

NATIONAL OPTICAL ASTRONOMY OBSERVATORY

Effective January 1, 2006

CN002

37669 11-05 Printed in U.S.A.



TABLE OF CONTENTS

	Page
Case Management.....	5
Notice of Federal Requirements.....	7
Certification.....	9
The Schedule	11
Section 125 Plan.....	19
How to File Your Claim	21
Accident and Health Provisions.....	23
Eligibility — Effective Date	24
Comprehensive Medical Benefits	29
Prescription Drug Benefits.....	44
Dental Benefits.....	48
General Limitations	56
Medicare Eligibles	60
Coordination of Benefits	62
Conditional Claim.....	66
Payment of Benefits	67
Termination of Insurance.....	68
Benefits Extension	78
Our Appeals Process	80
ERISA Required Information	86
Definitions	95

Case Management

Case Management is a service provided through Intracorp, a CIGNA Company, 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.

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

1. You, your dependent or an attending physician can request Case Management services by calling the **CIGNA International Service Center directly at 1-302-797-3100 (outside the U.S. and Canada, call collect) or 1-800-441-2668 (inside the U.S. and Canada)**. In addition, your employer, a claim office or a utilization review program (see the PAC/CSR section of your certificate) may refer an individual for Case Management.
2. Intracorp assesses each case to determine whether Case Management is appropriate.
3. You or your dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.

4. Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
5. The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
6. The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
7. Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

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.

NOTICE of Federal Requirements

Coverage for Reconstructive Surgery Following Mastectomy

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

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

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

Coverage for Maternity Hospital Stay

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

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

NOTICE OF AN APPEAL OR A GRIEVANCE

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

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

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

POLICYHOLDER: NATIONAL OPTICAL ASTRONOMY OBSERVATORY

GROUP POLICY(S) — COVERAGE
02016A MEDICAL EXPENSE
 PRESCRIPTION DRUG
 INSURANCE
 DENTAL INSURANCE

EFFECTIVE DATE: January 1, 2006

NOTICE

Any insurance benefits in this certificate will apply to an Employee only if: a) he has elected that benefit; and b) he has a "Final Confirmation Letter," with his name, which shows his election of that benefit.

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.

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

Susan L. Cooper

Corporate Secretary

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.

THE SCHEDULE

COMPREHENSIVE MEDICAL BENEFITS

To receive Comprehensive Medical Benefits, you and your Dependent must pay a portion of the Covered Expenses. That portion is the Deductible and Coinsurance.

Daily Limits shown below are Covered Expense allowances to which coinsurance is generally applied. The amounts that "This Plan Will Pay" may differ. Please refer to the section of The Schedule entitled "How Your Comprehensive Medical Plan Works" and to the Comprehensive Medical Benefits text in this certificate for a complete explanation of your benefits and any restrictions.

For You and Your Dependents This Plan Will Pay:

Lifetime Maximum Benefit	
	Unlimited
Home Infusion Therapy Benefit Lifetime Maximum	\$5,000,000
Lifetime Mental Illness, Alcohol and Drug Abuse Maximum (In-Hospital)	27 days
Lifetime Mental Illness, Alcohol and Drug Abuse Maximum (Out-of-Hospital)	35 visits
Calendar Year Mental Illness, Alcohol and Drug Abuse Maximum (Out-of-Hospital)	23 visits
Adult Routine Physical Examination Maximum	\$250 every 2 years
Child Preventive Care Services Calendar Year Maximums:	
Children up to age 1	\$250
Children ages 1 through 17	\$125
Chiropractic Treatment Calendar Year Maximum	\$750
TMJ - Lifetime Maximum	\$1,000
Hospice Care Services Lifetime Maximum	\$10,000

THE SCHEDULE

COMPREHENSIVE MEDICAL BENEFITS (Cont.)

For You and Your Dependents This Plan Will Pay:

Hospital Bed and Board

Daily Limit for a
semiprivate room

The Reasonable and
Customary Charge

Daily Limit for a
private room

The Hospital's most
common daily rate for a
semiprivate room

Hospice Care Facility
Daily Limit

The Reasonable and
Customary Charge

A person must satisfy the deductible amount(s) before Comprehensive Medical Benefits are payable.

Individual Deductible \$100

Family Deductible \$200

After Comprehensive Medical Deductibles totaling \$200 have been applied in a calendar year for either (a) you and your Dependents or (b) your Dependents, your family need not satisfy any further Comprehensive Medical Deductibles for the rest of that year.

Covered Expenses that were incurred and applied toward any Comprehensive Medical or Family Deductible during the last 3 months of the calendar year, will be applied toward the next year's deductible.

THE SCHEDULE

COMPREHENSIVE MEDICAL BENEFITS (Cont.)

For You and Your Dependents

HOW YOUR COMPREHENSIVE MEDICAL PLAN WORKS

You or your Dependent pays \$100 Deductible.

Then

This Plan pays 80% of Covered Expenses except for Special Provisions and Conditions as noted below.	You or Your Dependent pays 20% (except for Special Provisions and Conditions as noted below) of those Covered Expenses until you have paid \$1,000.
---	---

Then

This Plan pays 100% of Covered Expenses.*

* Note: See Special Provisions and Conditions as noted below, "Full Payment Area" and coinsurance provisions in the Comprehensive Medical Benefits section of this certificate for exceptions to this provision.

<u>SPECIAL PROVISIONS</u>	<u>CONDITIONS</u>	<u>THIS PLAN WILL PAY</u>
Adult Routine Physical Examinations	For Employees and Dependents age 18 and over	100%, not subject to the Deductible
Child Preventive Care Services	Children from birth through age 17	100%, not subject to the Deductible
Mammograms, Pap Tests and Prostate Specific Antigen (PSA) Tests and Colorectal Cancer Screenings		80%
Travel Immunizations	For Employees and Dependents age 18 and over	80%

THE SCHEDULE

COMPREHENSIVE MEDICAL BENEFITS (Cont.)

For You and Your Dependents

<u>SPECIAL PROVISIONS</u>	<u>CONDITIONS</u>	<u>THIS PLAN WILL PAY</u>
Childhood immunization against: diphtheria; hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; varicella; haemophilus; influenzae B; and hepatitis A	Children from birth age 18	80%
Lead Poisoning Screening Tests	For Children under age 6	80%
Prescription Drug Benefits	Purchased outside the United States	80%
Home Health Care Benefits	40 visits per calendar year	80%
Skilled Nursing Facility Benefits	60 days per calendar year	80%
Chiropractic Treatment		80%
TMJ Treatment		80%
Hospice Care Benefits		80%
Mental Illness, Alcoholism or Drug Abuse Benefits	In-Hospital	80%
Mental Illness, Alcoholism or Drug Abuse Benefits	Out-of- Hospital	50%
Benefit for Hospital charges during any inpatient admission in the United States	Without approval of Review Organization	50% of the amount otherwise payable

COMPREHENSIVE MEDICAL BENEFITS

For You and Your Dependents

PAC/CSR REQUIREMENTS.

This provision is applicable to:

- you or your Dependents residing in the United States.
- you or your Dependents who reside outside the United States but who elect to receive medical treatment in the United States.

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the medical necessity and length of any Hospital Confinement as a registered bed patient. PAC and CSR are performed through a utilization review program by a Review Organization with which CG has contracted. PAC should be requested by you or your Dependent for each inpatient Hospital admission. CSR should be requested, prior to the end of the certified length of stay, for continued inpatient Hospital Confinement.

Expenses incurred for which benefits would otherwise be paid under this plan will not include the first \$300 of Hospital charges made for each separate admission to the Hospital as a registered bed patient unless PAC is received: (a) prior to the date of admission; or (b) in the case of an emergency admission, by the end of the first scheduled work day after the date of admission.

The amount otherwise payable under this plan for the Hospital charges listed below will be reduced by 50% for:

- Hospital charges for Bed and Board, during a Hospital Confinement for which PAC is performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- any Hospital charges made during any Hospital Confinement as a registered bed patient: (a) for which PAC was performed; but (b) which was not certified as medically necessary.

COMPREHENSIVE MEDICAL BENEFITS

For You and Your Dependents (Continued)

PAC/CSR REQUIREMENTS (Continued)

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

You should start the PAC process by calling the Review Organization prior to an elective admission, or in the case of an emergency admission, by the end of the first scheduled work day after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. The Review Organization will continue to monitor the confinement until you are discharged from the Hospital. The results of the review will be communicated to you, the attending Physician, and CG.

The Review Organization is an organization with a staff of Registered Graduate Nurses and other trained staff members who perform the PAC and CSR process in conjunction with consultant Physicians qualified in treatment of the condition, including Mental Illness, alcohol or drug abuse.

PRESCRIPTION DRUG BENEFITS

This section describes coverage for Prescriptions obtained inside the United States only. Prescriptions obtained outside of the United States are covered under the Comprehensive Medical Benefits section of this certificate.

You and your Dependent must pay a portion of Covered Prescription Drugs to receive Prescription Drug Benefits. That portion is described below.

Coinsurance

Coinsurance is that percentage of Covered Prescription Drugs which you or your Dependent is required to pay under this benefit.

Participating Retail Pharmacy Coinsurance

For each Prescription Order 20%

Non-Participating Retail Pharmacy Coinsurance

For each Prescription Order 20%, subject to the \$100 Individual Deductible

Participating Mail-Order Pharmacy Coinsurance

For each Prescription Order 20%

————— THE SCHEDULE —————

CIGNA TRADITIONAL DENTAL
For You and Your Dependents

HOW YOUR DENTAL PLAN WORKS

Class I Preventive Care	Plan pays 100% There is no Deductible	
Class II Basic Restorative	You or Your Dependent pays \$50 Deductible	Plan pays 80%
Class III Major Restorative		Plan pays 50%
Class IV Orthodontia		Plan pays 50%

Class IV Orthodontia applies only to a Dependent Child less than 19 years of age.

Maximum Benefit

Classes I, II, III Combined

Calendar Year Maximum \$1,500

Class IV

Lifetime Maximum \$1,000

Individual Deductible

\$50

A person must satisfy this deductible amount for each calendar year before Dental Benefits are payable.

Family Deductible

\$150

After Dental Deductibles totaling \$150 have been applied in a calendar year for either (a) you and your Dependents; or (b) your Dependents, your family need not satisfy any further Dental Deductibles for the rest of that year.

Dental Expenses that were incurred and applied toward the Individual or Family Deductible during the last 3 months of the calendar year will be applied toward the next year's Deductible.

EFFECT OF SECTION 125 REGULATIONS ON THIS PLAN

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

Provisions in this certificate which allow for enrollment or coverage changes not consistent with Section 125 Regulations are superseded by this section.

COVERAGE ELECTIONS

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

Special Enrollment

Special Enrollment per federal requirements as described in the Section entitled "ELIGIBILITY – EFFECTIVE DATE/Exception to Late Entrant Definition" **if** included in this document.

EFFECT OF SECTION 125 REGULATIONS ON THIS PLAN (Continued)

Change in Status

A change in coverage due to the following changes in status: (a) change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation; (b) change in number of Dependents due to birth, adoption, placement for adoption or death of a Dependent; (c) change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under Family and Medical Leave Act (FMLA) or change in worksite; (d) changes in employment status of Employee, spouse or dependent resulting in eligibility or ineligibility for coverage; (e) change in residence of Employee, spouse or Dependent; and (f) changes which cause a dependent to become eligible or ineligible for coverage.

Any changes in coverage must pertain directly to the change in status.

Court Order

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

Medicare Eligibility/Entitlement

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

CHANGE IN COST OF COVERAGE

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

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

CHANGES IN COVERAGE OF SPOUSE OR DEPENDENT UNDER ANOTHER EMPLOYER'S PLAN

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

HOW TO FILE YOUR CLAIM

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

You may get the required claim forms from your Benefit Plan Administrator. All fully completed claim forms and bills should be mailed directly to:

CIGNA International Service Center
P.O. Box 15050
Wilmington, DE 19850 U.S.A.

If remitting via a courier service use the following street address:

590 Naamans Road
Claymont, DE 19703 U.S.A.

You may fax claims to: Direct: (302) 797-3150 or 1-800-243-6998 (USA & Canada)

If dialing internationally: AT&T access code + 800-243-6998

You may call our Customer Service Center: direct (302) 797-3100 or 1-800-441-2668 (USA & Canada)

If dialing internationally: ATT access code + 800-441-2668

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

Hospital Confinement

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

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

Doctor's Bills, Other Medical, and Dental Expenses

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

You must follow the Predetermination of Benefits procedure when it is necessary for dental forms.

HOW TO FILE YOUR CLAIM

CLAIM REMINDERS:

- BE SURE TO USE YOUR POLICY NUMBER WHEN YOU FILE CIGNA INTERNATIONAL CLAIM FORMS, OR WHEN YOU CALL THE CIGNA INTERNATIONAL SERVICE CENTER.

YOUR POLICY NUMBER IS 02016A.

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

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

ACCIDENT AND HEALTH PROVISIONS

CLAIMS

Notice of Claim

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

Claim Forms

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

Proof of Loss

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

Physical Examination

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

Legal Actions

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

ELIGIBILITY — EFFECTIVE DATE

Eligibility for Employee Insurance

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

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least 20 hours a week.

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

Initial Employee Group: You are in the Initial Employee Group if you are employed in a class of employees on the date that class of employees becomes a Class of Eligible Employees as determined by your Employer.

New Employee Group: You are in the New Employee Group if you are not in the Initial Employee Group.

Eligibility For Dependent Insurance

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

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

Waiting Period

Initial and New Employee Group: 1st of the month or Coincident with the date of hire.

Classes of Eligible Employees

All full-time U.S. Expatriate Employees and Third Country National Employees working outside of the United States.

"Expatriate" means an Employee who is working outside his country of citizenship.

"Third Country National" generally means an Employee of the Policyholder who works outside his country of citizenship, and outside the Policyholder's country of domicile.

Persons for whom coverage is prohibited under applicable law will not be considered eligible under this plan.

ELIGIBILITY — EFFECTIVE DATE

Employee Insurance

This Plan is offered to you as an Employee.

Effective Date of Your Insurance

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

Dependent Insurance

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

Effective Date of Dependent Insurance

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

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

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

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

CG may require evidence of good health at your expense if you are a Late Entrant. Such requirement will not apply to Medical Insurance.

Exception for Newborns

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

ELIGIBILITY - EFFECTIVE DATE

Exception to Late Entrant Definition

A person will not be considered a Late Entrant when enrolling outside a designated enrollment period if: he had existing coverage, and he certified in writing, if applicable, that he declined coverage due to such coverage; Employer contributions toward the other coverage have been terminated; he is no longer eligible for prior coverage; or if such prior coverage was continuation coverage and the continuation period has been exhausted: and he enrolls for this coverage within 30 days after losing or exhausting prior coverage. In addition, a Dependent spouse or minor child enrolled within 30 days following a court order of such coverage will not be considered a Late Entrant.

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption, you may enroll your eligible Dependents and yourself, if you are not already enrolled, within 30 days of such event. Coverage will be effective, on the date of marriage, birth, adoption, or placement for adoption.

Any applicable Pre-existing Condition limitation will apply to you and your Dependents upon enrollment, reduced by prior Creditable Coverage, but will not be extended as for a Late Entrant.

Pre-Existing Condition Limitation for Late Entrant

For plans which include a Pre-existing Condition limitation, the one-year waiting period before coverage begins for such conditions, will be increased to 18 months from the date a Late Entrant applies for coverage.

For plans which do not include a Pre-existing Condition limitation, you may be required to wait until the next plan enrollment period to enroll for coverage under the plan, if you are a Late Entrant.

For plans which do not standardly include a Pre-existing Condition limitation and which do not include an annual open enrollment period, a Pre-existing condition limitation of 18 months will apply from the date a Late Entrant applies for coverage.

REQUIREMENTS OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1993 (OBRA'93)

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

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

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

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

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

Qualified Medical Child Support Order

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

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

**REQUIREMENTS OF THE OMNIBUS BUDGET
RECONCILIATION ACT OF 1993 (OBRA'93) (Continued)**

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

Payment of Benefits

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

B. Eligibility for Coverage for Adopted Children

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

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

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

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

COMPREHENSIVE MEDICAL BENEFITS

For You And Your Dependents

If you or any one of your Dependents, while insured for these benefits, incurs Covered Expenses, CG will pay an amount determined as follows, subject to the Maximum Benefit Provision and to the Mental Illness, Alcohol and Drug Abuse Maximums:

100% of the charges made for or in connection with routine physical examinations for Employees and Dependents age 18 and over; and

100% of the charges made for or in connection with child preventive care services for Dependent children through age 17; and

with respect to all other Covered Expenses:

50% of the charges made for or in connection with Mental Illness, alcohol and drug abuse while a person is not Confined in a Hospital; and

80% of all other Covered Expenses incurred;

provided that the applicable Comprehensive Medical Deductible shown in The Schedule will first be deducted from such other Covered Expenses incurred for that person in each calendar year.

COMPREHENSIVE MEDICAL BENEFITS

Full Payment Area

When a person has incurred \$1,000 of Covered Expenses in a calendar year for which no payment is provided because of the coinsurance factor, benefits for him for Covered Expenses incurred during the rest of that calendar year will be payable at the rate of 100%.

When you and at least one of your Dependents or at least two of your Dependents have incurred a combined amount of Covered Expenses of \$2,000 in a calendar year for which no payment is provided because of the coinsurance factor, benefits for you and all of your Dependents for Covered Expenses incurred during the rest of that calendar year will become payable at the rate of 100%.

However, benefits for Covered Expenses incurred for or in connection with Mental Illness, alcohol or drug abuse will stay the same and the out-of-pocket expenses resulting from the treatment of Mental Illness, alcohol or drug abuse will not apply toward the out-of-pocket limitation. Additionally, any penalties resulting from failure to comply with the PAC/CSR Requirements shown in The Schedule will not apply toward the out-of-pocket limitation.

Maximum Benefit Provision

The total amount of Comprehensive Medical Benefits payable for all expenses incurred during a person's lifetime will not exceed the Maximum Benefit shown in The Schedule.

Calendar Year Mental Illness, Alcohol and Drug Abuse Maximums

The total number of days or visits for which Comprehensive Medical Benefits are payable for all expenses incurred for a person in a calendar year for or in connection with Mental Illness, alcohol and drug abuse will not exceed any Calendar Year Mental Illness, Alcohol and Drug Abuse Maximums as shown in The Schedule.

Lifetime Mental Illness, Alcohol and Drug Abuse Maximums

The total number of days or visits for which Comprehensive Medical Benefits are payable for all expenses incurred for a person in his lifetime for or in connection with Mental Illness, alcohol and drug abuse will not exceed any Lifetime Mental Illness, Alcohol and Drug Abuse Maximums as shown in The Schedule.

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 essential for the necessary care and treatment of an Injury or a Sickness.

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 in a private room, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Daily Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-standing Surgical Facility, on its own behalf, for medical care and treatment.
- charges made by a Skilled Nursing Facility, on its own behalf, for medical care and treatment; except that for any day of Skilled Nursing Facility confinement in a private room, Covered Expenses will not include that portion which is more than the Skilled Nursing Facility's most common rate for a semiprivate room, or charges for more than 60 days of confinement in a Skilled Nursing Facility during any one calendar year.
- charges made by a facility licensed to furnish mental health services, on its own behalf, for care and treatment of Mental Illness provided on an outpatient basis.
- charges made by a facility licensed to furnish treatment of alcohol and drug abuse, on its own behalf, for care and treatment provided on an outpatient basis.

COMPREHENSIVE MEDICAL BENEFITS

Covered Expenses (Continued)

- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse 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 and blood not donated or replaced; oxygen and other gases and their administration; rental or, at CG's option, purchase of Durable Medical Equipment; therapy provided by a licensed physical, occupational or speech therapist; prosthetic appliances; prostheses following a mastectomy; and dressings. Vitamins (other than prenatal vitamins), fluoride and smoking cessation products are not covered.
- charges made while a person is Confined in a Hospital for drugs and medicines lawfully dispensed only upon the written prescription of a Physician, excluding vitamins (other than prenatal vitamins), fluoride and smoking cessation products.
- charges made outside the United States for drugs and medicines lawfully dispensed only upon the written prescription of a Physician, excluding vitamins (other than prenatal vitamins), fluoride and smoking cessation products.
- charges made for or in connection with approved organ transplant services, including immunosuppressive medication; organ procurement costs; and donor's medical costs. The amount payable for donor's medical costs will be reduced by the amount payable for those costs from any other Plan. Certain transplants will not be covered based on General Limitations. Contact CG before you incur any such costs.
- charges made for or in connection with annual Papanicolaou screening test.
- charges made for or in connection with routine physical examinations for Employees and Dependents age 18 and over, including a chest x-ray, urinalysis, blood tests, and an EKG, not to exceed the Adult Routine Physical Examination Maximum shown in The Schedule. Charges for eye and ear examinations for corrective lenses and hearing apparatus are not considered Covered Expenses under this benefit.
- charges made for or in connection with travel immunizations for adults age 18 and over.

COMPREHENSIVE MEDICAL BENEFITS

Covered Expenses (Continued)

- charges made for or in connection with an annual prostate cancer screening, commonly known as a prostate specific antigen (PSA) test for males age 50 or older.
- charges made for or in connection with mammograms including; (a) a baseline mammogram for asymptomatic women at least age 35; (b) a mammogram every one or two years for asymptomatic women age 40-49, but no sooner than two years after a woman's baseline mammogram; (c) an annual mammogram for women age 50 and over; and (d) a mammogram, anytime, regardless of the woman's age, when prescribed by a Physician;
- charges for children from birth through age 18 for immunization against: (a) diphtheria; (b) hepatitis B; (c) measles; (d) mumps; (e) pertussis; (f) polio; (g) rubella; (h) tetanus; (i) varicella; (j) Haemophilus influenzae b; and (k) hepatitis A.
- charges made for or in connection with one baseline lead poisoning screening test for children at or around 12 months of age. Also, for children under the age of 6 who are considered to be at high risk (in accordance with guidelines set by the Division of Public Health) coverage will include lead poisoning screening and diagnostic evaluation.
- charges made for treatment of Biologically-Based Mental Illness. Such Covered Expenses will be payable the same as for other illnesses. Any Mental Illness Maximums in The Schedule and any Full Payment Area exceptions for Mental Illness will not apply to Biologically Based Mental Illness.
- charges made for prescription contraceptive drugs and devices approved by the Food and Drug Administration (FDA) and for outpatient contraceptive services including consultations, examinations, procedures and medical services related to the use of contraceptive methods to prevent unplanned pregnancy. Charges made for the insertion and removal and medically necessary examination associated with the use of such FDA approved contraceptive drug or device are also included.

COMPREHENSIVE MEDICAL BENEFITS

Covered Expenses (Continued)

- charges made for the following equipment and supplies for the treatment of diabetes, if recommended in writing or prescribed by a Physician: insulin pumps; blood glucose meters and strips; urine testing strips; insulin; syringes; lancets; alcohol swabs; and pharmacological agents for controlling blood sugar.
- charges made for colorectal cancer screening as follows:
 - (1) For persons 50 years of age or older: screening with annual fecal occult blood tests (three specimens), flexible sigmoidoscopy every five years, colonoscopy every ten years, double contrast barium enema every five years, or any combination of the most reliable, medically recognized screening tests available as may be determined by the Secretary of Health and Social Services of Delaware.
 - (2) For persons who are deemed at high risk of colon cancer because of:
 - a. family history of familial adenomatous polyposis;
 - b. family history of hereditary non-polyposis colon cancer;
 - c. chronic inflammatory bowel disease;
 - d. family history of breast, ovarian, endometrial, colon cancer, or polyps;
 - e. a background (ethnic or lifestyle) such that the health care provider treating the insured believes that he or she is at elevated risk;

screening by colonoscopy, barium enema, or any combination of the most reliable, medically recognized screening tests available as determined by the Secretary of Health and Social Services of Delaware are covered at a frequency determined by the Physician.

COMPREHENSIVE MEDICAL BENEFITS

Covered Expenses (Continued)

In addition, Covered Expenses will include expenses incurred for a Dependent child who is age 17 or less for charges made for Child Preventive Care Services consisting of the following services delivered or supervised by a Physician, in keeping with prevailing medical standards:

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

excluding any charges for:

- services which exceed the Child Preventive Care Services Calendar Year Maximums shown in The Schedule;
- services for which benefits are otherwise provided under this Comprehensive Medical Benefits section;
- services for which benefits are not payable according to the Expenses Not Covered section.

COMPREHENSIVE MEDICAL BENEFITS

Covered Expenses (Continued)

- charges made by a Home Health Care Agency for the following medical services and supplies provided under the terms of a Home Health Care Plan for the person named in that plan:
 - part-time or intermittent nursing care by or under the supervision of a Registered Graduate Nurse;
 - part-time or intermittent services of a Home Health Aide;
 - physical, occupational, or speech therapy;
 - medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent that such charges would have been considered Covered Expenses had a person required confinement in the Hospital as a registered bed patient or confinement in a Skilled Nursing Facility;

excluding any charges for:

- more than 40 home health care visits during a calendar year; (To determine the benefits payable, each visit by an Employee of a Home Health Care Agency will be considered one home health care visit and each 4 hours of Home Health Aide services will be considered one home health care visit.);
- care or treatment which is not stated in the Home Health Care Plan;
- the services of a person who is a member of your family or your Dependent's family or who normally lives in your home or your Dependent's home;
- a period when a person is not under the continuing care of a Physician.

COMPREHENSIVE MEDICAL BENEFITS

Covered Expenses (Continued)

- charges made due to Terminal Illness for the following Hospice Care Services provided under a Hospice Care Program:
 - by a Hospice Facility for Bed and Board and Services and Supplies, except that, for any day of confinement in a private room, Covered Expenses will not include that portion of charges which is more than the Hospice Bed and Board Limit shown in The Schedule;
 - by a Hospice Facility for services provided on an outpatient basis;
 - by a Physician for professional services;
 - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling, including bereavement counseling within one year after the person's death;
 - for pain relief treatment, including drugs, medicines and medical supplies;
 - by a Home Health Care Agency for:
 - part-time or intermittent nursing care by or under the supervision of a Nurse;
 - part-time or intermittent services of a Home Health Aide;

COMPREHENSIVE MEDICAL BENEFITS

Covered Expenses (Continued)

- 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 charges that exceed the Hospice Care Services Lifetime Maximum shown in The Schedule;
- 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;
- for more than three bereavement counseling sessions.

COMPREHENSIVE MEDICAL BENEFITS

Covered Expenses (Continued)

Home Infusion Therapy

Charges for home infusion therapy will include: (a) long-term or life-sustaining use of intravenous drip infusion primarily for artificial feeding; (b) the administration of drugs, and (c) the maintenance of body fluids. Benefits are limited to the Home Infusion Therapy Maximum shown in the Benefit Schedule.

COMPREHENSIVE MEDICAL BENEFITS

Expenses Not Covered

Covered Expenses will not include, and no payment will be made for, expenses incurred:

- for or in connection with cosmetic surgery unless: (a) a person receives an Injury which results in bodily damage requiring the surgery; or (b) it qualifies as reconstructive surgery performed on a person following surgery, and both the surgery and the reconstructive surgery are essential and medically necessary; or (c) it is performed to correct a congenital abnormality on one of your Dependents who has not reached skeletal maturity; or (d) it qualifies as reconstructive surgery following a mastectomy, including surgery and reconstruction of the other breast to achieve symmetry.
- for eyeglasses, hearing aids or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses or contact lenses that follows cataract surgery.
- for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an Injury to sound natural teeth; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; or (c) charges made by the outpatient department of a Hospital in connection with surgery.
- for charges made by a Physician for Chiropractic treatment, while not Confined in a Hospital, which exceed the Chiropractic Treatment Calendar Year Maximum shown in The Schedule.
- for charges made by a Physician for the treatment of Temporomandibular Joint Disorder (TMJ), which exceed the TMJ Lifetime Maximum shown in The Schedule.
- for which benefits are not payable according to the "General Limitations" section.

COMPREHENSIVE MEDICAL BENEFITS FOR LATE ENTRANTS ONLY

Expenses Not Covered (Continued)

- for or in connection with an Injury or a Sickness which is a Pre-existing Condition after benefits equal to \$750 have become payable, unless those expenses are incurred after a continuous, 18-month period during which a person is satisfying a waiting period and/or is insured for these benefits.

Pre-existing Condition

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

Exceptions to Pre-existing Condition Limitation

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

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

Credit for Coverage Under Prior Plan

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

CG will reduce any Pre-existing Condition limitation period under this policy by the number of days of prior Creditable Coverage you had under a creditable health plan or policy for up to 18 months for a Late Entrant.

COMPREHENSIVE MEDICAL BENEFITS FOR LATE ENTRANTS ONLY

Certification 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. Certification, or other proofs of coverage which need to be submitted outside the standard enrollment form process for any reason, may be sent directly to: CIGNA International Service Center, P.O. Box 15050, Wilmington, DE 19850. You should contact the plan administrator or 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: a self-insured employer group health plan; individual or group health insurance indemnity or HMO plans; state or federal continuation coverage; individual or group health conversion plans; Part A or Part B of Medicare; Medicaid, except coverage solely for pediatric vaccines; the Indian Health Service; the Peace Corps Act; a state health benefits risk pool; a public health plan; health coverage for current and former members of the armed forces and their Dependents; medical savings accounts; and health insurance for federal employees and their Dependents.

COMPREHENSIVE MEDICAL BENEFITS

Common Accident

If you and one or more of your insured Dependents or if two or more of your insured Dependents are injured in the same accident and incur Covered Expenses for those injuries in the calendar year in which the accident occurs, not more than one Comprehensive Medical Deductible will be deducted from the total Covered Expenses incurred for them during the rest of that calendar year.

Multiple Birth

Not more than one Comprehensive Medical Deductible will be deducted from the total Covered Expenses incurred in a calendar year for two or more of your Dependents born in a multiple birth if those Covered Expenses are incurred in the same calendar year in which they are born and are due to:

- premature birth;
- abnormal congenital condition; or
- Injury which is received or Sickness which starts not more than 30 days after their birth.

PRESCRIPTION DRUG BENEFITS

This section describes coverage for Prescriptions obtained inside the United States only. Prescriptions obtained outside of the United States are covered under the Comprehensive Medical Benefits section of this certificate.

If you or any one of your Dependents, while insured for these benefits, incurs expenses for charges made by a Pharmacy for Covered Prescription Drugs for an Injury or a Sickness, CG will pay that portion of the expense remaining after you or your Dependent has paid the required Coinsurance shown in the Schedule. A Deductible applies if you use a non-Participating Retail Pharmacy.

No payment will be made under any other section for expenses incurred to the extent that benefits are payable for those expenses under this section.

Covered Prescription Drugs

The term Covered Prescription Drugs means:

- a Prescription Legend Drug for which a written prescription is required;
- oral or injectable insulin dispensed only upon the written prescription of a Physician;
- insulin needles and syringes;
- tretinoin for individuals through age 35;
- a compound medication of which at least one ingredient is a Prescription Legend Drug;
- any other drug which, under the applicable state law, may be dispensed only upon the written prescription of a Physician;
- oral contraceptives or contraceptive devices, regardless of intended use, except that implantable contraceptive devices, such as Norplant, are not considered Covered Prescription Drugs;
- prenatal vitamins, upon written prescription;
- glucose test strips.

PRESCRIPTION DRUG BENEFITS (Continued)

This section describes coverage for Prescriptions obtained inside the United States only. Prescriptions obtained outside of the United States are covered under the Comprehensive Medical Benefits section of this certificate.

Limitations

No payment will be made for expenses incurred:

- for nonlegend drugs, other than those specified under "Covered Prescription Drugs";
- to the extent that payment is unlawful where the person resides when expenses are incurred;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person were not covered by these benefits;
- for experimental drugs or for drugs labeled: "Caution - limited by federal law to investigational use";
- for drugs which are not considered essential for the necessary care and treatment of an Injury or Sickness, as determined by Connecticut General Life Insurance Company or CIGNA Pharmacy Management;
- for drugs obtained from a non-Participating Mail-Order Pharmacy;
- for any prescription filled in excess of the number specified by the Physician or dispensed more than one year from the date of the Physician's order;
- for indications not approved by the Food and Drug Administration;

PRESCRIPTION DRUG BENEFITS

This section describes coverage for Prescriptions obtained inside the United States only. Prescriptions obtained outside of the United States are covered under the Comprehensive Medical Benefits section of this certificate.

Limitations (Continued)

- for immunization agents, biological sera, blood or blood plasma;
- for therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other nonmedicinal substances, excluding insulin syringes;
- for drugs for cosmetic purposes;
- for tretinoin for individuals age 36 and over;
- for administration of any drug;
- for medication which is taken or administered, in whole or in part, at the place where it is dispensed or while a person is a patient in an institution which operates, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
- for prescriptions which an eligible person is entitled to receive without charge from any workers' compensation or similar law or any public program other than Medicaid;
- for growth hormones and anabolic steroids;
- for nutritional or dietary supplements, antiobesity drugs or anorexients;
- for prescription vitamins, other than prenatal vitamins, upon written prescription;
- for oral infertility drugs;
- for smoking cessation products.

PRESCRIPTION DRUG BENEFITS (Continued)

This section describes coverage for Prescriptions obtained inside the United States only. *Prescriptions obtained outside of the United States are covered under the Comprehensive Medical Benefits section of this certificate.*

Reimbursement/Filing a Claim

If you or your Dependent purchases Covered Prescription Drugs from a Participating Retail Pharmacy, you pay only the portion shown on the Schedule at the time of purchase. You do not need to file a claim form. If you or your Dependent purchases Covered Prescription Drugs from a non-Participating Retail Pharmacy, you pay the full cost at the time of purchase. You must submit a claim form in order to be reimbursed for the amount payable by the plan.

You may obtain the required claim form from your Benefit Plan Administrator. All claim forms should be completed by you.

Refer to the section in your certificate entitled "How to File a Claim" for instructions on filing a claim for reimbursement.

DENTAL BENEFITS – CIGNA TRADITIONAL DENTAL

For You and Your Dependents

If you or any one of your Dependents incurs Covered Expenses, CG will:

- deduct any Dental Deductible that applies from the Covered Expenses first incurred in a calendar year for a person; and
- pay for the other Covered Expenses incurred in that calendar year up to the Maximum Covered Expense determined from the Dental Services Schedule for each Dental Service subject to the Alternate Benefit Provision.

The Dental Deductible is shown in The Schedule.

Missing Teeth and Late Entrant Limit

The amount payable is 50% of the amount otherwise payable for first replacement of teeth that are missing when a person becomes insured for these benefits. After a person has been continuously insured for these benefits for 24 months, this limit will no longer apply.

Late Entrant Limit

No benefits are payable for Class III Dental Services if you or your Dependent are a Late Entrant for Dental Insurance. After a person has been continuously insured for these benefits for 12 months, this limit will no longer apply.

Orthodontia Provision

The total amount payable for all expenses incurred for Orthodontics for a Dependent Child less than 19 years of age during his lifetime will not be more than the Orthodontia Maximum shown in The Schedule.

Maximum Benefit Provision

The total amount payable for all expenses incurred for other than Orthodontics for a person in a calendar year will not be more than the Maximum Benefit shown in The Schedule.

DENTAL BENEFITS – CIGNA TRADITIONAL DENTAL

Covered Expenses

The term Covered Expenses means expenses incurred by or on behalf of you or any one of your Dependents for charges made by a Dentist for the performance of a Dental Service listed in the Dental Services Schedule.

Covered Expenses will include only those expenses incurred for such charges when the Dental Service:

- is performed by or under the direction of a Dentist;
- is essential for the necessary care of the teeth; and
- starts and is completed while the person is insured.

Any portion of charges for a Dental Service that exceeds the Maximum Covered Expense shown for that service in the Dental Services Schedule is not included.

A Dental Service is deemed to start when the actual performance of the service starts except that:

- for fixed bridgework and full or partial dentures, it starts when the first impressions are taken and/or abutment teeth are fully prepared.
- for a crown, inlay or onlay, it starts on the first date of preparation of the tooth involved.
- for root canal therapy, it starts when the pulp chamber of the tooth is opened.

Alternate Benefit Provision

When more than one covered Dental Service could provide suitable treatment based on common dental standards, CG will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses. Benefits will be provided for treatment rendered in accordance with accepted dental standards for adequate and appropriate care. You and your Dentist are free to apply this benefit payment to the treatment of your choice; however, you are responsible for the expenses incurred which exceed Covered Expenses. For this reason, CG strongly recommends the use of predetermination of benefits when major dental services are needed, so that you and your Dentist know in advance what the benefit plan will cover before any treatment begins.

DENTAL BENEFITS - CIGNA TRADITIONAL DENTAL

Predetermination of Benefits

The term Predetermination of Benefits means a review by CG of a Dentist's description of planned treatment and expected charges, including those for diagnostic x-rays. This review should be made whenever extensive dental work is proposed. The information should be sent to CG before the dental work is started. If there is a major change in the treatment plan, a revised plan should be sent to CG.

The expenses that will be included as Covered Expenses will be determined by CG and are subject to the Alternate Benefit Provision. When there has not been a Predetermination of Benefits, CG will determine the expenses that will be included as Covered Expenses at the time the claim is received.

Predetermination of Benefits does not guarantee payment. The estimate of benefits payable may change based on the benefits, if any, for which a person qualifies at the time services are completed.

DENTAL SERVICES SCHEDULE – CIGNA TRADITIONAL DENTAL

Covered Dental Expenses will include expenses incurred for Dental Services listed in this Schedule. CG may agree to accept, as Covered Dental Expenses, expenses for services not listed. To be considered, services should be identified in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature and/or by description and submitted to CG.

CG will determine the Maximum Covered Expense for services that it accepts. The Maximum Covered Expense so determined will be consistent with the maximums listed.

A temporary Dental Service is included in the allowance for the final Dental Service and is not a separate Dental Service.

CLASS I SERVICES – Diagnostic and Preventive

Clinical oral examination – Only 2 per person per calendar year.

Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive Dental Services are performed. (Any x-ray taken in connection with such treatment is a separate Dental Service.)

X-rays – Complete series – Only one per person, including Panoramic film, in any 3 calendar years.

Bitewing x-rays – Only 2 charges per person per calendar year.

Panoramic (Panorex) x-ray – Only one per person in any 3 calendar years.

Prophylaxis (Cleaning) – Only 2 per person per calendar year.

Periodontal maintenance procedures (following active therapy), Periodontal Prophylaxis.

Topical application of fluoride (excluding prophylaxis) – Limited to persons less than 19 years old – Only one per person per calendar year.

Topical application of sealant, per tooth, on a posterior tooth for a person less than 14 years old - Only one treatment per tooth in any 3 calendar years.

Space Maintainers, fixed unilateral – Limited to nonorthodontic treatment.

**DENTAL SERVICES SCHEDULE
CIGNA TRADITIONAL DENTAL**

CLASS II SERVICES – Basic Restorations, Endodontics, Periodontics, Prosthodontic Maintenance and Oral Surgery

Amalgam Filling – One Surface

Composite/Resin Filling – One Surface

Root Canal Therapy – Any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Dental Service.

Osseous Surgery – Flap entry and closure is part of the allowance for osseous surgery and osseous graft and not a separate Dental Service.

If more than one periodontal surgical service is performed per quadrant only the one with the largest Maximum Covered Expense is a Dental Service.

Periodontal Scaling and Root Planing – Entire Mouth

Adjustments – Complete Denture

Any adjustment of or repair to a denture within 6 months of its installation is not a separate Dental Service.

Recement Bridge

Routine Extractions

Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth

Removal of Impacted Tooth, Soft Tissue

Removal of Impacted Tooth, Partially Bony

Removal of Impacted Tooth, Completely Bony

Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery are part of the allowance for each Dental Service.

General Anesthesia – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by CG, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

I. V. Sedation – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by CG, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

**DENTAL SERVICES SCHEDULE - CIGNA TRADITIONAL DENTAL
CLASS III SERVICES - Major Restorations, Dentures and
Bridgework**

High Noble Metal (gold) or Crown restorations are Dental Services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

Crowns

Porcelain Fused to High Noble Metal

Full Cast, High Noble Metal

Three-Fourths Cast, Metallic

Fixed or Removable Appliances

Complete (Full) Dentures, Upper or Lower

Partial Dentures

Lower, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)

Upper, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)

Bridge Pontics - Cast High Noble Metal

Bridge Pontics - Porcelain Fused to High Noble Metal

Bridge Pontics - Resin with High Noble Metal

Retainer Crowns - Resin with High Noble Metal

Retainer Crowns - Porcelain Fused to High Noble Metal

Retainer Crowns - Full Cast Gold

CLASS IV SERVICES - Orthodontics

Each month of active treatment is a separate Dental Service.

Orthodontic work-up including x-rays, diagnostic casts and treatment plan and first month of active treatment including all active treatment and retention appliance

Active treatment per month after the first month

Fixed or Removable Appliances - Only one appliance per person

For Tooth Guidance

To Control Harmful Habits

DENTAL BENEFITS - CIGNA TRADITIONAL DENTAL

Expenses Not Covered

Covered Expenses will not include, and no payment will be made for, expenses incurred for:

- services performed solely for cosmetic reasons;
- replacement of a lost or stolen appliance;
- replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: (a) such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;
- orthodontic services or supplies for any person other than a Dependent child less than 19 years of age;
- porcelain or acrylic veneers of crowns or pontics on or replacing the upper and lower first, second and third molars;
- bite registrations; precision or semiprecision attachments; or splinting;

DENTAL BENEFITS – CIGNA TRADITIONAL DENTAL

Expenses Not Covered (Continued)

- a surgical implant of any type including any prosthetic device attached to it;
- instruction for plaque control, oral hygiene and diet;
- dental services that do not meet common dental standards;
- services that are deemed to be medical services;
- services and supplies received from a Hospital;
- services for which benefits are not payable according to the "General Limitations" section.

In addition, these benefits will be reduced so that the total payment under the items below will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under:

- this plan; and
- any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

GENERAL LIMITATIONS MEDICAL AND DENTAL BENEFITS

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

- for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;
- for or in connection with a Sickness which is covered under any workers' compensation or similar law;
- 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 Sickness or Injury;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- to the extent that they are more than Reasonable and Customary Charges;
- for charges for unnecessary care, treatment or surgery, except as specified in any certification requirement shown in The Schedule;
- for or in connection with Custodial Services, education or training;
- 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;
- for experimental drugs or substances not approved by the Food and Drug Administration, or for drugs labeled: "Caution - limited by federal law to investigational use";
- for or in connection with experimental procedures or treatment methods not approved by the American Medical Association or the appropriate medical specialty society;
- for charges for Injury or Sickness caused by war, or an act of war, whether declared or undeclared, riot, civil commotion or police action;
- for claim payments that are illegal under applicable law.

GENERAL LIMITATIONS

MEDICAL AND DENTAL BENEFITS (Continued)

- to the extent of the exclusions imposed by any certification requirement shown in The Schedule;
- for charges made by a Physician for or in connection with surgery which exceed the following maximum when two or more surgical procedures are performed at one time: the maximum amount payable will be the amount otherwise payable for the most expensive procedure, and $\frac{1}{2}$ of the amount otherwise payable for all other surgical procedures;
- for or in connection with in vitro fertilization, artificial insemination or similar procedures.

GENERAL LIMITATIONS

MEDICAL AND DENTAL BENEFITS (Continued)

- for charges made by an assistant surgeon in excess of 20 percent of the surgeon's allowable charge; or for charges made by a cosurgeon in excess of the surgeon's allowable charge plus 20 percent (for purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts);
- for charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn;
- for charges for supplies, care, treatment or surgery which are not considered essential for the necessary care and treatment of an Injury or Sickness, as determined by CG;
- for charges made for or in connection with tired, weak or strained feet for which treatment consists of routine footcare, including but not limited to, the removal of calluses and corns or the trimming of nails unless medically necessary;
- for or in connection with speech therapy, if such therapy is:
(a) used to improve speech skills that have not fully developed; (b) can be considered custodial or educational; or (c) is intended to maintain speech communication; speech therapy which is not restorative in nature will not be covered;
- for charges made by any covered provider who is a member of your family or your Dependent's family.

GENERAL LIMITATIONS

MEDICAL AND DENTAL BENEFITS (Continued)

No payment will be made for expenses incurred by you or any one of your Dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with:

- a "no-fault" insurance law; or
- an uninsured motorist insurance law.

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

MEDICARE ELIGIBLES

The Medical Expense Insurance for:

- (a) a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;
- (b) a former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;
- (c) an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;
- (d) the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;
- (e) an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;
- (f) an Employee or 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;

MEDICARE ELIGIBLES (Cont.)

will be modified, where permitted by the rules established by the Social Security Act of 1965 as amended, as follows:

The amount payable under this plan will be reduced so that the total amount payable by Medicare and by CG will be no more than 100% of the expenses incurred.

CG will assume the amount payable under:

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

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

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

COORDINATION OF BENEFITS

If you or any one of your Dependents is covered under more than one Plan, benefits payable from all such Plans will be coordinated.

Coordination of Benefits will be used to determine the benefits payable for a person for any Claim Determination Period if, for the Allowable Expenses incurred in that Period, the sum of:

- (a) the benefits that would be payable from this Plan in the absence of coordination; and
- (b) the benefits that would be payable from all other Plans without Coordination of Benefits provisions in those Plans;

would exceed such Allowable Expenses.

The benefits that would be payable from this Plan for Allowable Expenses incurred in any Claim Determination Period in the absence of Coordination of Benefits will be reduced to the extent required so that the sum of:

- (a) those reduced benefits; and
- (b) all the benefits payable for those Allowable Expenses from all other Plans;

will not exceed the total of such Allowable Expenses. Benefits payable from all other Plans include the benefits that would have been payable had proper claim been made for them.

However, the benefits of another Plan will be ignored when the benefits of this Plan are determined if: (a) the Benefit Determination Rules would require this Plan to determine its benefits before that Plan; and (b) the other Plan has a provision that coordinates its benefits with those of this Plan and would, based on its rules, determine its benefits after this Plan.

COORDINATION OF BENEFITS

CG reserves the right to release to or obtain from any other Insurance Company or other organization or person any information which, in its opinion, it needs for the purpose of Coordination of Benefits.

When payments which should have been made under this Plan based on the terms of this section have been made under any other Plans, CG will have the right to pay to any organizations making these payments the amount it determines to be warranted. Amounts paid in this manner will be considered to be benefits paid under this Plan. CG will be released from all liability under this Plan to the extent of these payments. When an overpayment has been made by CG at any time, it will have the right to recover that payment, to the extent of the excess, from the person to whom it was made or any other Insurance Company or organization, as it may determine.

Plan

Plan means any of the following which provides medical benefits or services: (a) group, blanket or franchise insurance coverage; (b) service plan contracts, group or individual practice or other prepayment plans; or (c) coverage under any: labor-management trustee plans; union welfare plans; employer organization plans; or employee benefit organization plans. Plan does not include coverage under individual policies or contracts. Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Allowable Expense

Allowable Expense means any necessary, reasonable and customary item of expense, at least a part of which is covered by any one of the Plans that covers the person for whom claim is made. When the benefits from a Plan are in the form of services, not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid. Allowable Expense will not include the difference between: (a) the cost of a private room; and (b) the cost of a semiprivate room; except while the person's stay in a private room is medically necessary in terms of generally accepted medical practice.

Claim Determination Period

Claim Determination Period means a calendar year or that part of a calendar year in which the person has been covered under this Plan.

COORDINATION OF BENEFITS

Benefit Determination Rules

The rules below establish the order in which benefits will be determined:

1. The benefits of a Plan which covers the person for whom claim is made other than as a dependent will be determined before a Plan which covers that person as a dependent.
2. The benefits of a Plan which covers the person for whom claim is made as a dependent of a person whose day of birth occurs first in a calendar year will be determined before a Plan which covers that person as a dependent of a person whose day of birth occurs later in that year; except that: (a) if the other Plan does not have this rule, its alternate rule will govern; and (b) in the case of a dependent child of divorced or separated parents, the rules in item (3) will apply.
3. If there is a court decree which establishes financial responsibility for medical, dental or other health care of the child, the benefits of the Plan which covers the child as a dependent of the parent so responsible will be determined before any other plan; otherwise:
 - a. The benefits of a Plan which covers the child as a dependent of the parent with custody will be determined before a Plan which covers the child as a dependent of a stepparent or a parent without custody.
 - b. The benefits of a Plan which covers the child as a dependent of a stepparent will be determined before a plan which covers the child as a dependent of the parent without custody.

COORDINATION OF BENEFITS

Benefit Determination Rules (Continued)

4. When the above rules do not establish the order, the benefits of a plan which has covered the person for whom claim is made for the longer period of time will be determined before a Plan which has covered the person for the shorter period of time; except that:
 - a. The benefits of a Plan which covers the person as a laid-off or retired employee, or his dependent will be determined after a Plan which covers the person as an employee, other than a laid-off or retired employee, or his dependent.
 - b. If the other Plan does not have the rule in item 4.a., which results in each Plan determining its benefits after the other, then item 4.a. will not apply.

EXPENSES FOR WHICH A THIRD PARTY MAY BE LIABLE

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

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

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

PAYMENT OF BENEFITS

To Whom Payable

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

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

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

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

Time of Payment

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

Recovery of Overpayment

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

TERMINATION OF INSURANCE - EMPLOYEES

Your insurance will cease on the earliest date below:

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

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

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer: (a) stops paying premium for you; or (b) otherwise cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

Injury or Sickness (For Medical and Dental Insurance)

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

TERMINATION OF INSURANCE – DEPENDENTS

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

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

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

TERMINATION OF INSURANCE EMPLOYEES AND DEPENDENTS

Special Continuation of Medical and Dental Insurance

If your insurance is terminated for any reason other than failure to make any required contributions and you are hospitalized on the date of termination for a single hospitalization, you may continue the insurance for up to 10 consecutive days. In no event will the insurance be continued beyond the earliest of the following:

- 10 consecutive days;
- the date of your discharge from the hospital.

For Dependents

If your insurance is being continued as described above, the insurance for any one of your Dependents insured on the date your insurance would otherwise cease may be continued, subject to the above provisions. In no event will the insurance be continued beyond the earliest of the following:

- the date of the dependent's discharge from the hospital;
- 10 consecutive days; or
- with respect to any one Dependent, the date that Dependent ceases to qualify as a Dependent.

TERMINATION OF INSURANCE

CONTINUATION REQUIRED BY FEDERAL LAW FOR YOU AND YOUR DEPENDENTS

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

Federal law enables you or your Dependent to continue health insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than for gross misconduct). Federal law also enables your Dependents to continue health insurance if their coverage ceases due to your death, divorce or legal separation, or with respect to a Dependent child, failure to continue to qualify as a Dependent. Continuation must be elected in accordance with the rules of your Employer's group health plan(s) and is subject to federal law, regulations and interpretations.

A. Employees and Dependents Continuation Provision

If you and your Dependent's insurance would otherwise cease because of a reduction in the number of hours you work or your termination of employment for any reason other than gross misconduct, you or your Dependent may continue health insurance upon payment of the required premium to the Employer. You and your Dependents must elect to continue insurance within 60 days from the later of: (a) the date of a reduction of your work hours or your termination of employment; (b) the date notice of the right to continue insurance is sent; or (c) the date the insurance would otherwise cease. You must pay the first premium within 45 days from the date you elect to continue coverage. Such insurance will not be continued by CG for you and/or your Dependents, as applicable, beyond the earliest of the following dates:

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

TERMINATION OF INSURANCE

CONTINUATION REQUIRED BY FEDERAL LAW FOR YOU AND YOUR DEPENDENTS (Continued)

B. Dependent Continuation Provision

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

1. your death;
2. divorce or legal separation; or
3. with respect to a Dependent child, failure to continue to qualify as a Dependent,

such insurance may be continued upon payment of the required premium to the Employer. In the case of (2) or (3) above, you or your Dependent must notify your Employer within 60 days of such event. In addition, a Dependent must elect to continue insurance within 60 days from the later of: (a) the date the insurance would otherwise cease; or (b) the date notice of the right to continue insurance is sent.

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

- 36 months from the date of (1), (2) or (3) above, whichever may occur first;
- the date coverage ends due to failure to pay the required subsequent premium within 30 days of the due date;
- after the Dependent elects to continue this insurance, the date the Dependent first becomes entitled to Medicare;
- the date the policy cancels; or
- after the Dependent elects to continue this insurance, the date the Dependent first becomes covered under another group health plan, unless the Dependent has a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

C. Subsequent Events Affecting Dependent Coverage

If, within the initial 18-month continuation period, your Dependent would lose coverage because of an event described in (1), (2), or (3) of Section B, or because of your coverage loss due to your subsequent entitlement to Medicare, after you have continued your Dependent's coverage due to your employment termination or reduction in work hours, your Dependent may continue coverage for up to 36 months from the date of loss of employment or reduction in work hours.

TERMINATION OF INSURANCE

CONTINUATION REQUIRED BY FEDERAL LAW FOR YOU AND YOUR DEPENDENTS (Continued)

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

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

Disabled Individuals Continuation Provisions

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

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

To be eligible you or your Dependent must:

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

Termination of coverage for all covered persons during the additional 11 months will occur if the disabled person is found by the Social Security Administration to be no longer disabled. Termination for this reason will occur on the first day of the month beginning more than 30 days after the date of the final determination.

All reasons for termination described in sections A and B which apply to the initial 18 months will also apply to any or all covered persons for any additional months of coverage.

TERMINATION OF INSURANCE

CONTINUATION REQUIRED BY FEDERAL LAW FOR YOU AND YOUR DEPENDENTS (Continued)

D. Payment of Premium

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

Applicable Premium is determined as follows:

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

Timely Payment

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

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

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

**TERMINATION OF INSURANCE
CONTINUATION REQUIRED BY FEDERAL LAW
FOR YOU AND YOUR DEPENDENTS (Continued)**

F. Notification Requirements

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

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

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

TERMINATION OF INSURANCE

CONTINUATION REQUIRED BY FEDERAL LAW FOR YOU AND YOUR DEPENDENTS (Continued)

Interaction With Other Continuation Benefits

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

Newly Acquired Dependents

If, while your insurance is being continued under the continuation required by federal law provisions, you acquire a new Dependent, such Dependent will be eligible for this Continuation provided:

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

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

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

TERMINATION OF INSURANCE

REQUIREMENTS OF FAMILY AND MEDICAL LEAVE ACT OF 1993

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

A. Continuation of Health Insurance During Leave

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

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

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

B. Reinstatement of Canceled Insurance Following Leave

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

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

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

MEDICAL BENEFITS EXTENSION

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

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

Totally Disabled

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

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

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

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

DENTAL BENEFITS EXTENSION

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the prosthesis inserted within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

WHEN YOU HAVE A COMPLAINT OR AN APPEAL

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

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

Start with Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call the CIGNA International Service Center 1-800-441-2668 (inside the United States and Canada) or 1-302-797-3100 (outside the United States and Canada, call collect).

We will make every attempt to resolve the matter on your initial contact. However, if additional time is needed to investigate your concern, we will notify you within 30 days.

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

Appeals Procedure

CG has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. Please submit your written appeal to:

CIGNA International
Attn: Appeal Department
P.O. Box 15050
Wilmington, DE 19850-5050

You may also contact the CIGNA International Service Center directly to initiate the appeal process.

WHEN YOU HAVE A COMPLAINT OR AN APPEAL

Level One Appeal

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

For level one appeals, we will respond in writing with a decision within five working days after we receive an appeal for a required preservice or concurrent care coverage determination (decision).

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

WHEN YOU HAVE A COMPLAINT OR AN APPEAL

Level Two Appeal

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

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

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

You may request a 30-day extension during the Committee review period due to your necessity or convenience. Your request for this extension must be made within five calendar days from receipt of the appeals acknowledgment letter.

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

WHEN YOU HAVE A COMPLAINT OR AN APPEAL

Independent Review Procedure

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

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

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

To request a review, you must notify the Appeals Coordinator within 60 days of your receipt of CG's level-two appeal review denial. CG will then forward the file to the Department of Health which assigns an Independent Review Organization under the Department's Independent Health Care Appeals Program.

The Independent Review Organization will render an opinion within 45 days. When requested and when a delay would be detrimental to your condition, as determined by CG's Physician or Dentist reviewer, the review shall be completed within three days.

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

Appeal to the State of Delaware

You have the right to contact the Department of Health and Social Services to have the appeal reviewed for the appropriate inclusion in the independent review, if your benefit excludes you from the independent review process. The request must be in writing. The Department of Health may be contacted at the following address:

Department of Health and Social Services
2055 Limestone Road, Suite 200
Wilmington, DE 19080

WHEN YOU HAVE A COMPLAINT OR AN APPEAL

Notice of Benefit Determination on Appeal

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

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

Relevant Information

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

Legal Action

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

ARBITRATION (This provision does not apply to Dental Coverage)

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

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

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

The arbitrator(s) shall render his (their) decision within 30 days after the termination of the arbitration hearing. To the extent allowed by law, the decision of the arbitrator, or the decision of any two arbitrators if there are three arbitrators, shall be binding upon both parties conclusive of the controversy in question, and enforceable in any court of competent jurisdiction.

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

ERISA REQUIRED INFORMATION

The name of the Plan is:

Association of Universities for Research in Astronomy, Inc.
National Optical Astronomy Observatory

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

National Optical Astronomy Observatory
950 N. Cherry Ave.
Tucson, AZ 85726
(520) 318-8386

Employer Identification
Number (EIN)

Plan Number

86-0138043

506

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

Employer named above

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

Employer named above

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

CIGNA International Service Center, Wilmington, Delaware

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

The Plan's fiscal year ends on December 31.

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

ERISA REQUIRED INFORMATION (Continued)

Plan Trustees

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

Plan Type

The Plan is a healthcare benefit plan.

Collective Bargaining Agreements

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

Discretionary Authority

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

ERISA REQUIRED INFORMATION

Plan Modification, Amendment and Termination

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

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

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

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

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

ERISA REQUIRED INFORMATION

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

Continue Group Health Plan Coverage

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

ERISA REQUIRED INFORMATION

Prudent Actions by Plan Fiduciaries

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

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

Enforce Your Rights

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.

ERISA REQUIRED INFORMATION

CLAIM DETERMINATION PROCEDURES UNDER ERISA

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

Procedures Regarding Medical Necessity Determinations

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

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

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

Preservice Medical Necessity Determinations

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

ERISA REQUIRED INFORMATION

CLAIM DETERMINATION PROCEDURES UNDER ERISA

Preservice Medical Necessity Determinations (Continued)

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

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

Concurrent Medical Necessity Determinations

When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a required concurrent Medical Necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, CG will notify you or your representative of the determination within 24 hours after receiving the request.

Postservice Medical Necessity Determinations

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

ERISA REQUIRED INFORMATION

CLAIM DETERMINATION PROCEDURES UNDER ERISA

Postservice Medical Necessity Determinations (Continued)

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

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; (6) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

ERISA REQUIRED INFORMATION

Assistance With Your Questions

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

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

Benefits provided under this certificate are fully guaranteed by CG.

This certificate is issued by:

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

DEFINITIONS

Active Service

You will be considered in Active Service:

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

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.

Biologically-Based Mental Illness

A Biologically Based Mental Illness is defined as: schizophrenia; bipolar disorder; obsessive-compulsive disorder; major depressive disorder; panic disorder; Anorexia Nervosa; Bulimia Nervosa; schizoaffective disorder; and delusional disorder. The diagnostic criteria set out in the Diagnostic and Statistical Manual of Mental Disorders will be used to determine if a condition qualifies.

Coinurance

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

Custodial Services

The term Custodial Services means any services which are not intended primarily to treat a specific Injury or Sickness (including mental illness, alcohol or drug abuse). Custodial Services include, but shall not be limited to:

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

Dentist

The term Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the Dental Services described in the policy.

DEFINITIONS

Dependent

Dependents are:

- your lawful spouse; and
- any unmarried child of yours who is
 - less than 19 years old;
 - 19 years but less than 23 years old, enrolled in school as a full-time student and primarily supported by you;
 - 19 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CG within 31 days after the date the child ceases to qualify above. During the next two years CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

A child includes a legally adopted child. It also includes a stepchild who lives with you.

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.

Coverage for your Dependent Child will cease on the day that your Dependent Child is no longer a full-time student.

DEFINITIONS

Domestic Partner

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

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

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

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

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

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

DEFINITIONS

Durable Medical Equipment

The term Durable Medical Equipment means equipment which:

- can withstand repeated use;
- is primarily and customarily used to serve a medical purpose;
- is generally not useful to a person in the absence of Sickness or Injury; and
- is appropriate for use in the home.

Employee – For Medical and Dental Insurance

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 20 hours a week for the Employer.

Employer

The term Employer means the Policyholder and all Affiliated Employers.

Expense Incurred

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

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.

Home Health Aide

The term Home Health Aide means a person who: (a) provides care of a medical or therapeutic nature; and (b) reports to and is under the direct supervision of a Home Health Care Agency.

DEFINITIONS

Home Health Care Agency

The term Home Health Care Agency means a Hospital or a nonprofit or public home health care agency which:

- primarily provides skilled nursing service and other therapeutic service under the supervision of a Physician or a Registered Graduate Nurse;
- is run according to rules established by a group of professional persons;
- maintains clinical records on all patients;
- does not primarily provide custodial care or care and treatment of the mentally ill;

but only if, in those jurisdictions where licensure by statute exists, that Home Health Care Agency is licensed and run according to the laws that pertain to agencies which provide home health care.

Home Health Care Plan

The term Home Health Care Plan means a plan for care and treatment of a person in his home. To qualify, the plan must be established and approved in writing by a Physician who certifies that the person would require confinement in a Hospital or Skilled Nursing Facility if he did not have the care and treatment stated in the plan.

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.

Hospice Care Services

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

Hospice Facility

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

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

DEFINITIONS

Hospital

The term Hospital means:

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

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

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;
- an outpatient in a Hospital because of: (a) chemotherapy treatment; or (b) surgery;
- receiving emergency care in a Hospital for an Injury, on his first visit as an outpatient within 48 hours after the Injury is received;
- Partially Confined for treatment of Mental Illness, alcohol or drug abuse or other related illness. Two days of being Partially Confined will be equal to one day of being Confined in a Hospital.

The term Partially Confined means continually treated for at least 3 hours but not more than 12 hours in any 24-hour period.

Injury

The term Injury means an accidental bodily injury.

Mail-Order Pharmacy

The term Mail-Order Pharmacy means a pharmacy designated as a primary distribution center for a mail-service program.

DEFINITIONS

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.

Medicare

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

Mental Illness

The term "mental illness" means any disorder, other than a disorder induced by alcohol or drug abuse, which impairs the behavior, emotional reaction or thought process of a person, regardless of medical origin. In determining benefits payable, charges made for the treatment of any physiological symptoms related to a mental illness will not be considered to be charges made for treatment of a mental illness.

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.

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."

Participating Mail-Order Pharmacy

The term Participating Mail-Order Pharmacy means a Mail-Order Pharmacy which has contracted directly or indirectly with Connecticut General Life Insurance Company on behalf of CIGNA Pharmacy Management.

Participating Retail Pharmacy

The term Participating Retail Pharmacy means a Retail Pharmacy which has contracted directly or indirectly with Connecticut General Life Insurance Company on behalf of CIGNA Pharmacy Management.

DEFINITIONS

Pharmacy

The term Pharmacy means a licensed establishment where prescription drugs are dispensed by a pharmacist.

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.

Prescription Legend Drug

The term Prescription Legend Drug means any medicinal substance requiring, under the Federal Food, Drug and Cosmetic Act, a label that reads: "Caution: Federal law prohibits dispensing without a prescription."

Prescription Order

The term Prescription Order means the request for each separate drug or medication by a Physician or each authorized refill of such request.

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.

Reasonable and Customary Charge

A charge will be considered Reasonable and Customary if:

- it is the normal charge made by the provider for a similar service or supply; and
- it does not exceed the normal charge made by most providers of such service or supply in the geographic area where the service is received, as determined by CG.

To determine if a charge is Reasonable and Customary, the nature and severity of the Injury or Sickness being treated will be considered.

DEFINITIONS

Retail Pharmacy

The term Retail Pharmacy means any pharmacy other than a pharmacy designated as a primary distribution center for a mail service program.

Sickness - For Medical Insurance

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

Skilled Nursing Facility

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

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

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

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.