

BORGWARNER INC.

COMPREHENSIVE MEDICAL BENEFITS
OOA Medicare Retiree No Rx

EFFECTIVE DATE: January 1, 2016

ASO99 –OOA1X
3207248

This document printed in July, 2016 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

Important Information	4
Special Plan Provisions	6
How To File Your Claim	7
Eligibility - Effective Date	7
Employee Insurance	7
Dependent Insurance	7
Comprehensive Medical Benefits	9
The Schedule	9
Covered Expenses	18
Exclusions, Expenses Not Covered and General Limitations	26
Coordination of Benefits	29
Expenses For Which A Third Party May Be Responsible	30
Payment of Benefits	32
Termination of Insurance	32
Employees	32
Dependents	32
Federal Requirements	32
Qualified Medical Child Support Order (QMCSO)	33
Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)	33
Coverage of Students on Medically Necessary Leave of Absence	34
Eligibility for Coverage for Adopted Children	35
Coverage for Maternity Hospital Stay	35
Women’s Health and Cancer Rights Act (WHCRA)	35
Group Plan Coverage Instead of Medicaid	35
Pre-Existing Conditions Under the Health Insurance Portability & Accountability Act (HIPAA)	35
Claim Determination Procedures under ERISA	36
Medical - When You Have a Complaint or an Appeal	37
COBRA Continuation Rights Under Federal Law	39
ERISA Required Information	41
Definitions	43

Important Information

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

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

Explanation of Terms

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

The Schedule

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

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.
- 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.

HC-SPP2

04-10
V1

Additional Programs

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

HC-SPP3

04-10
V1

Care Management and Care Coordination Services

Your plan may enter into specific collaborative arrangements with health care professionals committed to improving quality care, patient satisfaction and affordability. Through these collaborative arrangements, health care professionals commit to proactively providing participants with certain care management and care coordination services to facilitate achievement of these goals. Reimbursement is provided at 100% for these services when rendered by designated health care professionals in these collaborative arrangements.

HC-SPP27

06-15
VI

How To File Your Claim

Claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

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

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE CIGNA'S CLAIM FORMS, OR WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.
YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

Timely Filing of Claims

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

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of

misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

HC-CLM25

01-11
VII

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as a retired Employee.

Eligibility for Employee Insurance

You will become eligible for insurance on the date you retire if you are in a Class of Eligible Employees.

Eligibility for Dependent Insurance

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

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

Classes of Eligible Employees

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

Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing a written agreement with the Policyholder to make the required contribution, but no earlier than the date you become eligible.

To be insured for these benefits, you must elect the insurance for yourself no later than 30 days after your retirement.

Dependent Insurance

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

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing a written agreement with the Policyholder to make the required contribution, but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

For your Dependents to be insured for these benefits, you must elect the Dependent insurance for yourself no later than 30 days after you become eligible.

Your Dependents will be insured only if you are insured.

Exception for Newborns

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

HC-ELG1

04-10

V6 M

Comprehensive Medical Benefits	
The Schedule	
For You and Your Dependents	
To receive Comprehensive Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Deductible and Coinsurance.	
Coinsurance	The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the plan.
Deductibles	Deductibles are expenses to be paid by you or your Dependent. Deductible amounts are separate from and 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	<p>Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan. The following Expenses contribute to the Out-of-Pocket Maximum, and when the Out-of-Pocket Maximum shown in The Schedule is reached, they are payable by the benefit plan at 100%:</p> <ul style="list-style-type: none"> • Coinsurance. • Plan Deductible. <p>The following Out-of-Pocket Expenses and charges do not contribute to the Out-of-Pocket Maximum, and they are not payable by the benefit plan at 100% when the Out-of-Pocket Maximum shown in The Schedule is reached:</p> <ul style="list-style-type: none"> • Non-compliance penalties. • Provider charges in excess of the Maximum Reimbursable Charge.
Multiple Surgical Reduction	Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.
Assistant Surgeon and Co-Surgeon Charges	
Assistant Surgeon	The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed a percentage of the surgeon's allowable charge as specified in Cigna Reimbursement Policies. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)
Co-Surgeon	The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna Reimbursement Policies.

BENEFIT HIGHLIGHTS	
Lifetime Maximum	Unlimited
The Percentage of Covered Expenses the Plan Pays Note: "No charge" means an insured person is not required to pay Coinsurance.	80% of the Maximum Reimbursable Charge
Maximum Reimbursable Charge Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or A percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database we have selected. Note: The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles and coinsurance. Note: Some providers forgive or waive the cost share obligation (e.g. your deductible and/or coinsurance) that this plan requires you to pay. Waiver of your required cost share obligation can jeopardize your coverage under this plan. For more details, see the Exclusions Section.	90th Percentile
Calendar Year Deductible Individual Family Maximum Family Maximum Calculation Individual Calculation: Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.	\$200 per person \$400 per family

BENEFIT HIGHLIGHTS	
<p>Out-of-Pocket Maximum</p> <p>Individual Family Maximum</p> <p>Family Maximum Calculation Individual Calculation: Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.</p>	<p>\$3,000 per person \$6,000 per family</p>
<p>Physician's Services</p> <p>Primary Care Physician's Office Visit Specialty Care Physician's Office Visits Consultant and Referral Physician's Services</p> <p>Note: OB/GYN provider is considered a Specialist.</p> <p>Surgery Performed in the Physician's Office Second Opinion Consultations (provided on a voluntary basis) Allergy Treatment/Injections Allergy Serum (dispensed by the Physician in the office)</p>	<p>80% no deductible 80% no deductible</p> <p>80% no deductible 80% no deductible 80% no deductible No charge</p>
<p>Preventive Care</p> <p>Note: Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.</p> <p>Routine Preventive Care for children through age 2 (including immunizations) Routine Preventive Care - for ages 3 and above (including immunizations):</p> <p>Note: Well-woman OB/GYN visits will be considered a Specialist visit.</p> <p>Note: Annual Preventive Care Maximum includes routine PAP, PSA and Mammogram. Preventive Colonoscopy, sigmoidoscopy, etc. performed and billed by an outpatient hospital does not apply to the Preventive Care maximum. Professional charges when billed separately, and charges for lab and radiology services, when billed by the physician's office or an independent diagnostic facility or outpatient hospital will be subject to the plan's Preventive Care dollar maximum.</p>	<p>No charge No charge up to \$300 calendar year maximum, then 80% after deductible</p>

BENEFIT HIGHLIGHTS	
<p>Mammograms, PSA, PAP Smear</p> <p>Preventive Care Related Services (i.e. “routine” services)</p> <p>Diagnostic Related Services (i.e. “non-routine” services)</p>	<p>No charge up to \$300 Preventive Care Maximum per calendar year, then 80% after plan deductible</p> <p>Subject to the plan’s x-ray & lab benefit; based on place of service</p>
<p>Inpatient Hospital - Facility Services</p> <p>Semi-Private Room and Board</p> <p>Private Room</p> <p>Special Care Units (ICU/CCU)</p>	<p>80% after plan deductible</p> <p>Limited to the semi-private room rate</p> <p>Limited to the semi-private room rate</p> <p>Limited to the ICU/CCU daily room rate</p>
<p>Outpatient Facility Services</p> <p>Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room</p>	<p>80% after plan deductible</p>
<p>Inpatient Hospital Physician’s Visits/Consultations</p>	<p>80% after plan deductible</p>
<p>Inpatient Hospital Professional Services</p> <p>Surgeon</p> <p>Radiologist</p> <p>Pathologist</p> <p>Anesthesiologist</p>	<p>80% after plan deductible</p>
<p>Outpatient Professional Services</p> <p>Surgeon</p> <p>Radiologist</p> <p>Pathologist</p> <p>Anesthesiologist</p>	<p>80% after plan deductible</p>
<p>Emergency and Urgent Care Services</p> <p>Physician’s Office Visit</p> <p>Hospital Emergency Room</p> <p>Outpatient Professional services (radiology, pathology and ER Physician)</p> <p>Urgent Care Facility or Outpatient Facility</p> <p>X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)</p> <p>Independent x-ray and/or Lab Facility in conjunction with an ER visit</p> <p>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)</p> <p>Ambulance</p>	<p>80% no deductible</p> <p>80% after plan deductible</p> <p>80% after plan deductible</p> <p>80% after plan deductible</p> <p>80% after plan deductible</p> <p>80% after plan deductible</p> <p>80% after plan deductible</p> <p>80% after plan deductible</p> <p>80% after plan deductible</p>

BENEFIT HIGHLIGHTS	
<p>Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: Unlimited</p>	80% after plan deductible
<p>Laboratory and Radiology Services (includes pre-admission testing) Physician's Office Visit Outpatient Hospital Facility Independent X-ray and/or Lab Facility</p>	<p>80% no deductible 80% after plan deductible 80% after plan deductible</p>
<p>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans) Physician's Office Visit Inpatient Facility Outpatient Facility</p>	<p>80% no deductible 80% after plan deductible 80% after plan deductible</p>
<p>Outpatient Short-Term Rehabilitative Therapy Calendar Year Maximum: Unlimited Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy</p>	80% after plan deductible
<p>Chiropractic Care Calendar Year Maximum: \$500 Physician's Office Visit</p>	80% after plan deductible
<p>Home Health Care Calendar Year Maximum: 120 days (includes outpatient private nursing when approved as Medically Necessary)</p>	80% after plan deductible
<p>Hospice Inpatient Services Outpatient Services (same coinsurance level as Home Health Care)</p>	<p>80% after plan deductible 80% after plan deductible</p>

BENEFIT HIGHLIGHTS	
<p>Bereavement Counseling</p> <p>Services Provided as part of Hospice Care</p> <p style="padding-left: 20px;">Inpatient</p> <p style="padding-left: 20px;">Outpatient</p> <p>Services Provided by Mental Health Professional</p>	<p>80% after plan deductible</p> <p>80% after plan deductible</p> <p>Covered under Mental Health benefit</p>
<p>Maternity Care Services</p> <p>Initial Visit to Confirm Pregnancy</p> <p>Note: OB/GYN provider is considered a Specialist.</p> <p>All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)</p> <p>Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist</p> <p>Delivery - Facility (Inpatient Hospital, Birthing Center)</p>	<p>80% no deductible</p> <p>80% after plan deductible</p> <p>80% no deductible</p> <p>80% after plan deductible</p>
<p>Abortion</p> <p>Includes only non-elective procedures</p> <p style="padding-left: 20px;">Physician's Office Visit</p> <p style="padding-left: 20px;">Inpatient Facility</p> <p style="padding-left: 20px;">Outpatient Facility</p> <p style="padding-left: 20px;">Physician's Services</p>	<p>80% no deductible</p> <p>80% after plan deductible</p> <p>80% after plan deductible</p> <p>80% after plan deductible</p>
<p>Family Planning Services</p> <p>Office Visits, Lab and Radiology Tests and Counseling</p> <p>Note: This benefit will exclude coverage for contraceptive devices (e.g. Depo-Provera, Norplant and Intrauterine Devices (IUDs), Lunelle, etc.). Diaphragms will be covered when services are provided in the physician's office.</p> <p>Surgical Sterilization Procedures for Vasectomy/Tubal Ligation (excludes reversals)</p> <p style="padding-left: 20px;">Physician's Office Visit</p> <p style="padding-left: 20px;">Inpatient Facility</p> <p style="padding-left: 20px;">Outpatient Facility</p> <p style="padding-left: 20px;">Physician's Services</p>	<p>80% no deductible</p> <p>80% no deductible</p> <p>80% after plan deductible</p> <p>80% after plan deductible</p> <p>80% after plan deductible</p>

BENEFIT HIGHLIGHTS	
<p>Infertility Treatment Coverage will be provided for the following services:</p> <ul style="list-style-type: none"> • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). <p>Surgical Treatment: Limited to procedures for the correction of infertility (excludes Artificial Insemination, In-vitro, GIFT, ZIFT, etc.)</p>	
Physician's Office Visit (Lab and Radiology Tests, Counseling)	80% no deductible
Inpatient Facility	80% after plan deductible
Outpatient Facility	80% after plan deductible
Physician's Services	80% after plan deductible
<p>Organ Transplants Lifetime Maximum: \$1,000,000 Includes all medically appropriate, non-experimental transplants</p>	
Physician's Office Visit	80% no deductible
Inpatient Facility	No charge at a Lifesource facility, otherwise 80% after plan deductible
Physician's Services	No charge at a Lifesource facility, otherwise 80% after plan deductible
Lifetime Travel Maximum: \$10,000 per transplant	No charge (only available when using Lifesource facility)
<p>Durable Medical Equipment Calendar Year Maximum: Unlimited</p>	
	80% after plan deductible
<p>External Prosthetic Appliances Calendar Year Maximum: Unlimited</p>	
	80% after plan deductible
<p>Nutritional Evaluation Calendar Year Maximum: 3 visits per person</p>	
Physician's Office Visit	80% no deductible
Inpatient Facility	80% after plan deductible
Outpatient Facility	80% after plan deductible
Physician's Services	80% after plan deductible

BENEFIT HIGHLIGHTS	
<p>Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.</p> <p>Physician's Office Visit Inpatient Facility Outpatient Facility Physician's Services</p>	<p>80% no deductible 80% after plan deductible 80% after plan deductible 80% after plan deductible</p>
<p>Oral Surgery The following procedures are covered: Extract Tooth Soft Tissue Impaction; Extract Partial Bony Impaction; Removal of Impacted Tooth – Completely Bony; and Removal of Impacted Tooth – Completely Bony, with Unusual Surgical Complications.</p> <p>Physician's Office Visit Inpatient Facility Outpatient Facility Physician's Services</p>	<p>80% no plan deductible 80% after plan deductible 80% after plan deductible 80% after plan deductible</p>
<p>Surgical TMJ Always excludes appliances and orthodontic treatment. Subject to medical necessity. Coverage limited to surgical treatment of TMJ Disorders and injections made directly into the Temporomandibular Joint.</p> <p>Physician's Office Visit Inpatient Facility Outpatient Facility Physician's Services</p>	<p>80% no deductible 80% after plan deductible 80% after plan deductible 80% after plan deductible</p>
<p>Routine Foot Disorders</p>	<p>Not covered except for services associated with foot care for diabetes and peripheral vascular disease when Medically Necessary.</p>
<p>Treatment Resulting From Life Threatening Emergencies Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized and will not count toward any plan limits that are shown in the Schedule for mental health and substance abuse services including in-hospital services. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.</p>	
<p>Mental Health Inpatient Outpatient (Includes Individual, Group and Intensive Outpatient) Physician's Office Visit Outpatient Facility</p>	<p>80% after plan deductible 80% no deductible 80% after plan deductible</p>

BENEFIT HIGHLIGHTS**Substance Abuse**

Inpatient

80% after plan deductible

Outpatient (Includes Individual and Intensive
Outpatient)

Physician's Office Visit

80% no deductible

Outpatient Facility

80% after plan deductible

Comprehensive Medical Benefits

Covered Expenses

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

Covered Expenses

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

Clinical Trials

This benefit plan covers routine patient care costs related to a qualified clinical trial for an individual who meets the following requirements:

- (a) is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and
- (b) either
 - the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a); or
 - the individual provides medical and scientific information establishing that the individual's

participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a).

For purposes of clinical trials, the term “life-threatening disease or condition” means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

The clinical trial must meet the following requirements:

The study or investigation must:

- be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
- be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- involve a drug trial that is exempt from having such an investigational new drug application.

Routine patient care costs are costs associated with the provision of health care items and services including drugs, items, devices and services otherwise covered by this benefit plan for an individual who is not enrolled in a clinical trial and, in addition:

- services required solely for the provision of the investigational drug, item, device or service;
- services required for the clinically appropriate monitoring of the investigational drug, device, item or service;
- services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service; and
- reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.

Routine patient care costs do not include:

- the investigational drug, item, device, or service, itself; or
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

If your plan includes In-Network providers, Clinical trials conducted by non-participating providers will be covered at the In-Network benefit level if:

- there are not In-Network providers participating in the clinical trial that are willing to accept the individual as a patient, or
- the clinical trial is conducted outside the individual's state of residence.

Genetic Testing

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

- a person has symptoms or signs of a genetically-linked inheritable disease;
- it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
- the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

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

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

Nutritional Evaluation

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

Internal Prosthetic/Medical Appliances

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

HC-COVI

06-14

V12 M

Orthognathic Surgery

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

- the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

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

HC-COV3

04-10
V1

Home Health Services

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

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

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

HC-COV5

04-10
V1

Hospice Care Services

- charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
 - by a Hospice Facility for Bed and Board and Services and Supplies;
 - by a Hospice Facility for services provided on an outpatient basis;
 - by a Physician for professional services;
 - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
 - for pain relief treatment, including drugs, medicines and medical supplies;
 - by an Other Health Care Facility for:
 - part-time or intermittent nursing care by or under the supervision of a Nurse;
 - part-time or intermittent services of an Other Health Care Professional;
 - physical, occupational and speech therapy;
 - medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

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

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

HC-COV6

04-10
V1

Mental Health and Substance Abuse Services

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

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

Inpatient Mental Health Services

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

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

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

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

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

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

Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is

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

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

Inpatient Substance Abuse Rehabilitation Services

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

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

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

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

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

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

Outpatient Substance Abuse Rehabilitation Services

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

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

Substance Abuse Intensive Outpatient Therapy Program services are exchanged with Outpatient Substance Abuse services at a rate of one visit of Substance Abuse Intensive Outpatient Therapy being equal to one visit of Outpatient Substance Abuse Rehabilitation Services.

Substance Abuse Detoxification Services

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

Exclusions

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

- any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.
- treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- counseling for activities of an educational nature.
- counseling for borderline intellectual functioning.
- counseling for occupational problems.
- counseling related to consciousness raising.
- vocational or religious counseling.
- I.Q. testing.

- custodial care, including but not limited to geriatric day care.
- psychological testing on children requested by or for a school system.
- occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

HC-COV7

04-10

V4

Durable Medical Equipment

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

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

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

- **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses.
- **Bath Related Items:** bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs.
- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
- **Car/Van Modifications.**

- **Air Quality Items:** room humidifiers, vaporizers, air purifiers and electrostatic machines.
- **Blood/Injection Related Items:** blood pressure cuffs, centrifuges, nova pens and needleless injectors.
- **Other Equipment:** heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

HC-COV8

04-10

V2

External Prosthetic Appliances and Devices

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

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

Prostheses/Prosthetic Appliances and Devices

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

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

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

Orthoses and Orthotic Devices

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

- Nonfoot orthoses – only the following nonfoot orthoses are covered:
 - rigid and semirigid custom fabricated orthoses;
 - semirigid prefabricated and flexible orthoses; and
 - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.

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

The following are specifically excluded orthoses and orthotic devices:

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

Braces

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

The following braces are specifically excluded: Copes scoliosis braces.

Splints

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

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

- replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.

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

The following are specifically excluded external prosthetic appliances and devices:

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

HC-COV9

04-10
V2

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

HC-COV10

04-10
V2 M

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 limitation applies to Short-term Rehabilitative Therapy:

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

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

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

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

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

Chiropractic Care Services

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

The following limitation applies to Chiropractic Care Services:

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

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

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

HC-COV13

04-10
v2

Breast Reconstruction and Breast Prostheses

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

Reconstructive Surgery

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: the surgery or therapy restores or improves function; reconstruction is required as a result of Medically Necessary, noncosmetic surgery; or the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

HC-COV14

04-10
v1

Transplant Services

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

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

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 (refer to Transplant Travel Services), 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 non-taxable 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 and lodging 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: evaluation, candidacy, transplant event, or post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); and lodging 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 who is at least 18 years of age. The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within 60 miles of your home; food and meals; 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/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above.

Charges for the expenses of a donor companion are not covered. No benefits are available when the covered person is a donor.

HC-COV482

12-15

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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

- care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- treatment of an Injury or Sickness which is due to war, declared, or undeclared, riot or insurrection.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) you are required to pay for a Covered Service (as shown on the Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Service, or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a Non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.
- charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.
Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:
 - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
 - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
 - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" section(s) of this plan; or
 - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" section(s) of this plan.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- The following services are excluded from coverage regardless of clinical indications: Macromastia or Gynecomastia Surgeries; Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch. Additionally, charges made by a Physician for any of

the following Surgical Procedures are covered: excision of unerupted impacted tooth, including removal of alveolar bone and sectioning of tooth; removal of residual root (when performed by a Dentist other than the one who extracted the tooth).

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

- anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
 - cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
 - cosmetics, dietary supplements and health and beauty aids.
 - all nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
 - medical treatment for a person age 65 or older, who is covered under this plan as a retiree, or their Dependent, when payment is denied by the Medicare plan because treatment was received from a nonparticipating provider.
 - 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.
 - abortions, unless a Physician certifies in writing that the pregnancy would endanger the life of the mother, or the expenses are incurred to treat medical complications due to abortion.
 - charges made for nonsurgical treatment of Temporomandibular Joint Dysfunction.

General Limitations

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

- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- for charges which would not have been made if the person had no insurance.
- to the extent that they are more than Maximum Reimbursable Charges.

- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- charges made by any covered provider who is a member of your or your Dependent's family.
- expenses incurred outside the United States other than expenses for medically necessary urgent or emergent care while temporarily traveling abroad.

HC-EXC56

10-14
V6 M

Pre-existing Condition Limitations

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

Pre-existing Condition

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

Exceptions to Pre-existing Condition Limitation

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

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

Credit for Coverage Under Prior Plan

If a person was previously covered under a plan which qualifies as Creditable Coverage, the following will apply, provided he notifies the Employer of such prior coverage, and fewer than 63 days elapse between coverage under the prior plan and coverage under this plan, exclusive of any waiting period.

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

HC-EXC60

01-11 M

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% 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.

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.
- 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.

Recovery of Excess Benefits

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

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments 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

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

Medicare Eligibles

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

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

- (b) a former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;
- (c) a retired Employee, or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

Cigna will assume the amount payable under:

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

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

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

HC-COB2

04-10
V3 M

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

- Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

Subrogation/Right of Reimbursement

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:

- Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.
- Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

Lien of the Plan

By accepting benefits under this plan, a Participant:

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

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the

application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- The plan hereby disavows all equitable defenses in pursuit of its right of recovery. The plan's subrogation or recovery rights are neither affected nor diminished by equitable defenses.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.
- Participants must assist the plan in pursuing any subrogation or recovery rights by providing requested information.

Payment of Benefits

To Whom Payable

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

Cigna may, at its option, make payment to you for the cost of any Covered Expenses even if benefits have been assigned. When benefits are paid to you or your Dependents, you or your Dependents are responsible for reimbursing the provider.

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

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

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

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment. In addition, your acceptance of benefits under this plan and/or assignment of Medical Benefits separately creates an equitable lien by agreement pursuant to which Cigna may seek recovery of any overpayment. You agree that Cigna, in seeking recovery of any overpayment as a contractual right or as an equitable line by agreement, may pursue the general assets of the person or entity to whom or on whose behalf the overpayment was made.

Calculation of Covered Expenses

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

- the methodologies in the most recent edition of the Current Procedural terminology,

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

HC-POB1

09-13
V7

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.

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

Dependents

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

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

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

HC-TRM1

04-10
V1.M

Federal Requirements

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

HC-FED1

10-10

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order.

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

Qualified Medical Child Support Order Defined

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

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

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

Payment of Benefits

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

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

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

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; spouse only; Employee and spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, spouse and Dependent child(ren). Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage.
- **Loss of eligibility for State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.
- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
 - divorce or legal separation;
 - cessation of Dependent status (such as reaching the limiting age);
 - death of the Employee;

- termination of employment;
 - reduction in work hours to below the minimum required for eligibility;
 - you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
 - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
 - the other plan no longer offers any benefits to a class of similarly situated individuals.
- **Termination of employer contributions (excluding continuation coverage).** If a current or former employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).
 - **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: due to failure of the employer or other responsible entity to remit premiums on a timely basis; when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.
 - **Eligibility for employment assistance under State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

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

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

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

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

HC-FED71

12-14

Coverage of Students on Medically Necessary Leave of Absence

If your Dependent child is covered by this plan as a student, as defined in the Definition of Dependent, coverage will remain active for that child if the child is on a medically necessary leave of absence from a postsecondary educational institution (such as a college, university or trade school.)

Coverage will terminate on the earlier of:

- The date that is one year after the first day of the medically necessary leave of absence; or
- The date on which coverage would otherwise terminate under the terms of the plan.

The child must be a Dependent under the terms of the plan and must have been enrolled in the plan on the basis of being a student at a postsecondary educational institution immediately before the first day of the medically necessary leave of absence.

The plan must receive written certification from the treating physician that the child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

A "medically necessary leave of absence" is a leave of absence from a postsecondary educational institution, or any other change in enrollment of the child at the institution that: starts while the child is suffering from a serious illness or condition; is medically necessary; and causes the child to lose student status under the terms of the plan.

HC-FED36

04-12

Eligibility for Coverage for Adopted Children

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

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

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

HC-FED67

09-14

Coverage for Maternity Hospital Stay

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

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

HC-FED11

10-10

Women's Health and Cancer Rights Act (WHCRA)

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

HC-FED12

10-10

Group Plan Coverage Instead of Medicaid

If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

HC-FED13

10-10

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

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

Pre-Existing Condition Limitation

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

Exceptions to Pre-existing Condition Limitation

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

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

Credit for Coverage Under Prior Plan

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

If you and/or your Dependent enrolled or re-enrolled in COBRA continuation coverage or state continuation coverage under the extended election period allowed in the American Recovery and Reinvestment Act of 2009 (“ARRA”), this lapse in coverage will be disregarded for the purposes of determining Creditable Coverage.

Certificate of Prior Creditable Coverage

You must provide proof of your prior Creditable Coverage in order to reduce a Pre-Existing Condition limitation period. You should submit proof of prior coverage with your enrollment material. A certificate of prior Creditable Coverage, or other proofs of coverage which need to be submitted outside the standard enrollment form process for any reason, may be sent directly to: Eligibility Production Services, 900 Cottage Grove Road, Routing C2ECC, Hartford, CT 06152. You should contact the Plan Administrator or a Cigna Customer Service Representative if assistance is needed to obtain proof of prior Creditable Coverage. Once your prior coverage records are reviewed and credit is calculated, you will receive a notice of any remaining Pre-existing Condition limitation period.

Creditable Coverage

Creditable Coverage will include coverage under any of the following: A self-insured employer group health plan; Individual or group health insurance indemnity or HMO plans; Part A or Part B of Medicare; Medicaid, except coverage solely for pediatric vaccines; A health plan for certain members of the uniformed armed services and their dependents, including the Commissioned Corps of the

National Oceanic and Atmospheric Administration and of the Public Health Service; A medical care program of the Indian Health Service or of a tribal organization; A state health benefits risk pool; The Federal Employees Health Benefits Program; A public health plan established by a State, the U.S. government, or a foreign country; the Peace Corps Act; Or a State Children’s Health Insurance Program.

HC-FED69

09-14

Claim Determination Procedures under ERISA

The following complies with federal law. Provisions of the laws of your state may supersede.

Procedures Regarding Medical Necessity Determinations

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

Certain services require prior authorization in order to be covered. The booklet describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care professional) must request prior authorization according to the procedures described below, in the booklet, and in your provider’s network participation documents as applicable.

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

Preservice Determinations

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

determination period will resume on the date you or your representative responds to the notice.

If the determination periods above would seriously jeopardize your life or health, your ability to regain maximum function, or in the opinion of a Physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited determination is necessary. Cigna will notify you or your representative of an expedited determination within 72 hours after receiving the request.

However, if necessary information is missing from the request, Cigna will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to Cigna within 48 hours after receiving the notice. Cigna will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

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

Concurrent 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 coverage determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, Cigna will notify you or your representative of the determination within 24 hours after receiving the request.

Postservice Determinations

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

If more time is needed because necessary information is missing from the request, the notice will also specify what

information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

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: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal, (if applicable); 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; in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

HC-FED47

03-13

Medical - When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "you" or "your" 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 Customer Service

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

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

any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

Internal Appeals Procedure

To initiate an appeal, you must submit a request for an appeal in writing to Cigna within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone. Call or write us at the toll-free number on your ID card, explanation of benefits, or claim form.

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

We will respond in writing with a decision within 30 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination or a postservice Medical Necessity determination. We will respond within 60 calendar days after we receive an appeal for any other postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

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

When an appeal is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.

External Review Procedure

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

There is no charge for you to initiate an external review. Cigna and your benefit plan will abide by the decision of the IRO.

In order to request a referral to an IRO, the reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. 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 4 months of your receipt of Cigna's appeal review denial. Cigna will then forward the file to a randomly selected IRO. The IRO will render an opinion within 30 days.

When requested and when a delay would be detrimental to your medical condition, as determined by Cigna's Physician Reviewer, the external review shall be completed within 3 days.

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: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined below; 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), if applicable; 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: was relied upon in making the benefit determination; was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the appeal processes. However, no action will be brought at all unless brought within three years after proof of claim is required under the Plan.

HC-FED60

03-14

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, your Dependents must be given the opportunity to continue health insurance when there is a “qualifying event” that would result in loss of coverage under the Plan. Your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan’s coverage area or the plan is no longer available. Your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

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

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

Who is Entitled to COBRA Continuation?

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

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, grandchildren (unless adopted by you), stepchildren (unless adopted by you).

Medicare Extension for Your Dependents

If you retire and you became enrolled in Medicare (Part A, Part B or both) within the 18 months retirement, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare.

Termination of COBRA Continuation

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

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

Employer’s Notification Requirements

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

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse’s) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
 - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
 - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the

occurrence of a qualifying event, 44 days after the qualifying event occurs; or

- in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

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

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect continuation coverage on behalf of all the qualified beneficiaries.

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. For example: If the spouse or one Dependent child alone elects COBRA continuation coverage, they will be charged 102% of the active Employee premium. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% of the applicable family premium.

When and How to Pay COBRA Premiums

First payment for COBRA continuation

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

Subsequent payments

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

Grace periods for subsequent payments

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

You Must Give Notice of Certain Qualifying Events

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

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.

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

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage.



COBRA Continuation for Retirees Following Employer's Bankruptcy

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

Interaction With Other Continuation Benefits

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

HC-FED66

07-14 M

ERISA Required Information

The name of the Plan is:

BorgWarner Retiree Health & Life Plan

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

BorgWarner Retiree Health & Life Plan
3850 Hamlin Rd
Auburn Hills, MI 48326
248-754-9200

Employer Identification
Number (EIN):

133404508

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 service of legal process is:

Employer named above

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

The Cigna Claim Office responsible for this Plan

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

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

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

Plan Trustees

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

Plan Type

The plan is a healthcare benefit plan.

Collective Bargaining Agreements

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

Discretionary Authority

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

Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. Contact the Employer for 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. No consent of any participant is required to terminate, modify, amend or change the Plan.

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

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

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

- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

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

Statement of Rights

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

Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

Continue Group Health Plan Coverage

- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the documents governing the Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise

discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Enforce Your Rights

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

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.

Definitions

Bed and Board

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

HC-DFS2 04-10
V2

Chiropractic Care

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

HC-DFS55 04-10
V1

Custodial Services

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

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

HC-DFS4 04-10
V1

Dependent

Dependents are:

- your lawful spouse; and

- any unmarried child of yours who is:
 - less than 19 years old.
 - 19 years but less than 25 years old, unmarried, enrolled in school as a full-time student and primarily supported by you.
 - 19 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

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

The term child means a child born to you or a child legally adopted by you. It also includes a stepchild or a child for whom you are the legal guardian who lives with you.

Benefits for a Dependent child will continue until the last day before your Dependent's birthday, in the year in which the limiting age is reached.

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

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

HC-DFS673 07-14
V1 M

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.

HC-DFS6 04-10
V1

Employee

The term Employee means a retired employee.

HC-DFS7 04-10
V3 M

Employer

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

HC-DFS8 04-10
V1

Expense Incurred

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

HC-DFS10 04-10
V1

Free-Standing Surgical Facility

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

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

HC-DFS11 04-10
V1

Hospice Care Program

The term Hospice Care Program means:

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

HC-DFS51 04-10
V1

Hospice Care Services

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

HC-DFS52 04-10
V1

Hospice Facility

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

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

HC-DFS53 04-10
V1

Hospital

The term Hospital means:

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

- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: specializes in treatment of Mental Health and Substance Abuse or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

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

HC-DFS48 04-10
V1

Hospital Confinement or Confined in a Hospital

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

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

HC-DFS49 04-10
V1

Injury

The term Injury means an accidental bodily injury.

HC-DFS12 04-10
V1

Maintenance Treatment

The term Maintenance Treatment means:

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

HC-DFS56 04-10
V1

Maximum Reimbursable Charge - Medical

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

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

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

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

HC-DFS13 04-10
V8

Medicaid

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

HC-DFS16 04-10
V1

Medically Necessary/Medical Necessity

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

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

HC-DFS19 04-10
V1

Medicare

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

HC-DFS17 04-10
V1

Necessary Services and Supplies

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

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

HC-DFS21 04-10
V1

Nurse

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

HC-DFS22 04-10
V1

Other Health Care Facility/Other Health Professional

The term Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities. The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses. Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical

Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.

HC-DFS23 04-10
V1

Physician

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

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

HC-DFS25 04-10
V1

Preventive Treatment

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

HC-DFS57 04-10
V1

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is operating within the scope of his license and performing a service for which benefits are provided under this plan when performed by a Psychologist.

HC-DFS26 04-10
V1

Review Organization

The term Review Organization refers to an affiliate of Cigna or another entity to which Cigna has delegated responsibility for performing utilization review services. The Review

Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.

HC-DFS30 04-10
V1

and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

HC-DFS34 04-10
V1

Sickness – For Medical Insurance

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

HC-DFS50 04-10
V1

Skilled Nursing Facility

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

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

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

HC-DFS31 04-10
V1

Terminal Illness

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

HC-DFS54 04-10
V1

Urgent Care

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by Cigna, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive