

AT&T

POINT OF SERVICE MEDICAL BENEFITS

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2470558 – BellSouth Point of Service Medical Plans

This document printed in June, 2008 takes the place of any documents previously issued to you which described your benefits.

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Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY AT&T, WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CONNECTICUT GENERAL PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CONNECTICUT GENERAL DOES NOT INSURE THE BENEFITS DESCRIBED.

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

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Explanation of Terms

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

The Schedule

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



Special Plan Provisions

Case Management

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

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

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

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- Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs

of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.

- The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
- The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

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

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Additional Programs

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

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Notice Regarding Emergency Services And Urgent Care

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

If you receive Emergency Services outside the service area, you must notify the Review Organization as soon as reasonably possible. The Review Organization may arrange to have you transferred to a Participating Provider for continuing



or follow-up care, if it is determined to be medically safe to do so.

Urgent Care Inside the Service Area

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

Urgent Care Outside the Service Area

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

Continuing or Follow-up Treatment

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

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How To File Your Claim

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

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

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

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

Hospital Confinement

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

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

Doctor's Bills and Other Medical Expenses

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

CLAIM REMINDERS

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

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

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

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

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

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Accident and Health Provisions

Notice of Claim

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

Claim Forms

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

Proof of Loss

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

Physical Examination

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

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Eligibility Provision

Effective Date of Coverage and Termination of Coverage

Eligibility, effective dates of coverage and termination are outlined in the Health and Insurance Plan for Retirees Summary Plan Description and Health and Insurance Plan for Represented Employees Summary Plan Description.

This document describes benefits available to BellSouth covered employees, former employees and their designated dependents enrolled in the CIGNA Network POS plan meeting the specified eligibility provisions. All references within this SPD refer to covered employees, former employees and dependents only.

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 a Primary Care Physician for yourself and your Dependents from a list provided by CG. 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 by contacting us at the member services number on your ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

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

Direct Access for Ob/Gyn Services:

Female insureds covered by this plan are allowed direct access to a licensed/certified Participating Provider 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 Provider of your choice for

pregnancy, well-woman gynecological exams, primary and preventive gynecological care, and acute gynecological conditions.

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Direct Access For Chiropractic Care Services:

Insureds covered by this plan are allowed direct access to a licensed/certified Participating Provider for In-Network covered Chiropractic Care services. There is no requirement to obtain an authorization of care from your Primary Care Physician for visits to the Participating Provider of your choice for Chiropractic Care.

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POINT OF SERVICE MEDICAL BENEFITS

The Schedule

For You and Your Dependents

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

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

Coinsurance

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

Copayments/Deductibles

Copayments are expenses to be paid by you or your Dependent for 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. Once the Deductible maximum in The Schedule has been reached you and your family need not satisfy any further medical deductible for the rest of that year.

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for In-Network and Out-of-Network charges for which no payment is provided because of the coinsurance factor and any In-Network or Out-of-Network inpatient hospital facility copayments or deductibles, outpatient facility copayments or deductibles and MRI/PET/CAT Scan copayments or deductibles. However, charges for Covered Expenses incurred for or in connection with a) non-compliance penalties, b) deductibles or c) in excess of the Maximum Reimbursable Charge levels will not accumulate toward the Out-of-Pocket Maximums and benefits for such expenses will not be increased. Once the out-of-pocket maximum as shown in The Schedule has been reached, benefits for accident or sickness are payable at 100% excluding mental health and substance abuse benefits.

Accumulation of Plan Deductibles Maximums

Deductibles and all other plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted. All In-Network services must be performed by the Primary Care Physician (PCP), referred by the PCP or approved by the local Healthplan.

Contract Year

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

**Guest Privileges**

If you or one of your Dependents will be residing temporarily in another location where there are In-Network Providers, you may be eligible for Point of Service Medical Benefits at that location. However, the benefits at the host location may differ from those described in this certificate. Refer to your Benefit Summary from the host location or contact your Employer for more information.

Multiple Surgical Reduction (Out-of-Network)

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

Assistant Surgeon and Co-Surgeon Charges**Assistant Surgeon**

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

Co-Surgeon

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

FOR ACTIVE CRAFT EMPLOYEES AND RETIRED CRAFT POST 1991 RETIRED EMPLOYEES

Plan Maximum Benefits	These Plans will Pay:	
	In-Network	Out-of-Network
Lifetime Maximum Benefit	Unlimited	

Plan Deductibles	You Pay:	
	In-Network	Out-of-Network
Individual Deductible	\$300 per person	\$400 per person



Family Deductible	<p>\$600 per family</p> <p>After In-Network Deductibles totaling \$600 have been applied in a Contract Year for either (a) you and your Dependents or (b) your Dependents, your family need not satisfy any further Medical Deductibles for the rest of that year.</p>	<p>\$800 per family</p> <p>After In-Network Deductibles totaling \$800 have been applied in a Contract Year for either (a) you and your Dependents or (b) your Dependents, your family need not satisfy any further Medical Deductibles for the rest of that year.</p>
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Out-of-Pocket Maximums	You Pay:	
	In-Network	Out-of-Network
Individual Out-of-Pocket Maximum	None	\$1,750 per person

Family Out-of-Pocket Maximum	None	<p>\$3,500 per person</p> <p>After Out-of-Network Out-of-Pocket Expenses totaling \$3,500 have been incurred in a Contract Year for either (a) you and your Dependents or (b) your Dependents, your family need not satisfy any further Out-of-Pocket Expenses for the rest of that year.</p>
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Benefits for care other than for Mental Health and Substance Abuse	How this Plan Works:	
	In-Network	Out-of-Network
	You and your Dependent pay the In-Network Deductible or Copayments and any benefit deductible shown below plus the Coinsurance, then the Plan pays the Benefit Percentage shown	You and your Dependent pay the Out-of-Network 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	\$20 per visit, then 100%	80% of R&C after plan deductible
Specialist Physician Office Visit	\$20 per visit, then 100%	80% of R&C after plan deductible
Surgery Performed in the Physician's Office	No Charge after plan's Physician or Specialist Office Visit copay	80% of R&C after plan deductible
Allergy Treatment/Injections	No Charge if visit is for injection only, otherwise \$20 per visit, then 100%	80% of R&C after plan deductible
Allergy Serum (dispensed by the Physician in the office)	No Charge	80% of R&C after plan deductible



Preventive Care		
Routine Physical, including Vision and Hearing screenings for children through age 17	\$20 per visit, then 100%	Not Covered
Child Immunizations birth to age 3	No Charge	Not Covered
Annual Routine Physicals age 18 and above	\$20 per visit, then 100%	Not Covered
Immunizations	No Charge	Not Covered
Well-Woman Coverage	\$20 per visit, then 100%	80% of R&C after plan deductible

Mammogram	No Charge	80% of R&C after plan deductible
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Pap Test	No Charge	80% of R&C after plan deductible
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Prostate Specific Antigen (PSA)	No Charge	80% of R&C after plan deductible
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Pre-Admission Testing		
Physician Office Visit	No Charge for x-ray and lab work done in Physician's office, however if other office visit services are provided, the visit will be paid the same as any other office visit	80% of R&C after plan deductible
Specialist Physician Office Visit	No Charge for x-ray and lab work done in Specialist's office, however if other office visit services are provided, the visit will be paid the same as any other Specialist office visit	80% of R&C after plan deductible
Outpatient Facility	Same as plan's Outpatient Hospital Facility Benefit for facility charges. Same as plan's Outpatient Professional Services for professional charges. Any copays for MRI/PET/CAT scans will continue to apply	80% of R&C after plan deductible
Independent Lab and X-Ray Facility	No Charge	80% of R&C after plan deductible
Inpatient Hospital Facility Services	100% after plan deductible	80% of R&C after plan deductible
Semi Private Room and Board	The Hospital's negotiated rate	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 a semi-private room
Outpatient Hospital Facility Services	No Charge after plan deductible	80% of R&C after plan deductible
Operating Room, Recovery Room, Procedure Room, and Treatment		



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

Emergency and Urgent Care Services		
Physician's Office	Same as Physician's Office Visit	Same as Physician's Office Visit
Hospital Emergency Room **	\$75 per visit, then 100% *	\$75 per visit, then 100% *
Urgent Care Facility or Outpatient Facility **	\$25 per visit, then 100% *	\$25 per visit, then 100% *
Ambulance **	No Charge	No Charge
	*Waived if Admitted ** If not a true emergency, services are not covered	*Waived if Admitted ** If not a true emergency, healthplan approval is required for coverage at the plan's out-of-network coinsurance level.



Inpatient Services at Other Health Care Facilities Includes: Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Inpatient Facility Room and Board Contract Year Maximum: Unlimited	No Charge after plan deductible The Facility's negotiated rate	Not Covered
Laboratory and Radiology Services Physician's Office Outpatient Hospital Facility X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit) Independent X-ray and/or Lab Facility Independent X-ray and/or Lab Facility in conjunction with an ER visit	No Charge No charge after the plan deductible for facility charges; No charge for outpatient professional charges No Charge No Charge No Charge	80% of R&C after plan deductible 80% of R&C after plan deductible No Charge 80% of R&C after plan deductible No Charge
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans, etc.)		



Inpatient Facility	No charge after plan deductible	80% of R&C after plan deductible
Outpatient Facility	No charge after plan deductible	80% of R&C after plan deductible
Emergency Room	No Charge	No Charge
Physician's Office	No Charge	80% of R&C after plan deductible

Home Health Care Contract Year Maximum: In-Network: Unlimited Out-of-Network: 40 visits, reduced by any In- Network visits	No Charge	80% of R&C after plan deductible
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Hospice Inpatient Facility	No Charge	80% of R&C after plan deductible
Outpatient Services	Same as plan's Home Health Care Benefit	Same as plan's Home Health Care Benefit
Hospice Room and Board	The Hospice Facility's negotiated rate	The Hospice Facility's most common daily rate for a semi-private room

Bereavement Counseling Inpatient (Same as Inpatient Hospice Facility)	No charge for services provided as part of the Hospice Care Program	80% of R&C after plan deductible, for services provided as part of the Hospice Care Program
Outpatient (Same as Outpatient Hospice)	No charge for services provided as part of the Hospice Care Program	80% of R&C after plan deductible, for services provided as part of the Hospice Care Program



Contract Year Maximum: Unlimited		
Outpatient Short-Term Rehabilitative Therapy Contract Year Maximum: Unlimited Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Chiropractic Care Contract Year Maximum: In-Network: Unlimited Out-of-Network: 20 visits, reduced by any In- Network visits Maintenance Physiotherapy Limited to 2 sessions per month; 24 sessions per calendar year	\$20 per visit, then 100% \$20 per visit, then 100% \$20 per session, then 100%	80% of R&C after plan deductible 80% of R&C after plan deductible 80% of R&C after plan deductible
Maternity Initial Visit to Confirm Pregnancy All Subsequent Physician's charges for Prenatal Visits, Postnatal Visits, and Delivery Delivery (Inpatient Hospital, Birthing Center)	\$20 per visit, then 100% No Charge Same as plan's Inpatient Hospital Facility Benefit	80% of R&C after plan deductible 80% of R&C after plan deductible Same as plan's Inpatient Hospital Facility Benefit



Abortion (Includes elective and non-elective procedures)		
Inpatient Facility	Same as plan's Inpatient Hospital Facility Benefit	Same as plan's Inpatient Hospital Facility Benefit
Outpatient Facility	Same as plan's Outpatient Hospital Facility Benefit	Same as plan's Outpatient Hospital Facility Benefit
Physician's Services	No Charge	80% of R&C after plan deductible

Family Planning		
Office Visits including Tests and Counseling	\$20 per visit, then 100%	80% of R&C after plan deductible
Surgical Sterilization Procedures for Vasectomy/Tubal Ligations (excluding reversals)		
Inpatient Facility	Same as plan's Inpatient Hospital Facility Benefit	Same as plan's Inpatient Hospital Facility Benefit
Outpatient Facility	Same as plan's Outpatient Hospital Facility Benefit	Same as plan's Outpatient Hospital Facility Benefit
Physician's Services	No Charge	80% of R&C after plan deductible



Infertility Treatment		
Office Visit (Tests, Counseling)	Same as plan's Specialist Physician Office Visit	80% of R&C after plan deductible
Surgical Treatment: Limited to Procedures for Correction of Infertility (excludes Artificial Insemination, In Vitro Fertilization, GIFT, ZIFT, and similar procedures)	No Charge	
Inpatient Facility	Same as plan's Inpatient Hospital Facility Benefit	80% of R&C after plan deductible
Outpatient Facility	Same as plan's Outpatient Hospital Facility Benefit	80% of R&C after plan deductible
Physician's Services	No Charge	80% of R&C after plan deductible

Organ Transplants Includes all medically appropriate non-experimental transplants		
Lifesource Facility	No Charge	80% of R&C after plan deductible
Other Inpatient Hospital Facility	Same as plan's Inpatient Hospital Facility benefit	Same as plan's Inpatient Hospital Facility Benefit
Physician's Services Lifesource Physician	No Charge	80% of R&C after plan deductible
Non-Lifesource Physician	No Charge	80% of R&C after plan deductible

Travel Services Maximum (Covered only when transplant procedure is performed at a Lifesource Facility)	\$10,000 Per Transplant Per Lifetime Maximum	Not Covered
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Durable Medical Equipment Contract Year Maximum: Unlimited	No Charge	80% of R&C after plan deductible
External Prosthetic Appliances Contract Year Maximum: Unlimited	No Charge	80% of R&C after plan deductible
Dental Care (Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth) Inpatient Facility Outpatient Facility Physician's Services	 Same as plan's Inpatient Hospital Facility benefit Same as plan's Outpatient Hospital Facility benefit No Charge	 Same as plan's Inpatient Hospital Facility benefit Same as plan's Outpatient Hospital Facility benefit 80% of R&C after plan deductible
Temporomandibular Joint Disorder (Surgical & Non-Surgical Treatment) Office Visit Inpatient Facility Outpatient Facility Physician's Services	 \$20 per visit, then 100% Same as plan's Inpatient Hospital Facility Benefit Same as plan's Outpatient Hospital Facility Benefit No Charge	 80% of R&C after plan deductible Same as plan's Inpatient Hospital Facility benefit Same as plan's Outpatient Facility Services benefit 80% of R&C after plan deductible
All Other Covered Expenses	100% after plan deductible	80% of R&C after plan deductible



FOR RETIRED MANAGEMENT PRE-1992 EMPLOYEES and RETIRED CRAFT PRE-1992 EMPLOYEES

Plan Maximum Benefits	These Plans will Pay:	
	In-Network	Out-of-Network
Lifetime Maximum Benefit	Unlimited	

Plan Deductibles	You Pay:	
	In-Network	Out-of-Network
Individual Deductible	\$200 per person	\$300 per person

Family Deductible	<p>\$450 per family</p> <p>After In-Network Deductibles totaling \$450 have been applied in a Contract Year for either (a) you and your Dependents or (b) your Dependents, your family need not satisfy any further Medical Deductibles for the rest of that year.</p>	<p>\$600 per family</p> <p>After Out-of-Network Deductibles totaling \$600 have been applied in a Contract 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 Maximums	You Pay:	
	In-Network	Out-of-Network
Individual Out-of-Pocket Maximum	None	\$1,750 per person



Family Out-of-Pocket Maximum	None	<p>\$3,500 per family</p> <p>After Out-of-Network Out-of-Pocket Expenses totaling \$3,500 have been incurred in a Contract Year for either (a) you and your Dependents or (b) your Dependents, your family need not satisfy any further Out-of-Pocket Expenses for the rest of that year.</p>
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Benefits for care other than for Mental Health and Substance Abuse	How this Plan Works:	
	In-Network	Out-of-Network
	You and your Dependent pay the In-Network Deductible or Copayments and any benefit deductible shown below plus the Coinsurance, then the Plan pays the Benefit Percentage shown	You and your Dependent pay the Out-of-Network 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	\$15 per visit, then 100%	80% of R&C after plan deductible
Specialist Physician Office Visit	\$15 per visit, then 100%	80% of R&C after plan deductible
Surgery Performed in the Physician's Office	No Charge after plan's Physician or Specialist Office Visit copay	80% of R&C after plan deductible
Allergy Treatment/Injections	No Charge if visit is for injection only, otherwise \$15 per visit, then 100%	80% of R&C after plan deductible
Allergy Serum (dispensed by the Physician in the office)	No Charge	80% of R&C after plan deductible



Preventive Care		
Routine Physical, including Vision and Hearing screenings for children through age 17	\$15 per visit, then 100%	Not Covered
Child Immunizations birth to age 3	No Charge	Not Covered
Annual Routine Physicals age 18 and above	\$15 per visit, then 100%	Not Covered
Immunizations	No Charge	Not Covered
Well-Woman Coverage	\$15 per visit, then 100%	80% of R&C after plan deductible

Mammogram	No Charge	80% of R&C after plan deductible
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Pap Test	No Charge	80% of R&C after plan deductible
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Prostate Specific Antigen (PSA)	No Charge	80% of R&C after plan deductible
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Pre-Admission Testing		
Physician Office Visit	No Charge for x-ray and lab work done in Physician's office, however if other office visit services are provided, the visit will be paid the same as any other office visit	80% of R&C after plan deductible
Specialist Physician Office Visit	No Charge for x-ray and lab work done in Specialist's office, however if other office visit services are provided, the visit will be paid the same as any other Specialist office visit	80% of R&C after plan deductible
Outpatient Facility	Same as plan's Outpatient Hospital Facility Benefit for facility charges. Same as plan's Outpatient Professional Services for professional charges. Any copays for MRI/PET/CAT scans will continue to apply	80% of R&C after plan deductible
Independent Lab and X-Ray Facility	No Charge	80% of R&C after plan deductible
Inpatient Hospital Facility Services	100% after plan deductible	80% of R&C after plan deductible
Semi Private Room and Board	The Hospital's negotiated rate	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 a semi-private room
Outpatient Hospital Facility Services	No Charge after plan deductible	80% of R&C after plan deductible
Operating Room, Recovery Room, Procedure Room, and Treatment		



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

Emergency and Urgent Care Services		
Physician's Office	Same as Physician's Office Visit	Same as Physician's Office Visit
Hospital Emergency Room **	\$25 per visit, then 100% *	\$25 per visit, then 100% *
Urgent Care Facility or Outpatient Facility **	\$25 per visit, then 100% *	\$25 per visit, then 100% *
Ambulance **	No Charge	No Charge
	*Waived if Admitted ** If not a true emergency, services are not covered	*Waived if Admitted ** If not a true emergency, healthplan approval is required for coverage at the plan's out-of-network coinsurance level.



Inpatient Services at Other Health Care Facilities Includes: Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Inpatient Facility Room and Board Contract Year Maximum: Unlimited	No Charge after plan deductible The Facility's negotiated rate	Not Covered
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Laboratory and Radiology Services Physician's Office Outpatient Hospital Facility X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit) Independent X-ray and/or Lab Facility Independent X-ray and/or Lab Facility in conjunction with an ER visit	No Charge No charge after the plan deductible for facility charges; No charge for outpatient professional charges No Charge No Charge No Charge	80% of R&C after plan deductible 80% of R&C after plan deductible No Charge 80% of R&C after plan deductible No Charge
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Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans, etc.)		
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Inpatient Facility	No charge after plan deductible	80% of R&C after plan deductible
Outpatient Facility	No charge after plan deductible	80% of R&C after plan deductible
Emergency Room	No Charge	No Charge
Physician's Office	No Charge	80% of R&C after plan deductible

Home Health Care Contract Year Maximum: In-Network: Unlimited Out-of-Network: 40 visits, reduced by any In- Network visits	No Charge	80% of R&C after plan deductible
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Hospice		
Inpatient Facility	No Charge	80% of R&C after plan deductible
Outpatient Services	Same as plan's Home Health Care Benefit	Same as plan's Home Health Care Benefit
Hospice Room and Board	The Hospice Facility's negotiated rate	The Hospice Facility's most common daily rate for a semi-private room

Bereavement Counseling		
Inpatient (Same as Inpatient Hospice Facility)	No charge for services provided as part of the Hospice Care Program	80% of R&C after plan deductible, for services provided as part of the Hospice Care Program
Outpatient (Same as Outpatient Hospice)	No charge for services provided as part of the Hospice Care Program	80% of R&C after plan deductible, for services provided as part of the Hospice Care Program



Contract Year Maximum: Unlimited		
Outpatient Short-Term Rehabilitative Therapy Contract Year Maximum: Unlimited Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Chiropractic Care Contract Year Maximum: In-Network: Unlimited Out-of-Network: 20 visits, reduced by any In- Network visits Maintenance Physiotherapy Limited to 2 sessions per month; 24 sessions per calendar year	\$15 per visit, then 100% \$15 per visit, then 100% \$15 per session, then 100%	80% of R&C after plan deductible 80% of R&C after plan deductible 80% of R&C after plan deductible
Maternity Initial Visit to Confirm Pregnancy All Subsequent Physician's charges for Prenatal Visits, Postnatal Visits, and Delivery Delivery (Inpatient Hospital, Birthing Center)	\$15 per visit, then 100% No Charge Same as plan's Inpatient Hospital Facility Benefit	80% of R&C after plan deductible 80% of R&C after plan deductible Same as plan's Inpatient Hospital Facility Benefit



Abortion (Includes elective and non-elective procedures)		
Inpatient Facility	Same as plan's Inpatient Hospital Facility Benefit	Same as plan's Inpatient Hospital Facility Benefit
Outpatient Facility	Same as plan's Outpatient Hospital Facility Benefit	Same as plan's Outpatient Hospital Facility Benefit
Physician's Services	No Charge	80% of R&C after plan deductible

Family Planning		
Office Visits including Tests and Counseling	\$15 per visit, then 100%	80% of R&C after plan deductible
Surgical Sterilization Procedures for Vasectomy/Tubal Ligations (excluding reversals)		
Inpatient Facility	Same as plan's Inpatient Hospital Facility Benefit	Same as plan's Inpatient Hospital Facility Benefit
Outpatient Facility	Same as plan's Outpatient Hospital Facility Benefit	Same as plan's Outpatient Hospital Facility Benefit
Physician's Services	No Charge	80% of R&C after plan deductible



Infertility Treatment		
Office Visit (Tests, Counseling)	Same as plan's Specialist Physician Office Visit	80% of R&C after plan deductible
Surgical Treatment: Limited to Procedures for Correction of Infertility (excludes Artificial Insemination, In Vitro Fertilization, GIFT, ZIFT, and similar procedures)	No Charge	
Inpatient Facility	Same as plan's Inpatient Hospital Facility Benefit	80% of R&C after plan deductible
Outpatient Facility	Same as plan's Outpatient Hospital Facility Benefit	80% of R&C after plan deductible
Physician's Services	No Charge	80% of R&C after plan deductible

Organ Transplants Includes all medically appropriate non-experimental transplants		
Lifesource Facility	No Charge	80% of R&C after plan deductible
Other Inpatient Hospital Facility	Same as plan's Inpatient Hospital Facility benefit	Same as plan's Inpatient Hospital Facility Benefit
Physician's Services Lifesource Physician	No Charge	80% of R&C after plan deductible
Non-Lifesource Physician	No Charge	80% of R&C after plan deductible

Travel Services Maximum (Covered only when transplant procedure is performed at a Lifesource Facility)	\$10,000 Per Transplant Per Lifetime Maximum	Not Covered
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Durable Medical Equipment Contract Year Maximum: Unlimited	No Charge	80% of R&C after plan deductible
External Prosthetic Appliances Contract Year Maximum: Unlimited	No Charge	80% of R&C after plan deductible
Dental Care (Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth) Inpatient Facility Outpatient Facility Physician's Services	 Same as plan's Inpatient Hospital Facility benefit Same as plan's Outpatient Hospital Facility benefit No Charge	 Same as plan's Inpatient Hospital Facility benefit Same as plan's Outpatient Hospital Facility benefit 80% of R&C after plan deductible
Temporomandibular Joint Disorder (Surgical & Non-Surgical Treatment) Office Visit Inpatient Facility Outpatient Facility Physician's Services	 \$15 per visit, then 100% Same as plan's Inpatient Hospital Facility Benefit Same as plan's Outpatient Hospital Facility Benefit No Charge	 80% of R&C after plan deductible Same as plan's Inpatient Hospital Facility benefit Same as plan's Outpatient Facility Services benefit 80% of R&C after plan deductible
All Other Covered Expenses	100% after plan deductible	80% of R&C after plan deductible



Point of Service Medical Benefits

Certification Requirements - Out-of-Network

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

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

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

Covered Expenses incurred will not include the first \$250 of Hospital charges made for each separate admission to the Hospital:

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

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

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

GM6000 PAC1V33C

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 PAC2V9C

Outpatient Certification Requirements - Out-of-Network

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

Covered Expenses incurred will not include the first \$250 for charges made for any outpatient diagnostic testing or procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

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

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

Diagnostic Testing and Outpatient Procedures

Including, but not limited to:

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

Hysterectomy

GM6000 SC1 PAC4OCR8V5

Prior Authorization/Pre-Authorized

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

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

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



- intensive outpatient programs;
- advanced radiological imaging;
- nonemergency ambulance; or
- transplant services.

GM6000 05BPT16 V6

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 member of your family or your Dependent's family, for professional nursing service.

GM6000 CM5
FLX107V126

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

GM6000 CM6
FLX108V745

- charges made for a mammogram for women ages 40 and older, annually, or at any age for women at risk, when recommended by a Physician.
- charges made for an annual Papanicolaou laboratory screening test.
- charges made for an annual prostate-specific antigen test (PSA).
- charges for appropriate counseling, medical services connected with surgical therapies, including vasectomy and tubal ligation.
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives.
- charges made for In-Network Routine Preventive Care, including immunizations. Routine Preventive Care means health care assessments, wellness visits and any related services.

GM6000 CM6
FLX108V746

- charges made for medical diagnostic services to determine the cause of erectile dysfunction. Penile implants are covered for an established medical condition that clearly is the cause of erectile dysfunction, such as postoperative prostatectomy and diabetes. Penile implants are not covered as treatment of psychogenic erectile dysfunction.
- surgical or nonsurgical treatment of TMJ Dysfunction excluding appliances and orthodontic treatment..
- charges made for acupuncture/acupressure.
- charges made for rhinoplasty or blepharoplasty surgery, if medically necessary.

GM6000 INDEM62 V26

Nutritional Evaluation

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



obesity.

Internal Prosthetic/Medical Appliances

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

GM6000 05BPT2 V1

Home Health Care Services

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

Home Health Care Services are provided under the terms of a Home Health Care plan for the person named in that plan.

If you are a minor or an adult who is dependent upon others for nonskilled care (e.g. bathing, eating, toileting), Home Health Care Services will only be provided for you during times when there is a family member or care giver present in the home to meet your nonskilled care needs.

Home Health Care Services are those skilled health care services that can be provided during intermittent visits of two hours or less by Other Health Care Professionals. Home Health Services are subject to a maximum of 24 hours in total per day. Necessary consumable medical supplies, home infusion therapy, and Durable Medical Equipment administered or used by Other Health Care Professionals in providing Home Health Care Services are covered. Home Health Care Services do not include services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house. Physical, occupational, and speech therapy provided in the home are subject to the benefit limitations described under "Short-Term Rehabilitative Therapy."

GM6000 INDEM2 V16

Hospice Care Services

- charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
 - by a Hospice Facility for Bed and Board and Services and Supplies, except that, for any day of confinement in a private room, Covered Expenses will not include that portion of charges which is more than the Hospice Bed and Board Daily Limit shown in The Schedule;

- by a Hospice Facility for services provided on an outpatient basis;
- by a Physician for professional services;
- by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
- for pain relief treatment, including drugs, medicines and medical supplies;
- by an Other Health Care Facility for:
 - part-time or intermittent nursing care by or under the supervision of a Nurse;
 - part-time or intermittent services of an Other Health Care Professional;

GM6000 CM34 FLX124V26

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

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

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

GM6000 CM35
FLX124V27

Durable Medical Equipment

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



alternative as determined by the utilization review Physician.

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

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

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

GM6000 05BPT3

External Prosthetic Appliances and Devices

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

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

Prostheses/Prosthetic Appliances and Devices

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

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

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

Orthoses and Orthotic Devices

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

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

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:
 - No more than once every 24 months for persons 19 years of age and older and
 - No more than once every 12 months for persons 18 years of age and under.
- Replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:

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

GM6000 05BPT5 (2)

Infertility Services

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

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

- Infertility drugs;

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

GM6000 05BPT6 V2

Short-Term Rehabilitative Therapy

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

The following limitations apply to Short-term Rehabilitative Therapy:

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

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

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

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

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



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

Chiropractic Care Services

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

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

GM6000 05BPT9 (2)

Covered Expenses

Chiropractic Care Services

The following limitations apply to Chiropractic Care Services:

- To be covered, all therapy services must be restorative in nature. Restorative Therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of Injury or Sickness. Restorative Therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the Injury or Sickness.
- Services are not covered if they are considered custodial, training, developmental or educational in nature.
- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.
- services of a chiropractor which are not within his scope of practice, as defined by state law;
- charges for care not provided in an office setting;
- Maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status;
- Vitamin therapy;
- Massage therapy in the absence of other modalities.

GM6000 05BPT10

Transplant Services

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

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

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

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

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

Transplant Travel Services

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

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



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

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

GM6000 05BPT7 V7 (2)

Breast Reconstruction and Breast Prostheses

- charges made for reconstructive surgery following a mastectomy, if the insured chooses to have surgery, and in the manner chosen by the insured and Physician. Services and benefits include:
 - surgical services for reconstruction of the breast on which surgery was performed;
 - surgical services for reconstruction of the nondiseased breast to produce symmetrical appearance;
 - postoperative breast prostheses; and
 - mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs.

During all stages of mastectomy, treatment of physical complications, including lymphedema therapy are covered.

Cosmetic Surgery

Charges made for cosmetic surgery or therapy to repair or correct severe facial disfigurements or severe physical deformities that are congenital or result from developmental abnormalities (other than abnormalities of the jaw or TMJ disorder), tumors, trauma, disease or the complications of Medically Necessary non-cosmetic surgery.

Reconstructive surgery for correction of congenital birth defects or developmental abnormalities must be performed prior to your attainment of age 19. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement, as determined by CG.

GM6000 INDEM13 V12

Medical Conversion Privilege For You and Your Dependents

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy). A Converted Policy will be issued by CG only to a person who is Entitled to Convert, and only if he applies in writing and pays the first premium for the Converted Policy to CG within 31 days after

the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled to Convert

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

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

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

Dependents Entitled to Convert

The following Dependents are also Entitled to Convert:

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

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

GM6000 CON1

Overinsured

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

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



available for the person by or through any state, provincial or federal law.

Converted Policy

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

GM6000 CON26

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

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

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

GM6000 CON29

Exclusions, Expenses Not Covered and General Limitations

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

- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.

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

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

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



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

- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- for medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute guideline is covered if the services are demonstrated, through peer-reviewed medical literature and scientifically based guidelines, to be safe and effective for treatment of the condition.
- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- private Hospital rooms and/or private duty nursing unless determined by the utilization review Physician to be Medically Necessary.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- medical benefits for eyeglasses, contact lenses or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery.
- charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.
- nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent,



when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.

- medical treatment when payment is denied by a Primary Plan because treatment was received from a nonparticipating provider.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- telephone, e-mail, and Internet consultations, and telemedicine.
- massage therapy.
- for charges which would not have been made if the person had no insurance.
- to the extent that they are more than Maximum Reimbursable Charges.
- expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure.
- charges made by any covered provider who is a member of your family or your Dependent's family.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- for genetic testing and therapy including germ line and somatic unless determined Medically Necessary by CG for the purpose of making treatment decisions.
- for orthognathic treatment/surgery, including but not limited to treatment/surgery for mandibular or maxillary prognathism, microprognathism or malocclusion, surgical augmentation for orthodontics, or maxillary constriction. However, Medically Necessary treatment of TMJ disorder is covered.

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GM6000 05BPT105

Coordination Of Benefits

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

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

Definitions

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

Plan

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

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

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

Closed Panel Plan

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

Primary Plan

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

Secondary Plan

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

GM6000 MOB1

Reasonable Cash Value

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

Order of Benefit Determination Rules

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

- The Plan that covers a person as an enrollee or an employee shall be the Primary Plan and the Plan that covers that person as a Dependent shall be the Secondary Plan;
- For a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year;



- For the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
 - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
 - then, the Plan of the parent with custody of the child;
 - then, the Plan of the spouse of the parent with custody of the child;
 - then, the Plan of the noncustodial parent of the child, and
 - finally, the Plan of the spouse of the parent not having custody of the child.

GM6000 MOB2

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

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

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

Effect on the Benefits of This Plan

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

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

GM6000 MOB3

Recovery of Excess Benefits

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

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

Right to Receive and Release Information

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

GM6000 MOB4

Medicare Eligibles

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

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



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

GM6000 MEL23 V4

Once you or your dependents meet the eligibility requirements for Medicare, if you enroll in Medicare Part A but fail to elect coverage for Medicare Part B, your Part A eligible charges will process secondary to Medicare and there is no coverage under the Plan for Medicare Part B eligible charges.

If you elect not to enroll in Medicare Part A and Medicare Part B, you have no benefits under the Plan for any A or B Medicare eligible service.

Right of Reimbursement

The Policy does not cover:

1. Expenses for which another party may be responsible as a result of liability for causing or contributing to the injury or illness of you or your Dependent(s).
2. Expenses to the extent they are covered under the terms of any automobile medical, automobile no fault, uninsured or underinsured motorist, workers' compensation, government insurance, other than Medicaid, or similar type of insurance or coverage when insurance coverage provides benefits on behalf of you or your Dependent(s).

If you or a Dependent incur health care Expenses as described in (1) and (2) above, Connecticut General shall automatically have a lien upon the proceeds of any recovery by you or your Dependent(s) from such party to the extent of any benefits provided to you or your Dependent(s) by the Policy. You or your Dependent(s) or their representative shall execute such

documents as may be required to secure Connecticut General's rights. Connecticut General shall be reimbursed the lesser of: the amount actually paid by CG [or the HealthPlan] under the Policy; or

an amount actually received from the third party;

at the time that the third party's liability is determined and satisfied; whether by settlement, judgment, arbitration or otherwise.

GM6000 CCP1 CCL1V4

Payment of Benefits

To Whom Payable

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

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

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

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

Time of Payment

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

Recovery of Overpayment

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



Calculation of Covered Expenses

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

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

GM6000 TRM366

Federal Information

Coverage for Reconstructive Surgery Following Mastectomy

When a person who is insured for benefits under this certificate and 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 Employer.

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 Directories and Provider Networks

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

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

NOT85

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 Employer, until the earliest of the following:

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

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

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

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

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.

GM6000 NOT99

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, as amended, 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 Employer 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 state 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

Continuation Required By Federal Law

For You and Your Dependents

The Continuation Required by Federal Law does not apply to any benefits for loss of life, dismemberment or loss of income.

Federal 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 (other than for gross misconduct). Federal law also enables your Dependents to continue health insurance if their coverage ceases due to your death, 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 Employer's group health plan(s) and is subject to federal law, regulations and interpretations.

A. Employees 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 other than gross misconduct, you or your Dependent may continue health insurance upon payment of the required premium to the Employer. 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; (b) the date notice of the right to continue insurance is sent; or (c) the date the insurance would otherwise cease. You must pay the first premium within 45 days from the date you elect to continue coverage. 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;
- after you elect to continue this insurance, the date you first become entitled to Medicare, and for your Dependent, the date he first becomes entitled to Medicare;

- after you elect to continue this insurance, for you, the date you first become covered 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.

COBRA13

B. Dependent Continuation Provision

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

- (1) your death;
- (2) divorce or legal separation; or
- (3) 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 Employer. In the case of (2) or (3) above, you or your Dependent must notify your Employer 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 the right to continue insurance is sent.

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

- 36 months from the date of (1), (2) or (3) 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;
- after the Dependent elects to continue this insurance, the date the Dependent first becomes entitled to Medicare;
- the date the policy cancels; or
- after the Dependent elects to continue this insurance, the date the Dependent first 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.

C. Subsequent Events Affecting Dependent Coverage

If, within the initial 18-month continuation period, your Dependent would lose coverage because of an event described in (1), (2), or (3) of Section B, or because of your coverage loss due to your subsequent entitlement to Medicare, 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.

COBRA14



If your employment ends or your work hours are reduced within 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 36 months from the date you become entitled to Medicare.

If your employment ends or your work hours are reduced more than 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 18 months from the date your employment ends or your work hours are reduced.

Disabled Individuals Continuation Provisions

If you or your Dependent is disabled before or within the first 60 days of continuation of coverage which follow termination of employment or a reduction in work hours, the disabled person may continue health insurance for up to an additional 11 months beyond the 18-month period.

If you or your Dependents who are not disabled elect to continue coverage, such family members of the disabled person may extend coverage for up to an additional 11 months, if they otherwise remain eligible, and notice of disability is provided as described in (b), below.

To be eligible you or your Dependent must:

- be declared disabled as of a day before or during the first 60 days of continuation, under Title II or XVI by the Social Security Administration; and
- 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 for all covered persons during the additional 11 months will occur if the disabled person is found by the Social Security Administration to be no longer disabled. Termination for this reason 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 described in Sections A and B which apply to the initial 18 months will also apply to any or all covered persons for any additional months of coverage.

COBRA4

D. Effect of Employer Chapter 11 Proceedings on Retiree Coverage

If you are covered as a retiree, and a proceeding under USC Chapter 11, bankruptcy for the Employer results in a substantial loss of coverage for you or your Dependents within one year before or after such proceeding, coverage will continue until: (a) for you, your death; and (b) for your Dependent surviving spouse or Dependent child, up to 36 months from your death.

COBRA15

E. Payment of Premium

This Plan may require the payment of an amount that does not exceed 102% of the applicable premium, except this Plan may require payment of up to 150% of the Applicable Premium for any extended period of continuation coverage for a covered person who is disabled. The additional 48% may only be applied to the premium for the rating category that includes the disabled individual, and only for the additional 11 months.

Applicable Premium is determined as follows:

1. if the Employee alone elects to continue coverage, the Employee will be charged the active Employee rate.
2. if a Dependent spouse alone elects to continue coverage, the spouse will be charged the active Employee rate.
3. if a Dependent child or children elect to continue coverage without a parent also electing the continuation, each child will be charged the active Employee rate.
4. if the entire family elects to continue coverage, they will be charged the family rate.
5. if the Schedule of Premium Rates is set up on a step-rate basis, the active rate basis that fits the individuals who elect to continue his coverage is the rate that will be charged. If only children elect to continue coverage, each child will be charged the Employee Only rate.

Timely Payment

If payment is made within the grace period in an amount not significantly less than the amount the Plan requires to be paid, the amount must be deemed to satisfy the Plan's requirement. However, you must be notified and allowed at least 30 days after notice is provided for payment to be made.

F. Providing Notification of Your Status to Health Care Providers During the Grace Period

If, after you elect to continue coverage, a health care provider contacts this Plan to confirm coverage for a period for which premium has not yet been received, the Plan must give a complete and accurate response.

GM6000 COBRA17

G. Notification Requirements

Your Employer should send you initial notification of coverage continuation rights as required by federal law; (a) when the Plan first becomes subject to federal continuation requirements; (b) when you are hired; and (c) when you add a spouse as a Dependent for benefits under the Plan. Receipt of



this certificate may serve as such notice.

If you become eligible to continue coverage per federal law, your Employer must send you notification within 14 days. If the Plan has a Plan Administrator, the Employer must notify the Plan Administrator within 30 days. The Plan Administrator must notify you within 14 days, thereafter.

If eligibility to continue coverage is due to divorce, legal separation or a Dependent child losing eligibility for coverage under the Plan, you or your Dependent spouse must notify your Employer within 60 days of such event. Your Employer must notify you of the right to continue coverage within 14 days after receipt of notification of such event.

GM6000 COBRA18

Conversion Available Following Continuation

If you or your Dependent's Continuation ends due to the expiration of the maximum 18-, 29- or 36-month continuation period, whichever applies, you or your Dependent may be entitled to convert to the insurance in accordance with the Medical Conversion benefit then available to Employees 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) the continuation required by federal law; or (2) any other continuation of insurance provided in this Certificate.

Newly Acquired Dependents

If, while your insurance is being continued under the continuation required by federal law provisions, 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.

If events (1) or (2) of Section B should subsequently occur for your newly acquired Dependent spouse, such spouse will not be entitled to continue his insurance. However, your Dependent child will be able to continue his insurance.

If events described in Section C should subsequently occur for your child who is born, adopted or placed for adoption as a newly acquired Dependent, coverage will be continued according to that section.

COBRAS

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 Employee under the terms of that Act.

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

B. Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, 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.

GM6000 TRM191V1

ERISA Required Information

The name of the Umbrella Plan is:

The AT&T Umbrella Benefit Plan No. 1

The names of the Plans are:

The BellSouth Medical Assistance Plan

The BellSouth Retiree Medical Assistance Plan

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

AT&T Inc.
P.O. Box 29690
San Antonio, TX 78229
(210) 351-3333



Employer Identification
Number (EIN)

43-1301883

Plan Number

600

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

Employer named above

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

Employer named above (May be Plan trustee, if any; or Plan Administrator.)

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

The CG Claim Office responsible for this Plan

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

The Plan's fiscal year ends on 12/31

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

GM6000 ERISA31

Plan Trustees

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

Plan Type

The Plan is a healthcare benefit plan.

Collective Bargaining Agreements

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

Discretionary Authority

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

GM6000 ERISA29

Plan Modification, Amendment and Termination

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

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

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

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

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

GM6000 ERISA15

Statement of Rights

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

Receive Information about Your Plan and Benefits

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union



halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your federal continuation coverage rights.
- reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect federal continuation coverage, when your federal continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

ERISA39

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or federal court.

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

GM6000 ERISA20

Claim Determination Procedures Under ERISA

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

Procedures Regarding Medical Necessity Determinations

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

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

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



Preservice Medical Necessity Determinations

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

ERISA21

If the determination periods above would (a) seriously jeopardize your life or health, your ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, CG will make the preservice determination on an expedited basis. CG's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. CG will notify you or your representative of an expedited determination within 72 hours after receiving the request. However, if necessary information is missing from the request, CG will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to CG within 48 hours after receiving the notice. CG will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

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

Concurrent Medical Necessity Determinations

When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a required concurrent medical necessity determination at least 24 hours prior to the

expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, CG will notify you or your representative of the determination within 24 hours after receiving the request.

Postservice Medical Necessity Determinations

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

ERISA22

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

Postservice Claim Determinations

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

Notice of Adverse Determination

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



applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; (6) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

ERISA33

Assistance With Your Questions

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

CG will provide administrative services of the following nature: Claim Administration; Cost Containment; Financial; Banking and Billing Administration.

Benefits provided under this plan are self-insured by the Employer.

This document is issued by:

Connecticut General Life Insurance Company
900 Cottage Grove Road
Hartford, CT 06152

ERISA41

When You Have A Complaint Or An Appeal

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

For the purposes of this section, any reference to "you," "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

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

Start With Member Services

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

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

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

Level One Appeal

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

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

GM6000 APL257

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



CG will respond orally with a decision within 72 hours, followed up in writing.

Level-Two Appeal

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

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

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

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

GM6000 APL258

Independent Review Procedure

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

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

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

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

The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your medical condition, as determined by CG's Physician reviewer, the review shall be completed within three days.

The Independent Review Program is a voluntary program arranged by CG.

GM6000 APL261

Notice of Benefit Determination on Appeal

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

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

Relevant Information

Relevant Information is any document, record, or other information which: (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard



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

Legal Action

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

GM6000 APL260

Arbitration

This provision does not apply to dental plans.

To the extent permitted by law, any controversy between CG and the Group, or an insured (including any legal representative acting on behalf of a Member), arising out of or in connection with this Certificate may be submitted to arbitration upon written notice by one party to another. Such arbitration shall be governed by the provisions of the Commercial Arbitration Rules of the American Arbitration Association, to the extent that such provisions are not inconsistent with the provisions of this section.

If the parties cannot agree upon a single arbitrator within 30 days of the effective date of the written notice of arbitration, each party shall choose one arbitrator within 15 working days after the expiration of such 30-day period and the two arbitrators so chosen shall choose a third arbitrator, who shall be an attorney duly licensed to practice law in the applicable state. If either party refuses or otherwise fails to choose an arbitrator within such 15 working day period, the arbitrator chosen shall choose a third arbitrator in accordance with these requirements.

The arbitration hearing shall be held within 30 days following appointment of the third arbitrator, unless otherwise agreed to by the parties. If either party refuses to or otherwise fails to participate in such arbitration hearing, such hearing shall proceed and shall be fully effective in accordance with this section, notwithstanding the absence of such party.

The arbitrator(s) shall render his (their) decision within 30 days after the termination of the arbitration hearing. To the extent permitted by law, the decision of the arbitrator, or the decision of any two arbitrators if there are three arbitrators, shall be binding upon both parties conclusive of the

controversy in question, and enforceable in any court of competent jurisdiction.

No party to this Certificate shall have a right to cease performance of services or otherwise refuse to carry out its obligations under this Certificate pending the outcome of arbitration in accordance with this section, except as otherwise specifically provided under this Certificate.

GM6000 ARB2

Definitions

Active Service

Please refer to the Health and Insurance Plan for Retirees Summary Plan Description and Health and Insurance Plan for Represented Employees Summary Plan Description.

Bed and Board

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

DFS14

Charges

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

DFS940

Chiropractic Care

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

DFS1689

Custodial Services

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



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

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking, (b) grooming, (c) bathing, (d) dressing, (e) getting in or out of bed, (f) toileting, (g) eating, (h) preparing foods, or (i) taking medications that can be self administered, and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

DFS1812

Dependent

Please refer to the Health and Insurance Plan for Retirees Summary Plan Description and Health and Insurance Plan for Represented Employees Summary Plan Description.

Domestic Partner

Please refer to the Health and Insurance Plan for Retirees Summary Plan Description and Health and Insurance Plan for Represented Employees Summary Plan Description.

Emergency Services

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

DFS1533

Employee

Please refer to the Health and Insurance Plan for Retirees Summary Plan Description and Health and Insurance Plan for Represented Employees Summary Plan Description.

Employer

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

DFS1595

Expense Incurred

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

DFS60

Free-Standing Surgical Facility

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

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

DFS682

Hospice Care Program

The term Hospice Care Program means:

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

DFS70



Hospice Care Services

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

DFS599

Hospice Facility

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

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

DFS72

Hospital

The term Hospital means:

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

DFS1748

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 Mental Health and Substance Abuse Services in a Partial Hospitalization program;
- receiving treatment for Substance Abuse Services in a Substance Abuse Residential Treatment Center.

DFS1815

Injury

The term Injury means an accidental bodily injury.

DFS147

In-Network/Out-of-Network

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

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

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

DFS1694

Maintenance Treatment

The term Maintenance Treatment means:

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

DFS1650

Maximum Reimbursable Charge

The Maximum Reimbursable Charge is the lesser of:

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

To determine if a charge exceeds the Maximum Reimbursable Charge, the nature and severity of the Injury or Sickness may



be considered.

CG uses the Ingenix Prevailing Health Care System database to determine the charges made by providers in an area. The database is updated semiannually.

The policyholder-selected percentile used to determine the Maximum Reimbursable Charge can be obtained by contacting Member Services/Customer Service.

Additional information about the Maximum Reimbursable Charge is available upon request.

GM6000 DFS1814

Medicaid

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

DFS192

Medically Necessary/Medical Necessity

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

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

DFS1813

Medicare

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

DFS149

Necessary Services and Supplies

The term Necessary Services and Supplies includes any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies

actually used during Hospital Confinement.

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

DFS285

Nurse

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

DFS155

Other Health Care Facility

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

DFS1686

Other Health Professional

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

DFS1685

Participating Provider

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

DFS1910



Physician

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

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

DFS164

Preventive Treatment

The term Preventive Treatment means:

- treatment rendered to prevent disease or its recurrence.

DFS1652

Primary Care Physician

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

DFS622

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include: (1) any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is: (a) operating within the scope of his license; and (b) performing a service for which benefits are provided under this plan when performed by a Psychologist; and (2) any psychotherapist while he is providing care authorized by the Provider Organization if he is: (a) state licensed or nationally certified by his professional discipline; and (b) performing a service for which benefits are provided under this plan when performed by a Psychologist.

DFS585

Review Organization

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

DFS1688

Sickness – For Medical Insurance

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

DFS531

Skilled Nursing Facility

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

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

DFS193

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



Umbrella Plan

The term Umbrella Plan means the AT&T Umbrella Benefit Plan No. 1 (as well as all programs, including the BellSouth Medical Assistance Plan and BellSouth Retiree Medical Assistance Plan, which are incorporated into the Umbrella Plan).

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

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