department of Public Health. Intermediate care shall include, but not be limited to, level III community-based detoxification, acute residential treatment, partial hospitalization, day treatment and crisis stabilization licensed or approved by the Department of Mental Health. Outpatient services may be provided in a licensed Hospital, a mental health or substance abuse clinic licensed by the Department of Public Health, a public community mental health center, a professional office, or home-based services, provided these latter two services are rendered by a licensed mental health professional acting within the scope of his/her license.
- Licensed mental health professionals include licensed Physicians with a specialty in psychiatry, licensed psychologists, licensed independent clinical social

workers, licensed mental health counselors, or licensed nurse mental health clinical specialists.

GM6000 R 7CEPV949

The following items are added to "Covered Expenses" in the medical benefits section of your certificate:

- charges made for or in connection with all nonexperimental Infertility diagnosis and treatment procedures, including oral and injectable drug therapy; sperm, egg and/or inseminated egg procurement and processing; cryopreservation of sperm and embryos and related charges; artificial insemination; in vitro fertilization and embryo placement; intracytoplasmic sperm injection (ICSI); gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT) and similar procedures. Such expenses will not be subject to Pre-existing Condition Limitations.
- charges made for an annual cytologic screening in women 18 years of age or older, and a baseline mammogram examination, on one occasion for women age 35 to 40 years, and on an annual basis from age 40 or older.
- charges made for nonprescription enteral formulas to treat malabsorption caused by Crohn's disease or ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited disorders of amino and organic acid metabolism. Foods modified to be low-protein for use by a person with disorders of amino and organic acid metabolism are covered to a maximum of \$2,500 per year.
- charges made for or in connection with a drug, and its administration, that has been prescribed for the treatment of HIV/AIDS for which the use of such drug has not been approved by the Food and Drug Administration (FDA) for that indication. Such drug must be covered, provided it is recognized for treatment of HIV/AIDS by one of the following: American Medical Association Drug Evaluations; American Hospital Formulary Service Drug Information; United States Pharmacopeia Drug Information; peer-reviewed medical literature; or the Commissioner.
- charges for a scalp hair prosthesis worn for hair loss due to the treatment of any form of cancer or leukemia, provided that a Physician verifies in writing that the scalp hair prosthesis is medically necessary. Benefits payable will not exceed \$350 per year.

GM6000 R 7

CEPV707

The following items are added to "Covered Expenses" in the medical benefits section of your certificate:



- charges made for or in connection with a drug, and its administration, that has been prescribed for the treatment of cancer for which the use of such drug has not been approved by the Food and Drug Administration (FDA) for that indication. Such drug must be covered, provided it is recognized for treatment of cancer by one of the following: American Medical Association Drug Evaluations; American Hospital Formulary Service Drug Information; United States Pharmacopeia Drug Information; peer-reviewed medical literature; or the Commissioner.
- charges for a newborn hearing screening test performed before the newborn is discharged from the Hospital or birthing center.

If you have Prescription Drug coverage, then the following is added to the section of your certificate entitled "Covered Expenses":

In addition, payment will be made:

- for charges for or in connection with oral and injectable infertility drugs;
- for charges for hypodermic needles and syringes when in connection with nonexperimental infertility diagnosis and treatment procedures.

GM6000 R 7

CEPV778

The following will be added to the Covered Expenses section of your Certificate:

The following benefits will apply to insulin and noninsulin dependent diabetics as well as covered individuals who have elevated blood sugar levels due to pregnancy or other medical conditions:

- charges for blood glucose monitoring strips for home use, urine glucose strips, ketone strips, lancets, prescribed oral diabetes medications that influence blood sugar levels, insulin and insulin syringes, pumps, supplies and pens;
- charges for Durable Medical Equipment, including blood glucose monitors, voice synthesizers for blood glucose monitors for use by the legally blind, and visual magnifying aids for the legally blind;
- charges for therapeutic/molded shoes and shoe inserts when certified by the treating Physician, prescribed by a podiatrist or other qualified provider and furnished by a podiatrist, orthotist, prosthetist or pedorthist;
- charges for laboratory tests including glycosylated hemoglobin or HbA1c and urinary protein/microalbumin and lipid profiles;

- charges for self-management training and education including medical nutrition therapy when provided by a certified diabetes health care provider.
- coverage for the cost of HLA or histocompatibility locus antigen testing that is necessary to establish bone marrow transplant donor suitability. Coverage includes the cost of testing for A, B, or DR antigens, or any combination thereof, consistent with rules, regulations, and criteria established by the department of public health.

GM6000 R7CEP

V954

The following is added to the medical benefits section of your certificate entitled "Covered Expenses":

- charges made for screening for lead poisoning of a Dependent child from birth until 6 years of age.
- charges for newborn care for the first 31 days of life, whether or not you enroll the newborn.

In addition, Covered Expenses will include expenses incurred at any of the Approximate Intervals shown below for a Dependent child who is age 5 or less, for charges made for Child Preventive Care Services consisting of the following services, delivered or supervised by a Physician, in keeping with prevailing medical standards:

- a history;
- physical examination;
- development assessment;
- anticipatory guidance; and
- appropriate immunizations and laboratory tests;

excluding any charges for:

- more than one visit to one provider for Child Preventive Care Services at each of the Approximate Intervals up to a total of 12 visits for each Dependent child;
- services for which benefits are otherwise provided under this medical benefits section;
- services for which benefits are not payable according to the "Expenses Not Covered" section.

Approximate Intervals are:

- six times during the first year of life;
- three times during the second year of life;
- annually each year thereafter through the fifth year of life.

Covered Expenses will also include expenses incurred for Dependent children from birth until the child's third birthday for Early Intervention Services to include: occupational, physical and speech therapy, nursing care and psychological



counseling. Early Intervention Services are subject to a calendar year maximum of \$5,200 per child and a lifetime maximum of \$15,600 per child.

These services must be provided by licensed persons working in early intervention programs approved by the Massachusetts Department of Public Health.

GM6000 R 7

CEPV1052

The following item is added to "Expenses Not Covered" in the medical benefits section of your certificate:

- charges made for or in connection with Infertility procedures that would include reversal of voluntary sterilization, surrogacy and experimental procedures.

GM6000R7

CEPV489

Exception to Late Entrant Definition

A person will not be considered a Late Entrant when enrolling outside a designated enrollment period if: he had existing coverage, and he certified in writing, if applicable, that he declined coverage due to other available coverage; he lost prior coverage due to the employer's failure to pay premium; he no longer qualifies in an eligible class for prior coverage; or his prior coverage ends, including continuation coverage; and he enrolls for this coverage within 30 days after losing or exhausting prior coverage. Any applicable Pre-existing Condition limitation will apply but will not be extended as for a Late Entrant.

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption, you may enroll your eligible Dependents and yourself, if you are not already enrolled, within 30 days of such event. Coverage will be effective, on the date of marriage, birth, adoption, or placement for adoption. Any applicable Pre-existing Condition limitation, will apply to you and your Dependents upon enrollment, reduced by prior Creditable Coverage.

Pre-Existing Condition Limitation for Late Entrant

For plans, which include a Pre-existing Condition limitation, the 6-month waiting period before coverage begins for such conditions, will be increased to 12 months for a Late Entrant.

For plans which do not include a Pre-existing Condition limitation, if you are a Late Entrant, you may be required to wait until the next plan enrollment period to enroll for coverage under the plan, but no longer than 12 months.

For plans which do not standardly include a Pre-existing Condition limitation and which do not include an annual open enrollment period, a Pre-existing condition limitation of 12 months will apply for a Late Entrant.

GM6000 R7

CEPV761

The following is added to the Exclusive Provider or Designated Provider Medical Benefits section entitled "Expenses Not Covered":

- for Out-of-Network care for or in connection with an Injury or a Sickness which is a Pre-existing Condition after benefits equal to \$750 have become payable, unless those expenses are incurred after a continuous 6-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 90 days prior to the date that person becomes insured for these benefits. The term Pre-existing Condition will also include any condition, which is related to any such Injury or Sickness.

Exception for Infertility

The Pre-existing Condition limitation will be waived for expenses incurred for or in connection with all nonexperimental Infertility diagnosis and treatments and related procedures as listed in the "Covered Expenses" section.

GM6000R7

CEPV924

The following is added to the section of your certificate entitled "General Limitations":

In addition, no payment will be made:

- for charges for or in connection with speech therapy, if such therapy is: (a) used to improve speech skills that have not fully developed; (b) can be considered custodial or educational; (c) intended to maintain speech communication; or (d) not restorative in nature; except for expenses incurred for Dependent children from birth until 3 months after the child's third birthday;
- for expenses incurred by you or any one of your Dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with:
 - a "no-fault" insurance law; or
 - an uninsured motorist insurance law.

CG will take into account any adjustment option chosen under such mandatory part by you or any one of your Dependents.

GM6000R7

CEPV779

The following is added to the section in your certificate entitled "Termination of Insurance - Continuation":



Special 31-Day Continuation

Upon payment of premium by your Employer, your insurance (except Life Insurance) will continue for 31 days after you:

- cease to be in a Class of Eligible Employees or cease to qualify as an Employee.
- terminate employment for any reason.

In no case will the insurance continue after you become insured under any other group policy for similar benefits or after the last day for which you have made any required contribution for the insurance.

GM6000R7

CEPV780

Special Continuation for Plant Closing

In the case of a plant closing, or a partial closing as determined by law, the Medical Insurance for you and your Dependents will be continued until the earlier of: (a) 90 days from the date your Active Service ends, or, (b) as shown in (1), (2), (3) or (4) of the "Other Dates of Termination" section. For continuation to take effect: (a) you must continue to pay any portion of the premium for which you were responsible prior to the end of your Active Service, and, (b) your Employer must continue to pay any portion of the premium for which he was responsible before the plant closing or partial closing. If the insurance terminates because your Employer fails to pay the premium, he will be liable for any Covered Expenses incurred between the last premium payment and the end of the 90-day continuation.

Any current collective bargaining agreement, with an extension at least equal to the continuation outlined here, will prevail.

After Your Death

Medical Insurance for your Dependents will be continued until the earliest of: 39 weeks from the date your insurance ceases, or as shown in (2), (3) or (4), of the "Other Dates of Termination" section; if the required payment is made to the Employer.

Other Dates of Termination

- (1) The date you become eligible for Medical Insurance under any other group policy or Medicare;
- (2) The last day of a period equal to the most recent time period during which you were insured under the Employer's policy, or, in the case of Dependent Medical Insurance continuation, a period equal to the most recent time period during which you were insured for your Dependents under the Employer's policy;

- (3) The last day for which any required premium has been paid;
- (4) With respect to any one Dependent, the earlier of: (a) the date that Dependent becomes eligible for Medical Insurance under another group policy or under Medicare, or (b) the date that Dependent no longer qualifies as a Dependent for any reason other than your death.

Conversion Available Following Continuation

The "Medical Conversion Privilege" section will apply when the insurance ceases.

GM6000R7

CEPV12

Medical Insurance for Former Spouse

If your spouse's Medical Insurance would otherwise cease because of divorce or annulment of marriage, the insurance for that spouse will be continued unless the court decree dissolving the marriage excludes such continuation. In any event the insurance will not be continued beyond the earliest of the following dates:

- the date you fail to make any required contribution;
- the date you are no longer insured under the group policy;
- the date Dependent Insurance cancels;
- the date your former spouse remarries;
- the date you remarry, unless you make arrangements with the Employer to continue the insurance in accordance with the paragraph below entitled "Effect of Remarriage of Employee."
- the date the court judgment no longer requires continued coverage.

Effect of Remarriage of Employee

If you remarry, an additional contribution will be required for your former spouse. You must notify your Employer of your remarriage within 30 days of the date of your remarriage and pay the additional contribution.

Conversion Available Following Continuation

The Medical Conversion Privilege will be available when the insurance for a former spouse ceases.

Special Continuations of Medical Insurance

If your Medical Insurance terminates for any of the reasons listed below, the Medical Insurance for you and your Dependents may be continued as outlined in each specific case.



Involuntary Layoff

Medical Insurance for you and your Dependents will be continued until the earlier of: (a) 39 weeks from the date your Active Service ends, or (b) as shown in (1), (2), (3) or (4) of the "Other Dates of Termination" section; upon payment of the required premium by you to your Employer.

GM6000R7

CEPV11 DG

The following is added to the section of your certificate entitled "Definitions":

Early Intervention Services

Early intervention services are defined as services provided to children who have identified handicapping conditions or who are at risk for developmental delays due to biological, established or environmental factors. Such services are for the purpose of minimizing the potential for developmental delay and for preventing the institutionalization of such children and shall be developmental services including, but not limited to, speech, occupational and physical therapy, social work, psychological, educational and nursing services.

Infertility

The term Infertility means the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year.

With respect to the definition of "Dependent" a Dependent child includes:

- a legally adopted child. Coverage for an adopted child will begin: (a) on the date of the filing of a petition to adopt such child, provided the child has been residing in your home as a foster child, and for whom you have been receiving foster care payments; or (b) when a child has been placed in your home by a licensed placement agency for purposes of adoption;
- for medical benefits only, a child born to one of your Dependent children, as long as your grandchild is living with you and: (a) your Dependent child is insured; or (b) your grandchild is primarily supported by you.

With respect to the definition of "Hospital Confinement or Confined in a Hospital" the following is added:

- a person will be considered Confined in a Hospital if he is Partially Confined for treatment of mental illness, alcohol or drug abuse, or other related illness. Two days of being Partially Confined will be equal to one day of being Confined in a Hospital. The term Partially Confined means continually treated for at least 3 hours but not more than 12 hours in any 24-hour period.

GM6000 R7

CEPV16

**Connecticut General Life Insurance Company
a CIGNA Company (called CG)**

Certificate Rider - Michigan Residents

Rider Eligibility: Each Employee who is located in Michigan

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

This certificate rider forms a part of the certificate issued to you by CG.

The provisions set forth in this certificate rider comply with legislative requirements of Michigan regarding group insurance plans covering insureds located in Michigan. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

The following is added to your certificate:

Managed Care Disclosure

If you are currently insured for benefits under this plan, you may request information from CG as follows by written request only:

1. detailed provider information including those not accepting new patients, practice type or specialty, and limitation of accessibility.
2. professional credentials of providers participating in the plan.
3. the Michigan Department of Consumer and Industry Services telephone number to obtain information regarding complaints and disciplinary action.
4. detailed drug formulary information.
5. information regarding financial relationship between CG and any closed provider panel.



6. a telephone number for additional information in regard to the above.

GM6000 R 7CEPV918

The following is added to the section in your certificate entitled "Definitions":

Emergency Services

Emergency Services are medical, surgical, Hospital, and related health care services, including ground, air, or other ambulance service. Coverage is for medically necessary services for the sudden onset of a medical condition with signs and symptoms so severe, that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to one's body or life, including a pregnancy. Regardless of the diagnosis, benefits will be paid at least to the point of stabilization. Prior authorization is not required.

GM6000 R7

CEPV943 M

**Connecticut General Life Insurance Company
a CIGNA Company (called CG)**

Certificate Rider - Minnesota Residents

Rider Eligibility: Each Employee who is located in Minnesota

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

This certificate rider forms a part of the certificate issued to you by CG.

The provisions set forth in this certificate rider comply with legislative requirements of the state of Minnesota regarding group insurance plans covering insureds located in Minnesota. These provisions supersede any provisions in the certificate to the contrary unless the provisions in the certificate result in greater benefits.

GM6000 R 7

CEPV215 M

The following is added to the medical benefits section of the certificate entitled "Covered Expenses":

Covered Expenses will also 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 in a private room, Covered Expenses will not include that portion of charges for Bed and Board which is more than

the Bed and Board Daily Limit shown in The Schedule. Covered Expenses will include charges for Hospital Confinement of the mother and newborn child for the first 48 hours after a vaginal delivery, or for the first 96 hours after a cesarean section, unless post delivery care is provided.

- charges for post delivery care of a mother and newborn child who were discharged from the Hospital less than 48 hours after a vaginal delivery, or less than 96 hours after a cesarean delivery. Post delivery care is provided by a Nurse during at least one home visit within four days of Hospital discharge. Such care includes, but is not limited to, parent education, assistance and training in breast or bottle feeding, and any necessary and appropriate diagnostic tests.

The following is added to the section of the certificate entitled "Termination of Insurance":

Reinstatement of Insurance

If your coverage ceases because of active duty in: (a) the armed forces of the United States, or (b) the National Guard, the insurance for you and your Dependents will be reinstated after your deactivation, provided that:

- you apply for such reinstatement within 90 days after deactivation; and
- you are otherwise eligible.

Such reinstatement will be without the application of: (a) a new waiting period, or (b) a new Pre-existing Condition Limitation. A new Pre-existing Condition Limitation will not be applied to a condition that you or your Dependent may have developed while coverage was interrupted, excluding any condition that the Veterans Administration has determined to be military-related. The remainder of a Pre-existing Condition Limitation which existed prior to interruption of coverage may still be applied.

GM6000 R7

CEPV469

The following terms are added to your certificate:

Effect of Prior Group Insurance Benefits for You and Your Dependents

1. If you and your Dependents would have been insured under the replaced policy had you satisfied a waiting period under that policy, you and your Dependents will become insured for these benefits, subject to the "Who is Eligible," "Who is Insured - Employees" and "Who is Insured - Dependents" sections. Credit will be given for time accrued toward the waiting period of the replaced policy.



2. The terms set forth below will apply to you if you:
- are in a Class of Eligible Employees under the policy specified above; and
 - were insured on the day before the Effective Date of the policy specified above under a medical expense policy: (a) in an eligible class of employees; (b) sponsored by the Employer; and (c) replaced by the policy specified above.

For Medical and/or Dental Benefits, these terms will also apply to your eligible Dependents who were also insured as set forth above.

Any Waiting Period in the "Who is Eligible" section will be waived.

The Active Service provision in the "Who is Insured - Employees" section will be waived.

GM6000 R7

CEPV93

The provision for any Dependent who is a patient in a Hospital set forth in the "Who is Insured - Dependents" section will be waived.

Credit will be given toward any deductibles under the policy specified above to the extent that all or part of any similar deductible amount was satisfied under the replaced policy.

The Pre-Existing Condition Limitation, if any, for this insurance will be waived.

If you were not in Active Service or your Dependent was a patient in a Hospital on the Effective Date of the policy specified above:

- (1) The amount of benefits payable will be the lesser of: (a) the amount which would have been payable under the replaced policy if it had not canceled; or (b) the amount payable under the policy specified above.
- (2) This section will cease on the earliest date below:
 - the date you or your Dependent would become insured under the policy specified above in absence of the section;
 - the date your insurance or your Dependent's insurance would otherwise cease in accordance with the section, "Termination of Insurance - Employees" or "Termination of Insurance - Dependents";
 - the date any period of extension or accrued liability set forth in the replaced policy or required by state law ends.

GM6000 R 7

CEPV94

**Connecticut General Life Insurance Company
a CIGNA Company (called CG)**

Certificate Rider - Mississippi Residents

Rider Eligibility: Each Employee who is located in Mississippi

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

This certificate rider forms a part of the certificate issued to you by CG.

The provisions set forth in this certificate rider comply with legislative requirements of the state of Mississippi regarding group insurance plans covering insureds located in Mississippi. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

The following is added to the Medical Benefits section of your certificate entitled "**Covered Expenses**":

- charges made for the surgical and nonsurgical treatment of temporomandibular joint disorders and craniomandibular joint disorders if prescribed by a Physician or a Dentist, subject to the limitations stated in the "Expenses Not Covered" section. Coverage must be the same as for any other joint in the body.

For Plans with Mail Order Drug Benefits:

Any copayment amount for a prescription filled at a Participating Mail-Order Pharmacy will be three times the copayment for a prescription filled at a Participating Retail Pharmacy.

GM6000 R 7

CEPV177

The following is added to the section of the certificate entitled "Termination":

Special Continuation of Medical Insurance

If your insurance ceases due to termination of employment for any reason other than fraud or nonpayment of any required premium or, regarding a covered Dependent, the death of the Employee, divorce from the Employee, or failure of a dependent child to qualify as a Dependent and:

- you or your Dependent has been insured under the policy (and any similar group coverage replaced by the policy) for at least 3 consecutive months immediately prior to the date of termination; and



- you or your Dependent is not eligible for other insured or uninsured coverage within 31 days following the date of termination; and
- you or your Dependent is not covered under Medicare, although a Dependent of an Employee who elects Medicare is eligible to continue coverage;

you or your Dependent may continue the insurance by paying the required premiums to the Policyholder. In no event will the insurance be continued beyond the earliest of the following dates:

- the expiration of 12 months from the date the insurance would otherwise terminate;
- the last day for which you or your Dependent has paid the required premium;
- the date you or your Dependent becomes eligible for insured or uninsured group medical coverage or elects Medicare, although a Dependent of an Employee who elects Medicare is eligible to continue coverage;
- the date the group policy is canceled; or
- the date a surviving or divorced spouse remarries and becomes covered for medical benefits under a health plan with no pre-existing condition limitations.

Notice Requirements

For Employees and Dependents upon termination of employment or ineligibility of Employee class, CG will send notice of the right to continue coverage prior to termination of coverage. For Dependents upon Employee death, Employee entitlement to Medicare, divorce, or loss of eligibility as a Dependent child, your Employer will send notice of the right to continue within 14 days after being notified of any event above. You must elect to continue coverage within 31 days of receiving notice of the right to continue.

GM6000 R7

CEPV370

The following is added to the Exclusive Provider or Designated Provider Medical Benefits section of the certificate entitled "Definitions," **if you or your Dependent is a covered Mississippi resident using the Mississippi Managed Care Network:**

Primary Care Physician

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

GM6000R7

CEPV297

The following is added to the section of the certificate entitled "Covered Expenses":

- a drug that has been prescribed for the treatment of a type of cancer for which it has not been approved by the Food and Drug Administration (FDA). Such drug must be covered, provided: (a) it is recognized as medically appropriate for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following reference compendia: United States Pharmacopeia Drug Information; American Medical Association Drug Evaluations; American Hospital Formulary Service Drug Information; or one article in a U.S. peer-reviewed national medical journal; (b) the drug has been otherwise approved by the FDA; and (c) its use for the specific type of cancer treatment prescribed has not been contraindicated by the FDA.
- charges for annual screenings by low-dose mammography for all women age 35 and older for the presence of occult breast cancer.

GM6000R7

CEPV999 M

**Connecticut General Life Insurance Company
a CIGNA Company (called CG)**

Certificate Rider - Missouri Residents

Rider Eligibility: Each Employee who is located in Missouri

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

This certificate rider forms a part of the certificate issued to you by CG.

The provisions set forth in this certificate rider comply with legislative requirements of the state of Missouri regarding group insurance plans covering insureds located in Missouri. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

GM6000 R 7

CEPV157 M

The following is added to the section of your certificate entitled "Covered Expenses":

- charges made by a Hospital or other facility that provides obstetrical care for inpatient Hospital services will include covered expenses for a mother and her newborn child for 48 hours following a vaginal delivery or for 96 hours following a cesarean delivery. A longer stay will be



covered if deemed medically necessary. The mother may request an earlier discharge if, after consulting with her Physician, it is determined that less time is needed for recovery. If discharged early, at least 2 postdischarge visits will be covered, one of which will be a home visit by either a registered nurse with experience in maternal and child health nursing or a Physician. These visits will include, but are not limited to, a physical assessment of the mother and the newborn; parent education; assistance and training in breast and bottle-feeding; education and services for complete childhood immunizations; medically necessary clinical tests; and the submission of a metabolic specimen to the state laboratory.

- charges for immunizations for children from birth to age 5 will include poliomyelitis, rubella, rubeola, mumps, tetanus, pertussis, diphtheria, hepatitis B, Hemophilus influenzae type b (Hib), and varicella. This includes the office visit in connection with immunizations. There will be no deductible and no copay.
- charges for a drug that has been prescribed as medically necessary to treat an illness for which it has not been approved by the Food and Drug Administration (FDA). Such a drug must be covered provided: (a) it is recognized in an established reference compendia such as the United States Pharmacopoeia Drug Information, American Hospital Formulary Service, or any peer-reviewed medical literature: for the specific type of illness for which it has been prescribed or (b) the drug has not been contraindicated by the FDA for the use prescribed.

GM6000 R7

CEPV986

The following is added to the section of your certificate entitled "Covered Expenses":

- charges for a colorectal examination and laboratory tests for cancer in accordance with current American Cancer Society guidelines for any nonsymptomatic person covered under the Plan. Benefits are payable on the same basis as for any other exams and tests covered under the Plan.
- charges for a pelvic examination and Pap smear in accordance with current American Cancer Society guidelines for any nonsymptomatic woman covered under the Plan. Benefits are payable on the same basis as for any other exams and tests covered under the Plan.
- charges for newborn hearing screening, necessary rescreening, audiological assessment and follow-up, and initial amplification. The screening will include the use of at least one of the following physiological technologies: (a) automated or diagnostic brainstem response (ABR); (b) otacoustic emissions, (OAE); or (c) other technologies

approved by the Missouri Department of Health. Coverage is provided on the same basis as coverage for other diagnostic tests.

- charges for prostate cancer examinations and laboratory tests for any insured nonsymptomatic male, in accordance with current American Cancer Society guidelines. Men age 50 and older should discuss getting an annual PSA blood test and a digital rectal exam with their Physician. Men who are at risk, which includes African American or men who have a family history of prostate cancer, should consider being tested at a younger age. Coverage is provided on the same basis as for the other covered benefits and services.

GM6000R7

CEPV864

The following is added to the section of your certificate entitled "**Termination of Insurance - Continuation**":

Special Continuation of Medical Insurance for Dependents of Deceased Employee

If you die while insured, your Dependents who are insured at the time of your death may continue their insurance by paying the required contribution to the Policyholder. Continuation shall begin only after the Continuation Required by Federal Law has expired, provided your spouse is at least 55 years of age at such time. Such coverage shall not continue beyond the earliest of the following dates:

- your spouse's 65th birthday;
- the last day of the period for which the required contribution has been paid;
- the date that your spouse becomes insured under any other group health plan, including Medicare;
- with respect to any one Dependent, (1) the date that Dependent becomes eligible for similar group coverage or (2) the date that Dependent ceases to qualify as a Dependent for any reason other than lack of primary support by you; or
- the date this policy cancels.

For Spouse Upon Legal Separation or Divorce from Employee

If your spouse's insurance would otherwise terminate because of legal separation, divorce or annulment of marriage, your spouse may continue that insurance, and the insurance of any eligible Dependent children, by paying the required contribution to the Policyholder. Continuation shall begin only after the Continuation Required by Federal Law has expired, provided your spouse is at least 55 years of age at such time.



Such coverage shall not continue beyond the earliest of the following dates:

- your spouse's 65th birthday;
- the last day of the period for which the required contribution has been paid;
- the date that your spouse becomes insured under any other group health plan, including Medicare;
- with respect to any one Dependent, (1) the date that Dependent becomes eligible for similar group coverage or (2) the date that Dependent ceases to qualify as a Dependent for any reason other than lack of primary support by you; or
- the date this policy cancels

GM6000 R 7

CEPV158

**Connecticut General Life Insurance Company
a CIGNA Company (called CG)**

Certificate Rider - Nevada Residents

Rider Eligibility: Each Employee who is located in Nevada

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

This certificate rider forms a part of the certificate issued to you by CG.

The provisions set forth in this certificate rider comply with legislative requirements of Nevada regarding group insurance plans covering insureds located in Nevada. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

Covered Expenses

The following is added to the "Covered Expenses" section of the certificate:

- charges for a drug that has been prescribed for the treatment of cancer for which use of the drug has not been approved by the U.S. Food and Drug Administration if that drug has been recognized as a treatment for cancer in one of the standard reference compendia or supported by articles in accepted, peer-reviewed medical literature. Coverage will also be provided for any medical services necessary to administer the drug.

GM6000 R 7

CEPV994 M

Exception to Late Entrant Definition

A person will not be considered a Late Entrant when enrolling outside a designated enrollment period if: he had existing coverage, and he certified in writing, if applicable, that he declined coverage due to other available coverage; he lost prior coverage due to the employer's failure to pay premium; he no longer qualifies in an eligible class for prior coverage, or his prior coverage ends, including continuation coverage; and he enrolls for this coverage within 30 days after losing or exhausting prior coverage; or if he is a Dependent spouse or minor child enrolled due to a court order within 30 days after the order is issued. Any applicable Pre-existing Condition limitation will apply but will not be extended as for a Late Entrant.

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption, you may enroll your eligible Dependents and yourself, if you are not already enrolled, within 30 days of such event. Coverage will be effective, on the date of marriage, birth, adoption or placement for adoption. Any applicable Pre-existing Condition limitation, will apply to you and your Dependents upon enrollment, reduced by prior Creditable Coverage.

Pre-Existing Condition Limitation for Late Entrant

For plans which include a Pre-existing Condition limitation, the one-year waiting period before coverage begins for such conditions, will be increased to 18 months for a Late Entrant.

For plans which do not include a Pre-existing Condition limitation, you may be required to wait until the next plan enrollment period to enroll for coverage under the plan, if you are a Late Entrant.

For plans which do not standardly include a Pre-existing Condition limitation and which do not include an annual open enrollment period, a Pre-existing condition limitation of 18 months will apply for a Late Entrant only.

GM6000 R7

CEPV750

**Connecticut General Life Insurance Company
a CIGNA Company (called CG)**

Certificate Rider - New Hampshire Residents

Rider Eligibility: Each Employee who is located in New Hampshire

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



This certificate rider forms a part of the certificate issued to you by CG.

The provisions set forth in this certificate rider comply with legislative requirements of the state of New Hampshire regarding group insurance plans covering insureds located in New Hampshire. These provisions supersede any provisions in your certificate to the contrary unless the provisions in the certificate result in greater benefits.

The following is added to the section of the certificate entitled "Eligibility - Effective Date" for Employee Medical Insurance Only:

- you are a permanent, part-time Employee who normally works at least 15 hours a week.

The following is added to the section of the certificate entitled "Eligibility - Effective Date" for Medical Insurance only:

Exception for Newborn Grandchildren

Any child born to your Dependent child while you are insured for Medical Insurance will be covered for the first 31 days of his life. Coverage for such child will not continue beyond the 31st day and no benefits for expenses incurred beyond the 31st day will be payable.

GM6000 R 7

CEPV450 M

The following inpatient mental illness benefits apply:

Inpatient Mental Illness Benefits

Payment will be made for Covered Expenses incurred for treatment of mental illness received while Confined in a Hospital as an inpatient on the same basis as for any other illness with respect to deductible, coinsurance, and the Full Payment Area provisions for up to 30 days per year.

Covered Expenses

The following is added to the medical benefits section of the certificate entitled "Covered Expenses":

- charges for or in connection with treatment of breast cancer by autologous bone marrow transplants, provided the treatment follows the guidelines reviewed and approved by the National Cancer Institute.
- charges for medically necessary reconstructive breast surgery when following a mastectomy in order to achieve and restore symmetry between the two breasts.
- charges by a community mental health center, on its own behalf, by a psychiatric program, or by a licensed pastoral counselor, for care and treatment of mental illness.
- charges for or in connection with mammograms for breast cancer screening or diagnostic purposes, including, but

not limited to: (a) one baseline low-dose mammogram for women age 35 to 39 years of age; (b) a mammogram every one to two years for women 40 to 49 years of age even if no symptoms are present; and (c) one annual mammogram for women age 50 and over.

- charges for or in connection with scalp prostheses worn for hair loss suffered as a result of alopecia areata, alopecia totalis, or permanent loss of scalp hair due to injury, upon the written recommendation of a Physician.
- charges for nonprescription enteral formulas and food products for the treatment of impaired absorption of nutrients caused by disorders of the gastrointestinal tract or inherited diseases of amino or organic acids. The Physician must issue a written order stating the enteral formula or food product is needed to sustain life, in the case of malabsorption; medically necessary; and the least restrictive and most cost-effective means for meeting the needs of the insured. Coverage for inherited diseases of amino and organic acids will be subject to an annual maximum of \$1,800.

GM6000 R7

CEPV629

- charges made for a 48-hour inpatient stay following a vaginal delivery or a 96-hour inpatient stay following a cesarian section. An earlier discharge may be determined by the mother and attending Physician. An additional length of stay will be covered if deemed medically necessary.
- If discharge is prior to the 48/96-hour inpatient stay at least 2 postpartum visits will be provided if the service is by a licensed Physician with experience in perinatal care.
- charges for medically necessary prenatal and/or postpartum homemaker services when a woman is confined to bed rest or her daily activities are restricted by her provider.
- charges made by a Hospital or Ambulatory Surgical Facility for anesthesia for inpatient Hospital dental procedures for: (a) a child under the age of 4; or (b) an individual with a developmental disability or exceptional medical circumstances.
- charges made for general anesthesia for dental procedures for: (a) a child under the age of 4 who has a dental condition of significant complexity; or (b) an individual with a developmental disability or exceptional medical circumstances.

GM6000 R7

CEPV745 M

The following will be added to the "Expenses Not Covered" section of the Certificate:



A Pre-existing Condition Limitation will apply to a Late Entrant for a total of 18 months.

For any covered person who has received treatment for a Pre-existing Condition the limitation will not be more than 6 consecutive months while continuously insured and actively at work full time, or 12 months after the effective date of coverage, whichever is earlier, for a timely enrollee and 18 months for a Late Entrant.

GM6000 R 7

CEPV854

In addition, the following benefits will apply to insulin and non-insulin dependent diabetics as well as covered individuals who have elevated blood sugar levels due to pregnancy or other medical conditions:

- charges for Durable Medical Equipment, including podiatric appliances, related to diabetes. A special maximum will not apply.
- charges for insulin; syringes; prefilled insulin cartridges for the blind; oral blood sugar control agents; glucose test strips; visual reading ketone strips; urine test strips; lancets; and alcohol swabs.
- charges for training by a Physician, including a podiatrist with recent education in diabetes management, but limited to the following:
 - (a) Medically Necessary visits when diabetes is diagnosed;
 - (b) visits following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management;
 - (c) visits when reeducation or refresher training is prescribed by the Physician; and
 - (d) Medical Nutrition therapy related to diabetes management.

GM6000 R7

CEPV617 M

Covered Expenses

The following is added to the medical benefits section of the certificate entitled "Covered Expenses":

- charges made for treatment of Biologically-Based Mental Illness. Such Covered Expenses will be payable the same as for other illnesses once you have met the Mental Illness Maximums shown in the Schedule. Any Full Payment Area exceptions for mental illness will not apply to Biologically-Based Mental Illness once you have met the Mental Illness Maximums shown in the Schedule.
- A Biologically-Based Mental Illness is defined as: schizophrenia; schizoaffective disorder; major depressive

disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder; and pervasive development disorder (autism).

GM6000 R 7

CEPV841

Special Continuation of Medical Insurance - Dependent

If you have been employed or insured for at least 6 months and health insurance for your Dependents would otherwise cease because of: (1) your death; (2) your entitlement to Medicare; (3) divorce or legal separation; or (4) with respect to a Dependent child, failure to continue to qualify as a Dependent, Medical insurance may be continued upon payment of the required premium to the Employer. It will continue until the earliest of:

For a spouse who is under age 55:

- 36 months from the date of (1), (2), (3) or (4) above, whichever may occur first;
- the last day for which the required premium has been paid;
- the date the Dependent becomes entitled to Medicare;
- the date the Dependent becomes covered under another group health plan;
- the date the policy is canceled.

For a spouse who is age 55 or over:

- the date you or your former spouse remarries, upon which coverage will continue as required under federal law;
- the date your former spouse becomes eligible for coverage under another group health plan;
- the date your former spouse becomes eligible for Medicare;
- the last day for which the required premium has been paid;
- the date the policy is canceled.

Notification and Election

Your Employer should notify you of your right to continue insurance within 15 days after termination. You and your Dependents must submit an application and first premium payment no later than 31 days after notice was sent.

GM6000 R7

CEPV363

The following is added to the section of the Certificate entitled: Termination of Insurance - Employees and Dependents:



Special Continuation of Medical Insurance

If group medical coverage for you or your Dependents is canceled for any reason, coverage may be continued from the date of cancellation until the earliest of the following:

- 39 weeks from the date group coverage is canceled.
- the date the person fails to make a timely premium payment;
- the date the person becomes eligible for benefits under another group plan or under Medicare; or
- the date your Dependent ceases to qualify as a Dependent under the provisions of the plan.

Notification and Election

You and your Dependents must submit an application and first premium payment no later than 31 days after the date the group plan terminates. If CG does not notify you or your Dependents within 15 days after the date the group plan terminates, the application period will be extended to the earlier of: (a) 15 days after notice is received; or (b) 6 months from the date the person's original 31-day application period expired. If coverage for you and your Dependents ends because CG does not provide required notice of continuation, CG will be liable for any benefits payable during the lapse in coverage.

Interaction with Other Continuation

If coverage for you or your Dependents is being continued as provided under federal law, and the group plan is cancelled before the continuation period expires, the person will be eligible for continued coverage as described above.

Conversion

Upon cancellation of the group plan, you or your Dependents may elect to continue coverage as described above or to convert coverage as described in the section of this certificate entitled "Conversion Privilege." If extended coverage is elected, converted coverage may be elected when extended coverage ends.

GM6000 R 7

CEPV339

Special Continuation of Life and Medical Insurance - Strike

If your Active Service ends due to strike, your insurance will be continued until the earliest of:

- (a) 6 months past the date your active service ends;
- (b) the date you fail to make a timely premium payment; or

- (c) the date you become eligible for insurance under another group policy for medical benefits or Medicare.

Medical benefits only may be continued for an additional 6 months in accordance with federal law.

GM6000R7

CEPV367

The following is added to the section of the certificate entitled "Coordination of Benefits":

Coordination of Benefits

CG has the right to receive information reasonably related to a claim for benefits under this plan. It may receive such information from or give it to any other organization or person with a legitimate interest in such information. Each person claiming benefits under this plan shall provide CG with such information as is required to pay the claim. This provision is not intended to permit dissemination of information to persons who do not have a legitimate interest in such information nor in any manner permit dissemination of information prohibited by law.

When payments which should have been made under this Plan based on the terms of this section have been made under any other Plans, CG will have the right to pay to any organizations making these payments the amount it determines to be warranted. Amounts paid in this manner will be considered to be benefits paid under this Plan. CG will be released from all liability under this Plan to the extent of these payments. When an overpayment has been made by CG at any time, it will have the right to recover that payment, to the extent of the excess, from the person to whom it was made or any other Insurance Company or organization, as it may determine.

Plan

Plan means any of the following which provides medical or dental benefits or services: (a) group, blanket or franchise insurance coverage; (b) service plan contracts, group or individual practice or other prepayment plans; or (c) coverage under any: labor-management trustee plans; union welfare plans; employer organization plans; or employee benefit organization plans. Plan does not include coverage under individual policies or contracts. Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Allowable Expense

Allowable Expense means any necessary, reasonable and customary item of expense, at least a part of which is covered by any one of the Plans that covers the person for whom claim is made. When the benefits from a Plan are in the form of services, not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid.



Allowable Expense will not include the difference between: (a) the cost of a private room; and (b) the cost of a semiprivate room; except while the person's stay in a private room is medically necessary in terms of generally accepted medical practice.

GM6000 R7

CEPV364

The following is added to the section of the certificate entitled "Coordination of Benefits":

Coordination of Benefits

Benefit Determination Rules

The rules below establish the order in which benefits will be determined:

- (1) The benefits of a Plan which covers the person for whom claim is made other than as a dependent will be determined before a Plan which covers that person as a dependent.
- (2) The benefits of a Plan which covers the person for whom claim is made as a dependent of a person whose day of birth occurs first in a calendar year will be determined before a Plan which covers that person as a dependent of a person whose day of birth occurs later in that year; except that: (a) if the other Plan does not have this rule, its alternate rule will govern; and (b) in the case of a dependent child of divorced or separated parents, the rules in item (3) will apply.
- (3) If there is a court decree which establishes financial responsibility for medical, dental or other health care of the child, the benefits of the Plan which covers the child as a dependent of the parent so responsible will be determined before any other plan; otherwise:
 - (a) The benefits of a Plan which covers the child as a dependent of the parent with custody will be determined before a Plan which covers the child as a dependent of a stepparent or a parent without custody.
 - (b) The benefits of a Plan which covers the child as a dependent of a stepparent will be determined before a plan which covers the child as a dependent of the parent without custody.
- (4) When the above rules do not establish the order, the benefits of a plan which has covered the person for whom claim is made for the longer period of time will be determined before a Plan which has covered the person for the shorter period of time.

Claim Determination Period

Claim Determination Period means a calendar year or that part of a calendar year in which the person has been covered under this Plan.

GM6000R7

CEPV365

The following is added to the section of the certificate entitled "Medical Conversion Privilege":

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 the later of: (a) 31 days after the date your insurance ceases; or (b) 15 days after you receive notice of the conversion privilege. Evidence of good health is not needed.

Employees Entitled to Convert

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

- You have been insured for at least 60 days under the policy or under it and a prior policy issued to the Policyholder.
- Your insurance ceased because: (a) you were no longer in Active Service; (b) you were no longer eligible for Medical Expense Insurance; or (c) the policy canceled.
- 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; or a former spouse whose insurance ceases due to remarriage;



- 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.

GM6000R7

CEPV369

The following is added to the section of the certificate entitled "Definitions":

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time or part-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business. Performing your work on a part-time basis means you normally work at least half of the weekly hours of a full-time Employee, but not less than 15 hours a week.
- 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.

The Term Employee means a full-time Employee of the Employer. The term does not include employees who are temporary, full-time Employees who normally work less than 30 hours a week for the Employer, or part-time Employees who normally work less than 15 hours a week for the Employer.

The term "child" in the definition of "Dependent" includes a child legally adopted by you including that child from the first day of placement in your custody. Coverage will terminate upon the withdrawal or dismissal of your petition of adoption.

The term Hospital means:

- an institution operated pursuant to law or legally operated as a Hospital which: (a) maintains, on the premises or in facilities available to the Hospital on a prearranged basis, all facilities necessary for medical, diagnostic 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 or under the direction of Registered Graduate Nurses; and (d) maintains permanent medical history records;
- an institution which qualifies as a Hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare;
- an institution which: (a) specializes in treatment of mental illness, alcohol or drug 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; or

- a Free-standing Surgical Facility.

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

GM6000R7

CEPV366

The following is added to the definition section of your certificate:

Emergency Services

Emergency Services are medical, surgical, Hospital and related health care services, including ambulance service, required for the alleviation of severe pain or to treat an Injury or a sudden, unexpected onset of a serious Sickness which, if not treated immediately, may result in serious medical complications, loss of life or permanent impairment to bodily functions. Included are conditions which produce loss of consciousness or excessive bleeding; or which may otherwise be determined by the Provider Organization, in accordance with generally accepted medical standards, to have been an acute condition requiring immediate medical attention. Prior authorization for services is not required. If prior authorization is received, that authorization cannot retroactively be denied if the emergency care was received and given in good faith and the insured's plan was active on the date of service.

GM6000R7

CEPV625

Connecticut General Life Insurance Company a CIGNA Company (called CG)

Certificate Rider - New Jersey Residents

Rider Eligibility: Each Employee who is located in New Jersey

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

This certificate rider forms a part of the certificate issued to you by CG.

The provisions set forth in this certificate rider comply with legislative requirements of New Jersey regarding group insurance plans covering insureds located in New Jersey. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.



The following is added to the section of your certificate entitled "Covered Expenses".

- charges for reconstructive surgery following a mastectomy on one or both breasts to restore and achieve symmetry between the two breasts. Benefits also include the cost of prostheses, outpatient chemotherapy, and radiation therapy. (GM6000 R7CEP10)

GM6000 R 7

CEP11 M

**Connecticut General Life Insurance Company
a CIGNA Company (called CG)**

Certificate Rider - North Carolina Residents

Rider Eligibility: Each Employee who is located in North Carolina

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

This certificate rider forms a part of the certificate issued to you by CG.

The provisions set forth in this certificate rider comply with legislative requirements of the state of North Carolina regarding group insurance plans covering insureds located in North Carolina. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

The following is added to the section of the certificate entitled "**Definitions**":

The term "child" within the definition of "Dependent" includes an adopted child or foster child including that child from the first day of placement in your home regardless of whether the adoption has become final.

The following is added to the section of your certificate entitled "**Eligibility/Effective Date**":

- waiting period: 90 days from date of Active Service.

For Plans with Mail Order Drug Benefits:

Any copayment amount for a prescription filled at a Participating Mail-Order Pharmacy will be three times the copayment for a prescription filled at a Participating Retail Pharmacy.

GM6000 R 7

CEPV430 M

The following is added to the medical benefits section of your certificate entitled "Covered Expenses":

- charges made for prostate-specific antigen (PSA) tests.
- charges for a qualified person for the diagnosis and evaluation of osteoporosis or low bone mass if at least 23 months have elapsed since the last Bone Mass Measurement was performed.

More frequent follow up measurements will be covered when deemed Medically Necessary. Conditions that would be considered Medically Necessary include, but are not limited to: (1) monitoring insureds on long-term glucocorticoid therapy of more than 3 months; or (2) a central Bone Mass Measurement to determine the effectiveness of adding an additional treatment program for a qualified person with low bone mass as long as the Bone Mass Measurement is performed 12 to 18 months from the start date of the additional program.

Bone Mass Measurement (BMM) means a scientifically proven radiologic, radioisotopic, or other procedure performed on a qualified person to identify bone mass or detect bone loss in order to initiate or modify treatment.

A Qualified Person means one who:

- (a) is estrogen deficient and at clinical risk for osteoporosis or low bone mass;
- (b) is experiencing radiographic osteopenia anywhere in the skeleton;
- (c) is receiving long term glucocorticoid (steroid) therapy;
- (d) is having primary hyperparathyroidism;
- (e) is being monitored to assess the response to commonly accepted osteoporosis drug therapies;
- (f) has a history of low-trauma fractures;
- (g) has other conditions or is on medical therapies known to cause osteoporosis or low bone mass

GM6000 R 7

CEPV831 M

The following is added to Covered Expenses:

- charges made by a Hospital or Ambulatory Surgical Facility for anesthesia and facility charges for services performed in the facility in connection with dental procedures for: (a) Dependent children below age 9; (b) covered persons with serious mental or physical conditions; or (c) covered persons with significant behavioral problems. The treating provider must certify that hospitalization or general anesthesia is required in order to safely and effectively perform the procedure because of the person's age, condition or problem.
- charges for prescription contraceptives and devices approved by the U.S. Food and Drug Administration. Benefits will also include the insertion and/or removal of



the contraceptive and any Medically Necessary exam associated with use of the contraceptive.

GM6000R7

CEPV936

The following is added to the Exclusive Provider or Designated Provider Medical Benefits section of the certificate entitled "Important Information":

Important Information About Your Medical Plan

Direct Access to OB/GYN

Any covered female age 13 or older may access the services of a Participating OB/GYN, or licensed practitioner working with the OB/GYN without an authorization of care. Services include those medically necessary for the care of, or related to, the female reproductive system and breasts, and in performing annual screening, counseling and immunizations for disorders and diseases in accordance with recommendations of the American College of OB/GYN's.

GM6000 R7

CEPV358 M

The following benefit is added to the Medical Benefits section entitled "Important Information":

Extended Authorization of Care for Specialist - An extended or standing authorization of care for a participating specialist may be obtained from the PCP. The extended authorization can be obtained if the insured has a serious or chronic degenerative, disabling, or life threatening disease or condition which, in the opinion of the PCP who consults with the specialist, requires ongoing specialty care. The extended period for access to the participating specialist shall not exceed 12 months.

GM6000R7

CEPV808 M

The following definition of Employee is added to the section of the certificate entitled "Definitions":

Employee

The term Employee means a full-time employee of the Employer. The term does not include employees who are part-time, seasonal, substitute or temporary or who normally work less than 30 hours a week for the Employer.

The following is added to the "Covered Expenses" section of your medical plan certificate:

- charges for Hospital Confinement of the mother and newborn child for the first 48 hours after a vaginal delivery, or for the first 96 hours after a cesarean delivery. A longer stay will be covered if medically necessary. The mother and newborn may be discharged prior to 48 or 96 hours if the attending Physician determines that a shorter stay is appropriate.

- charges for all stages and revisions of reconstructive breast surgery performed on non diseased breast to establish symmetry when reconstructive surgery on a diseased breast is performed. Coverage includes; (a) reconstruction of the mastectomy site; (b) creation of a new breast mound, and of a new nipple/areolar complex without regard to the lapse of time between the mastectomy and the reconstruction, upon the treating Physician's approval.

- charges made for or in connection with the treatment of congenital defects and abnormalities, including those charges for your newborn child from the moment of birth, and with the treatment of cleft lip or cleft palate.

GM6000R7

CEPV639

**Connecticut General Life Insurance Company
a CIGNA Company (called CG)**

Certificate Rider - Pennsylvania Residents

Rider Eligibility: Each Employee who is located in Pennsylvania

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

This certificate rider forms a part of the certificate issued to you by CG.

The provisions set forth in this certificate rider comply with legislative requirements of the Commonwealth of Pennsylvania regarding group insurance plans covering insureds located in Pennsylvania. These provisions supersede any provisions in your certificate to the contrary unless the provisions in the certificate result in greater benefits.

The following is added to the medical benefits section of the certificate entitled "**Covered Expenses**":

Covered Expenses will include and any deductible will be waived for charges made for or in connection with childhood immunizations, including medically necessary booster doses.

Covered Expenses will also include:

- charges made for or in connection with an annual gynecological exam, including a pelvic exam and a routine Pap smear. This benefit is exempt from any deductible or dollar limit.

GM6000 R 7

CEPV383 M



The following is added to the medical benefits section of the certificate entitled "**Covered Expenses**":

- charges made for or in connection with mammograms for breast cancer screening and diagnosis, including: (a) a baseline mammogram annually for women age 40 and over; and (b) upon a Physician's recommendation a mammogram for women under age 40.
- charges for medically necessary nutritional supplements for the treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia, and homocystinuria when administered under the direction of a Physician. A deductible will not apply.
- charges for reconstructive surgery and for two external breast prostheses incident to a mastectomy (the Copayments and Maximums for external prostheses do not apply to breast prostheses);
- charges for at least 48 hours of inpatient care following a mastectomy. A longer period of time will be covered if the treating Physician determines it is medically necessary. Home health care services will also be provided if the treating Physician deems these services medically necessary.

GM6000 R 7

CEPV731 M

The following benefits will apply to insulin and noninsulin dependent diabetics as well as covered individuals who have elevated blood sugar levels due to pregnancy or other medical conditions:

- charges for Durable Medical Equipment, including glucometers; blood glucose monitors for the legally blind; insulin pumps; infusion devices and related accessories, including those adaptable for the legally blind; podiatric appliances; and glucagon emergency kits. A special maximum will not apply.
- charges for insulin; syringes; needles; prefilled insulin cartridges for the blind; oral blood sugar control agents; glucose test strips; visual reading ketone strips; urine test strips; lancets; and alcohol swabs.
- charges for training by a Physician with recent education in diabetes management, but limited to the following:
 - (a) Medically Necessary visits when diabetes is diagnosed;
 - (b) Medically Necessary visits following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management;
 - (c) visits when reeducation or refresher training is prescribed by the Physician; and
 - (d) medical nutrition therapy related to diabetes management.

GM6000 R7

CEPV774

The following is added to the section of the Certificate entitled "**Expenses Not Covered**":

Exception for Persons Who are Exposed to Diethylstilbestrol (DES)

The Pre-existing Condition limitation will be waived for a person who took diethylstilbestrol (DES) while pregnant, who was exposed to DES prenatally, or the children of a person who was exposed prenatally.

The following is added to the medical and dental sections of the certificate entitled "**General Limitations**":

No payment will be made for expenses incurred by you or any one of your Dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with: (1) the Pennsylvania Motor Vehicle Financial Responsibility Law; or (2) a "no-fault" insurance law of any other state; or (3) an uninsured motorist insurance law.

CG will take into account any adjustment option chosen under such part by you or any one of your Dependents. (GM6000 R7CEPV224)

The following is added to the definition of "Dependent" in your certificate:

A child includes a legally adopted child, including that child from the first day of placement in your home regardless of whether the adoption has become final; or, an adopted child of whom you have custody according to the decree of the court provided you have paid premiums. Adoption proceedings must be instituted by you, and completed within 31 days after the child's birth date, and a decree of adoption must be entered within one year from the start of proceedings, unless extended by court order due to the child's special needs. (GM6000 R7CEPV504)

GM6000 R7

CEPV266 M

Connecticut General Life Insurance Company a CIGNA Company (called CG)

Certificate Rider - Rhode Island Residents

Rider Eligibility: Each Employee who is located in Rhode Island

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

This certificate rider forms a part of the certificate issued to you by CG.



The provisions set forth in this certificate rider comply with legislative requirements of the state of Rhode Island, regarding group insurance plans covering insureds located in Rhode Island. These provisions supersede any provisions in your certificate to the contrary, unless the provisions in your certificate result in greater benefits. This does not apply to Substance Abuse benefits for Rhode Island residents.

GM6000 R 7

CEPV169 M

The following is added to the section of the certificate entitled "Full Payment Area":

However, benefits for Covered Expenses incurred for or in connection with mental illness, alcohol or drug abuse will not be increased by the terms of this section with the exception of visits for the sole purpose of medication management.

The following limitation is added to The Schedule:

Inpatient Mental Illness	
Maximum	90 consecutive days per admission

GM6000 R7

CEPV359

The following is added to the medical section of your certificate entitled "Covered Expenses":

Substance Dependency and Abuse Benefits

If you or any one of your Dependents, while insured for these benefits, incurs expenses for charges made by a Covered Facility for the treatment of alcoholism and drug abuse when medically necessary, CG will pay for those charges subject to the following terms.

Charges for Inpatient Benefits will include:

- Detoxification benefits up to 3 detoxification occurrences or 21 days per calendar year, whichever occurs first; and
- Intensive rehabilitation service benefits up to 30 days in any 12-month period and up to 90 days in a person's lifetime. Two days of day/evening and/or partial hospitalization will be equal to one day of residential treatment.

The maximum amount payable for Bed and Board for each day of Confinement and for Necessary Services and Supplies will be subject to the Bed and Board and Necessary Services and Supplies rate of payment under the Comprehensive Medical Benefits.

Charges for Out-Patient Benefits will include:

- Benefits for up to 30 hours of treatment for you or any one of your Dependents under treatment for alcoholism and drug abuse in any 12-month period; and
- Benefits for remaining family members for up to 20 hours of treatment in any 12-month period.

The benefits provided under this section are subject to the Deductible, the coinsurance factor and the Maximum Benefit Provision.

Covered Facility. The term Covered Facility means a facility which is:

- a Hospital, as defined;
- a skilled nursing facility or other public or private facility licensed to provide treatment of alcoholism or drug abuse or rehabilitation of substance abusers; or
- a licensed community residential facility for treatment of alcoholism or drug abuse.

Limitations. No payment will be made under any other section of the policy for charges made by an institution which qualifies as a Covered Facility.

Other Limitations are shown in the "General Limitations" section.

GM6000 R 7

CEPV23 M

- charges made by a Home Health Care Agency for the following medical services and supplies provided under the terms of a Home Health Care Plan for the person named in that plan (to determine the benefits payable, each visit by an employee of a Home Health Care Agency will be considered one home health care visit, and each 4 hours of Home Health Aide services will be considered one home health care visit):
 - home or office visits by or to a Physician, not to exceed 6 visits per month;
 - part-time or intermittent nursing care by or under the supervision of a Registered Graduate Nurse, not to exceed 3 nursing visits per week;
 - part-time or intermittent services of a Home Health Aide, not to exceed 20 hours per week;
 - physical, occupational, or speech therapy as a rehabilitative service;
 - respiratory service;
 - medical social work;
 - nutrition counseling;
 - medical and surgical supplies; drugs and medicines lawfully dispensed only on the written prescription of



a Physician; x-rays and laboratory testing; minor durable medical equipment, EEG and EKG evaluation, but only to the extent that such charges would have been considered Covered Expenses had a person required confinement in the Hospital as a registered bed patient or confinement in a Skilled Nursing Facility;

excluding any charges for:

- care or treatment of a communicable disease, or nervous, emotional or mental illness;
- care or treatment which is not stated in the Home Health Care Plan;
- the services of a person who is a member of your family or your Dependent's family or who normally lives in your home or your Dependent's home;
- a period when a person is not under the continuing care of a Physician.

GM6000R7

CEPV935

The following is added to the "Termination of Insurance" section of your certificate:

Special Continuation of Medical Insurance for Employees

If your Active Service ends because of involuntary termination of employment and if the Policyholder stops paying premium for you before the earliest of:

- 18 months from the date your Active Service ends;
- the last day of a period equal to the most recent time you had been insured under the policy;
- the date you become eligible for similar group coverage or for Medicare;

the insurance will be continued if you pay this required premium to the Policyholder, until the earliest of the above dates. You must elect to continue the insurance within 30 days from the date the Policyholder stops paying premium.

This provision will not reduce any continuation of insurance otherwise provided.

For Dependents of Deceased Employees

If you die while insured for your Dependents under the policy, and if the Policyholder stops paying premium for such Dependents before the earliest of:

- 18 months from the date of your death;
- the last day of a period equal to the most recent time you had been insured for your Dependents under the policy;

- with respect to any one Dependent, the date that Dependent becomes eligible for similar group coverage or for Medicare;

the insurance will be continued if the premium is paid by the Dependents to the Policyholder, until the earliest of the above dates. The Dependent must elect to continue the insurance within 30 days from the date the Policyholder stops paying premium.

The provision will not reduce any continuation of insurance otherwise provided.

GM6000R7

CEPV644

The following is added to the "Termination of Insurance" section of your certificate:

For Former Spouse

If your spouse's Medical Insurance would otherwise cease due to divorce, and if the judgment for divorce requires you to provide continued coverage, the Medical Insurance for your former spouse will be continued until:

- a date specified in the final divorce decree;
- the end of the time required by the judgment for divorce;
- your former spouse becomes eligible for similar group coverage through employment;
- either party to the divorce remarries;
- you fail to make any required contribution for Dependent Insurance;
- your insurance for yourself ceases;
- the policy, or Dependent Insurance under it, is canceled;

whichever occurs first.

You must notify your Employer of the divorce decree and you must pay the required contribution to the Employer within 30 days after the spouse's insurance would otherwise terminate.

If you die, any other terms which continue Dependent Insurance after your death will apply.

This continuation can be elected instead of COBRA, but cannot be elected in addition to COBRA.

The Medical Conversion Privilege will be available when continuation of Dependent Insurance for a former spouse ceases.

GM6000R7

CEPV643



**Connecticut General Life Insurance Company
a CIGNA Company (called CG)**

Certificate Rider - South Carolina Residents

Rider Eligibility: Each Employee who is located in South Carolina

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

This certificate rider forms a part of the certificate issued to you by CG.

The provisions set forth in this certificate rider comply with legislative requirements of the state of South Carolina regarding group insurance plans covering insureds located in South Carolina. These provisions supersede any provisions in your certificate to the contrary unless the provisions in the certificate result in greater benefits.

GM6000 R 7

CEPV217 M

The following is added to the medical benefits section of your certificate entitled "Covered Expenses":

- for medically necessary care and treatment of cleft lip and palate and any condition or illness which is related to or developed as a result of cleft lip and palate. This includes, but is not limited to, oral/facial surgery, teeth capping, prosthodontics, orthodontics, otolaryngology, and audiological care. Medical benefits for prosthodontics (including teeth capping) and orthodontics can be excluded if the procedures are also covered under a dental policy;
- a drug that has been prescribed for the treatment of a specific type of cancer for which it has not been approved by the Food and Drug Administration (FDA). Such drug must be covered, provided: (a) the drug is recognized in any one of the following for the specific cancer treatment for which it has been prescribed: United States Pharmacopeia Drug Information; American Medical Association Drug Evaluations; American Hospital Formulary Service Drug Information; or two articles from major peer-reviewed medical literature;
- charges for prosthetic devices, reconstruction of the breast on which surgery has been performed, and surgery and reconstruction of the non-diseased breast when determined Medically Necessary by the attending Physician, following a mastectomy;
- charges for at least 48 hours of inpatient care following a mastectomy. A shorter stay is acceptable when ordered by

the attending Physician. In the case of an early release, charges for at least one home care visit will be covered, if ordered by the Physician;

- charges for a mammogram: (a) once for women age 35 to 39; (b) once every two years for women age 40 to 49; and (c) once a year for women who are at least 50;
- charges for Pap smears when recommended by a Physician.

GM6000 R 7

CEPV676

The following is added to the section of the certificate entitled "Expenses Not Covered" regarding the Pre-Existing Condition Limitation:

Credit for Coverage Under Prior Policy

If a person was insured under another substantially similar group insurance policy, including a policy providing any state or federally required continuation of coverage, on the day before his effective date of insurance under this policy, the following will apply, provided he notifies the Employer of such prior coverage:

- If the person was covered for the Pre-existing Condition under the prior policy, the Pre-existing Condition limitation under this policy will be waived for that condition.
- If the person had partially satisfied a waiting period for the Pre-existing Condition under the prior policy, he will be given credit under this policy's Pre-existing Condition limitation for that period of time.

This provision will not apply if the prior coverage was provided under a self-funded health care plan.

GM6000R7

CEPV495

The following is added to the medical benefits section of the certificate entitled "Termination of Insurance":

Special Continuation of Medical Insurance

If your insurance would otherwise cease for any reason other than failure to make any required contribution, and if you have been insured for at least three consecutive months under the policy, and if you pay your Employer the required premium, your Medical Insurance will be continued until the earliest of:

- six months from the end of the policy month in which the insurance otherwise would have ceased;
- the last day for which you have paid the required premium;
- the date you become eligible for insurance under another group policy for medical benefits or under Medicare;



- the date the policy is canceled.

Within 31 days after the date the insurance would otherwise cease, you may elect such continuation by paying the required premium to your Employer.

If your insurance is being continued as outlined above, the Medical Insurance for any of your Dependents insured on the date your insurance would otherwise cease may be continued, subject to the above provisions. The Dependent Medical Insurance will be continued until the earlier of:

- the date your insurance ceases; or
- with respect to any one Dependent, the date that Dependent no longer qualifies as a Dependent.

This option will not operate to reduce any continuation of insurance otherwise provided.

Conversion Available Following Continuation

The provisions of the "Medical Conversion Privilege" section will apply when the insurance ceases.

GM6000R7

CEPV112

The following creates or is added to the Medical Conversion Privilege:

When a Dependent spouse's Medical Expense Insurance ceases due to divorce from the Employee, such spouse may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy as described below), if the spouse makes written application and pays the required premium within 60 days after entry of a final decree.

Such Dependent must not be Overinsured as described below:

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 need not provide major medical coverage unless it is required by the laws of the jurisdiction in which the Converted Policy is issued.

The Converted Policy will be issued to you if your are Entitled to Convert, insuring you and those Dependents for whom you may convert. If you are not Entitled to Convert and your spouse and children are, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert.

The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: (a) class of risk and age; and (b) benefits.

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

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

GM6000 R7

CEPV1002

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 60 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.

GM6000 R7

CEPV1003

The following is added to the definition of "Dependent" in your certificate:

A child includes a legally adopted child, including that child from the first day of placement in your home regardless of whether the adoption has become final; or, an adopted child of whom you have custody according to the decree of the court provided you have paid premiums. Adoption proceedings must be instituted by you, and completed within 31 days after the child's birth date, and a decree of adoption must be entered within one year from the start of proceedings, unless extended by court order due to the child's special needs.

GM6000R7

CEPV504



**Connecticut General Life Insurance Company
a CIGNA Company (called CG)**

Certificate Rider - Vermont Residents

Rider Eligibility: Each Employee who is located in Vermont

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

This certificate rider forms a part of the certificate issued to you by CG.

The provisions set forth in this certificate rider comply with legislative requirements of the state of Vermont regarding group insurance plans covering insureds located in Vermont. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

The following is added to the medical section of your certificate entitled "Covered Expenses":

- charges made for or in connection with mammograms for breast cancer screening or diagnostic purposes, including, one annual mammogram for women age 50 years or older; and mammograms for women less than 50 years of age upon the Physician's recommendation.

GM6000 R 7

CEPV254 M

**Connecticut General Life Insurance Company
a CIGNA Company (called CG)**

Certificate Rider - Virginia Residents

Rider Eligibility: Each Employee who is located in Virginia

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

This certificate rider forms a part of the certificate issued to you by CG.

The provisions set forth in this certificate rider comply with legislative requirements of the Commonwealth of Virginia regarding group insurance plans covering insureds located in Virginia. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

The following is added to the section of the certificate entitled "Termination of Insurance":

Reinstatement of Insurance

If your Insurance ceases because of active duty in: (a) the United States Armed Forces; (b) Reserves of the United States Armed Forces; or (c) the National Guard, the insurance for you and your Dependents will be reinstated after your deactivation provided you apply for reinstatement and you are otherwise eligible.

Such reinstatement will be without the application of: (a) a new waiting period; or (b) a new Pre-existing Condition Limitation. A new Pre-existing Condition Limitation will not apply to a condition that you or your Dependents may have developed while coverage was interrupted. The remainder of a Pre-existing Condition Limitation in effect prior to interruption of coverage may still apply.

GM6000 R 7

CEPV35 M

**Connecticut General Life Insurance Company
a CIGNA Company (called CG)**

Certificate Rider - Washington Residents

Rider Eligibility: Each Employee who is located in Washington

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

This certificate rider forms a part of the certificate issued to you by CG.

The provisions set forth in this certificate rider comply with legislative requirements of the state of Washington regarding group insurance plans covering insureds located in Washington. These provisions supersede any provisions in your certificate to the contrary unless the provisions in the certificate result in greater benefits.

The following is added to the section of the certificate entitled "Definitions":

The term "child" within the definition of "Dependent" will include a legally adopted child, a child for whom you assume legal obligation for total or partial support, in anticipation of adoption, but with no requirement that the adoption be final.

GM6000 R 7

CEPV411 M

The following alcoholism and drug abuse benefits apply:



Inpatient and Outpatient Alcoholism and Drug Abuse Benefits

If you or one of your Dependents incurs Covered Expenses for treatment of alcoholism or drug abuse, CG will pay for charges on the same basis as benefits payable for any other illness, with regard to deductible and coinsurance, up to the Inpatient and Outpatient Alcohol and Drug Abuse Maximums. This benefit includes charges for family therapy for the patient and other covered persons.

Inpatient and Outpatient Alcoholism and Drug Abuse Maximums

Benefits payable for the treatment of alcoholism or drug abuse received on an inpatient and outpatient basis will not exceed \$5,000 in any period of twenty-four consecutive months. The maximum amount payable for inpatient and outpatient alcoholism and drug abuse benefits in a person's lifetime is \$10,000.

Benefits otherwise payable will be reduced by any benefits paid or payable by another group insurance plan for expenses incurred for or in connection with alcohol and drug abuse in the twenty-four months immediately preceding.

The following is added to the section of the certificate entitled "Accident and Health Provisions":

If benefits are denied because of an experimental and investigational exclusion, the claimant may appeal the denial. The appeal procedure for denial of benefits will be determined by CG as set forth in the denial letter.

The section titled "Eligibility - Effective Date" is changed to read:

Exception for Newborns

Any Dependent child born while you are insured for Dependent Insurance will be insured from the date of birth.

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 60 days after his birth.

Late Entrants

The effective date of coverage for late entrants is not contingent upon evidence of good health

GM6000 R 7

CEPV412

The following is also added to the "Covered Expenses" section of the certificate.

The following benefits will apply to insulin and non-insulin dependent diabetics as well as covered individuals who have

elevated blood sugar levels due to pregnancy or other medical conditions.

- charges for Durable Medical Equipment, including podiatric appliances related to diabetes. A special maximum will not apply.
- charges for insulin; syringes prefilled insulin cartridges for the blind; oral blood sugar control agents; glucose test strips; visual reading ketone strips; urine test strips; lancets; and alcohol swabs.
- charges for training by a Physician, including a podiatrist with recent education in diabetes management, but limited to the following:
 - (a) Medically Necessary visits when diabetes is diagnosed;
 - (b) visits following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management;
 - (c) visits when reeducation or refresher training is prescribed by the Physician; and
 - (d) Medical Nutrition therapy related to diabetes management

GM6000 R7

CEPV617

The following is added to the "Covered Expenses" section of the certificate:

Covered Expenses will also include:

- charges made by a Home Health Care Agency for the following medical services and supplies provided under the terms of a Home Health Care Plan for the person named in that plan:
 - part-time or intermittent nursing care by or under the supervision of a Registered Graduate Nurse;
 - part-time or intermittent services of a Home Health Aide;
 - physical, occupational, or 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 that such charges would have been considered Covered Expenses had a person required confinement in the Hospital as a registered bed patient or confinement in a Skilled Nursing Facility;
 - ambulance service which has been certified by a Physician as medically necessary;



- prosthetic devices and durable medical equipment required for treatment, but only to the extent that such charges would have been considered Covered Expenses had the person required confinement in a Hospital as a registered bed patient or confinement in a Skilled Nursing Facility;

excluding any charges for:

- more than 130 home health care visits during a calendar year (to determine the benefits payable, each visit by an employee of a Home Health Care Agency will be considered one home health care visit and each 4 hours of Home Health Aide services will be considered one home health care visit);
- care or treatment which is not stated in the Home Health Care Plan;
- the services of a person who is a member of your family or your Dependent's family or who normally lives in your home or your Dependent's home;
- a period when a person is not under the continuing care of a Physician.

This benefit will be subject to the plan deductible or a \$50 Home Health Care Deductible, whichever is less.

GM6000 CM7
GM6000 CM8 R7

CEPV208 M

The following is added to the **Important Information** section of the certificate:

Direct Access to Chiropractor

Individuals covered by this plan may have direct access to any participating chiropractor. No prior referral from your Primary Care Physician for visits to a participating practitioner of your choice is required. There is a requirement to obtain an authorization of care prior to participating in any chiropractic plan of care. After your first visit, your provider must submit a plan of treatment to us for approval.

Authorization to Specialist

When an insured has a complex or serious medical or psychiatric condition, a standing authorization of care may be given to a participating specialist up to a maximum of one year. If a specialist for a specific medical condition is not represented in-network, one may be selected out-of-network.

American Indian Health Services

American Indians who are covered by this plan, may use the services of the Indian Health System under the same terms and conditions as an insured who uses in-network benefits and services. (GM6000 R7 CEPV934).

GM6000 R7CEPV911M

Covered Expenses will also include:

- charges made for a drug that has been prescribed to treat a life-threatening illness for which it has not been approved by the Food and Drug Administration (FDA). Such drug must be covered, provided: (a) it is recognized for the specific type of illness for which the drug has been prescribed in any one of the following established reference compendia: United States Pharmacopeia Drug Information; American Medical Association Drug Evaluation; American Hospital Formulary Service; other compendia identified by state or federal government; the majority of related peer-reviewed medical literature; or the Federal Secretary of Health and Human Services; (b) the drug has been otherwise approved by the FDA; and (c) the drug has not been contraindicated by the FDA for the use prescribed.

The following is added to the Exclusive Provider or Designated Provider section of your certificate entitled **"Important Information"**:

Direct Access to OB/GYN

An enrolled female may choose a participating health care practitioner without an authorization of care, as long as the practitioner provides women's health care services. Covered services include, but are not limited to, maternity care, reproductive health services, gynecological care, a general exam, preventive care, and follow-up visits, as medically appropriate. Medically appropriate follow-up visits will also be covered for contraceptive services, testing and treatment of sexually transmitted diseases, pregnancy termination, breast feeding, and complications of pregnancy.

GM6000 R7

CEPV873 M

The following is added to the medical benefits section of the certificate entitled "Pre-Existing Condition":



Exception for Adopted Dependent Children

The Pre-Existing Condition limitation will be waived for a Dependent child who is adopted or placed for adoption.

The following is added to the medical benefits section of the certificate entitled "Covered Expenses." Covered Expenses will include:

- charges made for or in connection with phenylketonuria.
- charges made for or in connection with mammograms for breast cancer screening, if prescribed by a Physician, an advanced registered nurse practitioner or a physician assistant.
- charges made for speech, occupational or physical therapies for children age 6 or less up to a maximum of \$1,000 per calendar year and a lifetime maximum of \$3,000. Services must be given under the referral and review of a licensed Physician.

GM6000 R7

CEPV656

The following is added to the section of the certificate entitled "**Expenses Not Covered**":

- for or in connection with an Injury or a Sickness which is a Pre-existing Condition after benefits equal to \$750 have become payable, unless those expenses are incurred after the end of a continuous three-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 three months prior to the date that person becomes insured for these benefits. The

term Pre-existing Condition will also include any condition which is related to any such Injury or Sickness.

Exception for Persons with Phenylketonuria

The Pre-existing Condition limitation will be waived with respect to special dietary formulas for treatment of phenylketonuria (PKU).

Credit for Coverage Under Prior Policy

If a person was previously covered under another substantially similar group or individual insurance policy, including any state or federally required continuation of coverage, the following will apply, provided no more than three months have elapsed between coverage under the prior plan and coverage under this plan.

GM6000 R7

CEPV928

The following is added to the medical benefits section of the certificate entitled "**Expenses Not Covered**":

Covered Expenses will not include, and no payment will be made for, expenses incurred:

- for or in connection with cosmetic surgery unless while insured for these benefits: (a) a person receives an Injury, which results in bodily damage requiring the surgery; or (b) it qualifies as reconstructive surgery performed on a person following surgery, and both the surgery and the reconstructive surgery are essential and medically necessary; or (c) it is performed on any one of your Dependents who is less than 16 years old; or (d) it is a breast reconstruction performed on the nondiseased breast to make it equal in size to the diseased breast after definitive reconstructive surgery has been performed on the diseased breast.

GM6000R7

CEPV187



Connecticut General Life Insurance Company

a CIGNA company (called CG)

Certificate Rider

No. ETFLMF05A

Policyholder: Welfare Fund of Local 1 IATSE
Rider Eligibility: Each Employee who is located in Florida
Policy No. or Nos. 3319944
Effective Date: 07/01/2008

The benefits of the policy providing your coverage are primarily governed by the law of a state other than Florida.

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

This certificate rider forms a part of the certificate issued to you by CG describing the benefits provided under the policy(ies) specified above.

The provisions set forth in this certificate rider comply with legislative requirements of the state of Florida regarding group insurance plans covering insureds located in Florida. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

Susan L. Cooper

Corporate Secretary

GM6000 R7

CEPV937M



The following is added to the medical benefits section of your certificate entitled "Covered Expenses":

Covered Expenses will include expenses incurred at any of the Approximate Age Intervals shown below for a Dependent child from birth to the 16th birthday, for charges made for Child Health Supervision Services consisting of the following services delivered or supervised by a Physician, in keeping with prevailing medical standards:

- a history;
- physical examination;
- development assessment;
- anticipatory guidance; and
- appropriate immunizations and laboratory tests;

excluding any charges for:

- more than one visit to one provider for Child Health Supervision Services at each of the Approximate Age Intervals up to a total of 18 visits for each Dependent child;
- services for which benefits are otherwise provided under the Medical Benefits section;
- services for which benefits are not payable according to the "Expenses Not Covered" section.

It is provided that any Deductible that would otherwise apply will be waived for those Covered Expenses incurred for Child Health Supervision Services.

Approximate Age Intervals are: Birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years and 16 years.

GM6000 R7

CEPV964

- Covered Expenses will include charges for or in connection with mammograms for breast cancer screening or diagnostic purposes, not to exceed: (a) a baseline mammogram for women ages 35 to 39; (b) a mammogram for women ages 40 to 49 every two years or more frequently, if recommended by the attending Physician; (c) a mammogram every year for women age 50 and over; and (d) one or more mammograms upon the recommendation of a Physician for any woman who is at risk for breast cancer due to her family history; has biopsy-proven benign breast disease; or has not given birth before age 30.

- Covered Expenses will also include charges for or in connection with medically necessary diagnosis and treatment of osteoporosis for high-risk individuals. This includes, but is not limited to individuals who: (1) have vertebral abnormalities; (2) are receiving long-term glucocorticoid (steroid) therapy; (3) have primary hyperparathyroidism; (4) have a family history of osteoporosis; and/or (5) are estrogen-deficient individuals who are at clinical risk for osteoporosis.

GM6000 R7

CEPV441

The following is added to the "Important Information" section of your certificate:

Direct Access for OB/GYN Services

Female insureds covered by this Plan are allowed direct access to a licensed/certified participating practitioner for covered OB/GYN services. There is no requirement to obtain an authorization of care from your Primary Care Physician for visits to the participating practitioner of your choice for pregnancy, well-woman gynecological exams, primary and preventive gynecological care and acute gynecological conditions.

GM6000 R7

CEPV910

The following is added to the "Covered Expenses" section of your certificate:

- charges for reconstructive breast surgery and prosthetic devices to restore and achieve symmetry, following a mastectomy. The surgery will be done in a manner chosen by the Physician and in consultation with the patient and must be consistent with prevailing medical standards.
- charges for an inpatient Hospital stay following a mastectomy will be covered for a period determined to be medically necessary by the Physician in consultation with the patient. Postsurgical follow-up care may be provided at the Hospital, Physician's office, outpatient center, or at the home of the patient.
- charges for the treatment of cleft lip and cleft palate including medical, dental, speech therapy, audiology and nutrition services, when prescribed by a Physician.
- charges for general anesthesia and hospitalization services for dental procedures for an individual who (a) is under age 8 and it is determined by a licensed dentist and the child's Physician that treatment in a Hospital or ambulatory surgical center is necessary due to a significantly complex dental condition or developmental disability in which patient management in the dental office has proven to be ineffective; or (b) has one or more medical conditions that would create significant or undue



medical risk if the procedure were not rendered in a Hospital or ambulatory surgical center.

GM6000 R7

CEPV932

- charges for the services of certified nurse-midwives, licensed midwives, and licensed birth centers regardless of whether or not such services are received in a home birth setting.
- charges for routine follow-up care to determine whether or not breast cancer has recurred in a person who was previously diagnosed as free of breast cancer. This follow-up care does not constitute medical advice, diagnosis, care or treatment for determining preexisting conditions unless evidence of breast cancer is found during or as a result of the follow-up care.
- charges for a mother and her newborn for a 48-hour inpatient stay following a vaginal delivery or a 96-hour inpatient stay following a cesarean section. A shorter stay will be allowed if the Physician determines it is medically appropriate. Any stay beyond the 48/96 hours will be covered if determined to be Medically Necessary.

A postpartum mother and newborn assessment will also be covered whether it is provided at the Hospital, Physician's office, outpatient maternity center, or in the home. Postpartum health care must be provided by a licensed health care professional trained in mother and baby care and will include a physical assessment of the newborn and mother as well as the performance of any Medically Necessary clinical tests and immunizations.

- charges for Medically Necessary treatment of the bones and joints of the facial region, including treatment for TMJ will be covered on the same basis as any other bone or joint of the body.
- charges for newborn (birth through 29 days) and infant (30 days through 12 months) hearing screening and Medically Necessary follow-up evaluations. When ordered by the treating Physician, a newborn's hearing screening must include auditory brainstem responses or evoked otoacoustic emissions or to appropriate technology approved by the FDA. All screenings shall be conducted by a licensed audiologist, Physician, or supervised individual who has training specific to newborn hearing screening.

GM6000 R7

CEPV959

The following provision is added to your certificate:

Special Provisions for Newborn Dependent

Exception for Newborn Children and Grandchildren

Any Dependent child born while you are insured will become insured on the date of his birth if you elect Dependent Medical Insurance no later than 60 days after his birth. If you elect to insure the child after the first 60 days, coverage will be offered at an additional premium. If you do not elect to insure your newborn child within such 60 days, coverage for that child will end on the 60th day. No benefits for expenses incurred beyond the 60th day will be payable. If coverage is elected for a newborn grandchild, that coverage will terminate eighteen months after the birth of the child.

Benefits Payable

If a newborn Dependent, while insured, incurs expenses as a result of an Injury or Sickness, the insurance company will pay for those expenses to the same extent as those payable for any other insured Dependent. Benefits will also be payable for transportation charges to and from the nearest available facility staffed and equipped to treat the newborn Dependent's condition. The transportation must be certified by a Physician as medically necessary. The maximum amount payable for transportation charges for a newborn Dependent will be no less than \$1,000.

In addition to the above, expenses incurred for routine care of the newborn Dependent prior to the date of discharge from the Hospital nursery will be deemed to result from a Sickness for the purposes of benefits payable.

Sickness

Sickness also includes medically diagnosed congenital defects, birth abnormalities or Premature Birth.

Premature Birth

Premature Birth means that a child weighed less than 5¹/₂ pounds at birth.

Limitations

No payment will be made:

- for expenses incurred for transportation charges made in connection with routine care of a newborn Dependent;
- under any other section for expenses incurred to the extent that benefits are payable for those expenses under this section.



Other Limitations are shown in the "General Limitations" section.

GM6000 R7

CEPV962 DG

The following is added to the section of the certificate entitled "Termination of Insurance - Continuation":

Special Continuation of Medical Insurance For Dependents of Military Reservists

If your insurance ceases because you are called to active military duty in: (a) the Florida National Guard; or (b) the United States military reserves, you may elect to continue Dependent insurance. You must pay the required premiums to the Policyholder if you choose to continue Dependent insurance. In no event will coverage be continued beyond the earliest of the following dates:

- the expiration of 30 days from the date the Employee's military service ends;
- the last day for which the required contribution for Dependent insurance has been made;
- the date the Dependent becomes eligible for insurance under another group policy. Coverage under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is excluded from this provision;
- the date the Dependent becomes eligible for Medicare;
- the date the group policy cancels;
- the date the Dependent ceases to be an eligible Dependent.

GM6000 R7

CEPV32 DG

Reinstatement of Medical Insurance - Employees and Dependents

Upon completion of your active military duty in: (a) the Florida National Guard; or (b) the United States military reserves, you are entitled to the reinstatement of your insurance and that of your Dependents if continuation of Dependent insurance was not elected. Such reinstatement will be without the application of: (a) any new waiting periods; or (b) the Pre-existing Condition Limitation to any new condition that you or your Dependent may have developed during the period that coverage was interrupted due to active military duty.

Provisions Applicable to Reinstatement

- You must notify your Employer, before reporting for military duty, that you intend to return to Active Service with that Employer; and

- You must notify your Employer that you elect such reinstatement within 30 days after returning to Active Service with that Employer and pay any required premium.

Conversion Available Following Continuation

The provisions of the "Medical Conversion Privilege" section will apply when the insurance ceases.

GM6000 R7

CEPV33

The following is added to the certificate:

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 63 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled to Convert

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

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

If you retire you may apply for a Converted Policy within 63 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 R7

CEPV961

The following is added to the medical benefits section in your certificate entitled "Medical Benefits Extension":

Any expense incurred within 12 months after a person's Medical Benefits cease will be deemed to be incurred while he is insured if such expense is for an Injury or Sickness which causes him to be Totally Disabled from the day his insurance ceases until that expense is incurred.

The terms of this Medical Benefits Extension will not apply to: (a) a child born as a result of a pregnancy which exists when a person's benefits cease; or (b) any person when he becomes insured under another group policy for medical benefits.

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.

Effect of Cancellation of Policy on Medical Benefits Extension

If a person's Medical Expense Insurance ceases because the policy is cancelled, expenses incurred after that date for a pregnancy which began while insured, will be deemed to be incurred while that person was insured.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy, which exists while a person's benefits cease due to cancellation of the policy.

GM6000 R7

CEPV540

The following is added to the definition of "child" within the definition of "Dependent" in your certificate:

A child also includes a child born to an insured Dependent child of yours until such child is 18 months old.

A child also includes a legally adopted child, including that child from the date of placement in the home or from birth provided that a written agreement to adopt such child has been entered into prior to the birth of such child. Coverage for a legally adopted child will include the necessary care and treatment of an injury or a sickness existing prior to the date of placement or adoption. Such coverage is not required if the child is ultimately not placed in your home.

A child also includes a foster child or a child placed in your custody by a court order from the date of placement in the home. Such coverage is not required if the foster child is ultimately not placed in your home.

The following is added to the definition entitled "Hospital" in your certificate:

- a licensed birthing center.

GM6000 R7

CEPV933