

**Cotopaxi School
District RE 3
OAP Base Plan**

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SECTION I - MEDICAL AND PRESCRIPTION DRUG BENEFITS

PATIENT PROTECTION AND AFFORDABLE CARE ACT

■ PATIENT PROTECTION AND AFFORDABLE CARE ACT ENDORSEMENT

The Plan is amended as stated below.

In the event of a conflict between the provisions of your health Plan and the provisions of this Endorsement, the provisions that provide the better benefit shall apply.

Definitions

“Emergency Medical Condition” means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the Member (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

“Emergency Care” means, with respect to an Emergency Medical Condition:

- a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and
- such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, to Stabilize the patient.

“Essential Health Benefits” means, to the extent covered under the Plan, expenses incurred with respect to covered services, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services including oral and vision care.

“Patient Protection and Affordable Care Act of 2010” means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

“Stabilize” means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the Member from a facility.

Lifetime Benefit Maximums - Dollar Limits

Any “Maximum Benefit for all Covered Expenses” dollar value is deleted.

Any lifetime limits on the dollar value of any Essential Health Benefits are deleted.

Annual Dollar Limits

Any annual limits on the dollar value of Essential Health Benefits are deleted.

Rescissions

A Member’s health coverage may not be rescinded (retroactively terminated) unless:

- the Employer or a Member (or a person seeking coverage on behalf of the Member) performs an act, practice or omission that constitutes fraud; or
- the Employer or Member (or a person seeking coverage on behalf of the Member) makes an intentional misrepresentation of material fact.

PATIENT PROTECTION AND AFFORDABLE CARE ACT - Continued

Extension of Health Dependent Coverage

If the health Plan includes coverage of dependent children, dependent children are eligible for health coverage up to the age of 26. Any restrictions in the definition of Dependent in your health Plan which require a child to be unmarried, a student or financially dependent on the Employee, no longer apply. If the definition of Dependent in the Plan provides coverage for a child beyond age 26, the provision and all restrictions will continue to apply starting at age 26. Any provisions related to coverage of a handicapped/disabled child continue to apply starting at age 26.

Preventive Care Services

In addition to any other preventive care services described in the Plan, no deductible, copayment or coinsurance shall apply to the following Covered Services when provided by a network or out-of-area provider:

- evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force;
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Member involved;
- for infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- for women, such additional preventive care and screenings not described above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Pre-Service Medical Necessity Determinations

If standard determination periods would: seriously jeopardize your life or health, your ability to regain maximum function; or in the opinion of a Doctor with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services; then the pre-service determination will be made on an expedited basis. The physician reviewer, in consultation with the treating Doctor, will decide if an expedited determination is necessary. You or your representative will be notified of an expedited determination within 24 hours after receipt of the request.

Notice of Adverse Determination

In addition to the description provided in your Plan, a notice of adverse benefit determination will also include information sufficient for you to identify the claim, and information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process. In the case of a final adverse benefit determination, your notice will include a discussion of the decision.

Right to Appeal

You have the right to appeal any decision or action taken to deny, reduce, or terminate the provision of or payment for health care services covered by your Plan or to rescind your coverage. When a requested service or payment for the service has been denied, reduced or terminated based on a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service, you have the right to have the decision reviewed by an independent review organization not associated with CIGNA.

Except where life or health would be seriously jeopardized, you must first exhaust the internal appeal process set forth in your Plan before your request for an external independent review will be granted. If the Plan does not strictly adhere to all internal claim and appeal processes, you can be deemed to have exhausted the internal appeal process.

Your appeal rights are outlined in your Plan. In addition, before a final internal adverse benefit determination is issued, if applicable, you will be provided, free of charge, any new or additional evidence considered, or rationale relied upon, in sufficient time to allow you the opportunity to respond before the final notice is issued.

PATIENT PROTECTION AND AFFORDABLE CARE ACT - Continued

Emergency Care

Emergency Care, as defined above, is covered without the need for any prior authorization determination and without regard as to whether the health care provider furnishing such services is a network provider. Emergency Care, as defined above, provided by a provider who is not a network provider, will be covered as if the services were provided by a network provider.

Selection of a Primary Care Provider

This Plan allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of network primary care providers, visit the website or contact Member Services at the phone number listed on your ID card. If the Plan includes coverage of dependent children, a pediatrician may be designated as a child's primary care provider.

Pre-Existing Conditions Limitation

Any Pre-Existing Conditions Limitation provision described in the health Plan does not apply to anyone who is under 19 years of age.

INTRODUCTION

■ Notices

CIGNA Commitment to Quality

Our **Commitment to Quality** guide gives you access to the latest information about our program activities and results, including how we met our goals, as well as details about key guidelines and procedures. Log on to the website shown on your ID card to access this information. If you have questions about the quality program, would like to provide your feedback and/or cannot access the information online and would like a paper copy, please call the phone number on your ID card.

Women's Health and Cancer Rights Act

This Notice is required by the Women's Health and Cancer Rights Act of 1998 (WHCRA) to inform you, as a member of the Plan, of your rights relating to coverage provided through the Plan in connection with a mastectomy. As a Plan Member, you have rights to coverage provided in a manner determined in consultation with your attending Physician for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage may be subject to deductible and copayment provisions, if your Plan includes such provisions. Additional details regarding this coverage are provided in the Plan. Keep this notice for your records and call your Plan Administrator for more information.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under the federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

■ About This Plan

Cotopaxi School District RE 3 (the Employer) has established an Employee Welfare Benefit Plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). As of December 1, 2010, the medical and drug benefits described in this booklet form a part of the Employee Welfare Benefit Plan and are referred to collectively in this booklet as the Plan. The Employee Welfare Benefit Plan will be maintained pursuant to the medical and drug benefit terms described in this booklet. The Plan may be amended from time to time.

The medical and drug benefits described in this booklet are self-funded by the Employer. The Employer is fully responsible for the self-funded benefits. Connecticut General Life Insurance Company (CIGNA) processes claims and provides other services to the Employer related to the self-funded benefits. CIGNA does not insure or guarantee the self-funded benefits.

Defined terms are capitalized and have specific meaning with respect to medical and drug benefits, see GLOSSARY.

INTRODUCTION - Continued

Discretionary Authority

The Plan Administrator has the discretionary authority to control and manage the operation and administration of the Employer's self-funded medical and drug benefit Plan. The Plan Administrator in his or her discretionary authority, will determine benefit eligibility under such self-funded Plan, construe the terms of the self-funded Plan and resolve any disputes which may arise with regard to the rights of any person under the terms of the self-funded Plan, including but not limited to eligibility for participation and claims for benefits.

For initial claim determination, the Plan Administrator has the discretionary authority to determine eligibility and to interpret the Plan. For claim appeals, the Plan Administrator has designated Connecticut General Life Insurance Company (CIGNA) as the appeals fiduciary. CIGNA will have the discretionary authority to determine whether a claim should be paid or denied on appeal and according to the Plan provisions.

Plan Modification/Termination

The Employer may:

- change the contributions a Member must pay for benefits; or
- amend or terminate the benefits provided to you in the Plan.

If the Plan is amended or terminated it will not affect coverage for services provided prior to the effective date of the change.

OPEN ACCESS PLUS MEDICAL BENEFITS SUMMARY

This summary provides a general description of your medical benefits. It does not list all benefits. The Plan contains limitations and restrictions that could reduce the benefits payable under the Plan. Please read the entire booklet for details about your benefits.

The plan includes a nationwide **Open Access Plus Network** of Hospitals and Doctors and a Medical Management Program.

Copay Amount for Network Services

Outpatient Mental Health Conditions and Chemical Dependency Treatment (Office Visits)	\$60.00
Chiropractic Services	\$60.00
Outpatient Physical Therapy	\$60.00
Outpatient Speech, Hearing and Occupational Therapy	\$60.00
Other Office Visits	
- Primary Care (including Preventive Care)	\$40.00
- Specialist Care	\$60.00

Deductible

The calendar year deductible applies to all covered expenses except:

- expenses subject to a copay
- facility expenses that are subject to the Per Confinement Deductible
- Outpatient surgery expenses that are subject to the Outpatient Surgery Per Confinement Deductible
- expenses for Network Preventive Care
- expenses for surgery performed in a Network Doctor's office
- expenses for outpatient x-rays and lab tests unless x-rays and lab tests are considered high technology radiology (including MRI, CAT scan, or PET scan), or have been ordered as part of testing for infertility

Individual Calendar Year Deductible

Network	\$2,500.00
Non-network and outside the Network Area	\$5,000.00

Family Deductible

Network	\$5,000.00
Non-network and outside the Network Area	\$10,000.00

Per Confinement Deductible

The Inpatient Per Confinement Deductible applies to facility charges for each inpatient confinement in a Hospital, Skilled Nursing Facility, Hospice facility or Mental Health and Chemical Dependency Treatment facility.

Network Facility	None
Non-network Facility	\$500.00

The Outpatient Surgery Per Confinement Deductible applies to outpatient surgery in a Hospital or an Ambulatory Surgical Center.

Network Facility	None
Non-network Facility	\$500.00

Medical Management Program

Ineligible Expense Penalty per claim	\$250.00
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OPEN ACCESS PLUS MEDICAL BENEFITS SUMMARY - Continued

Percentage Payable after any applicable Deductible, Copay or Contracted Rate Reduction

Home Health Care	
- Network	80%
- Services outside the Network Area	80%
- Non-network	50%
Skilled Nursing Facility	
- Network	80%
- Services outside the Network Area	80%
- Non-network	50%
Outpatient Surgery	
- Network	
* Doctor's office	100%
* All other locations	80%
- Services outside the Network Area	80%
- Non-network	50%
Hospice Care	
- Network	80%
- Services outside the Network Area	80%
- Non-network	50%
Preventive Care Services	
- Network	100%
- Services outside the Network Area	100%
- Non-network	50%
Hospital Care (including Mental Health Conditions and Chemical Dependency inpatient treatment)	
- Network	80%
- Services outside the Network Area	80%
- Non-network	50%
Physician charges for Hospital care (including Mental Health Conditions and Chemical Dependency inpatient treatment) and inpatient surgery	
- Network	80%
- Services outside the Network Area	80%
- Non-network	50%
Inpatient Hospital X-rays and Lab Tests in a	
- Network Hospital	80%
- Hospital outside the Network Area	80%
- Non-network Hospital	50%
High Technology X-rays and Lab Tests (MRI, PET, and CAT scans)	
- ordered as part of an Office Visit and performed in a	
* Network provider's office	80%
* Provider's office outside the Network Area	80%
* Non-network provider's office	50%
- ordered in an x-ray or lab facility, such as an outpatient service at a Hospital	

OPEN ACCESS PLUS MEDICAL BENEFITS SUMMARY - Continued

* Network or independent facility	80%
* facility outside the Network area	80%
* Non-network facility	50%
Outpatient X-rays and Lab Tests	
- ordered as part of Preventive Care and performed in a	
* Network provider's office	100%
* Network x-ray or lab facility, such as an outpatient service at a Network Hospital	100%
* Provider's office or x-ray or lab facility outside the Network Area	100%
* Non-network provider's office or Non-network x-ray or lab facility	50%
- ordered as part of an Office Visit and performed in a	
* Network provider's office	80%
* Network x-ray or lab facility, such as an outpatient service at a Network Hospital	100%
* Provider's office, x-ray or lab facility, outside the Network Area	80%
* Non-network provider's office or Non-network x-ray or lab facility	50%
- other outpatient x-rays and lab tests	
* Network	100%
* Services outside the Network Area	80%
* Non-network	50%
Durable Medical Equipment	
- Network	80%
- Services outside the Network Area	80%
- Non-network	50%
Office Visits	
- Network	100%
- Services outside the Network Area	80%
- Non-network	50%
Office Services, other than outpatient surgery and x-ray and lab tests	
- Network	80%
- Services outside the Network Area	80%
- Non-network	50%
Outpatient Mental Health Conditions and Chemical Dependency Treatment (including Office Visits)	
- Network	100%
- Services outside the Network Area	80%
- Non-network	50%
Urgent Care Facility Visit (including x-rays and lab tests ordered as part of the visit)	
- Network	80%
- Services outside the Network Area	80%
- Non-network	50%
Emergency Room Care Visit (including x-rays and lab tests ordered as part of the visit)	
- Network	80%
- Services outside the Network Area	80%
- Non-network	80%

OPEN ACCESS PLUS MEDICAL BENEFITS SUMMARY - Continued

Chiropractic Services	
- Network	100%
- Services outside the Network Area	80%
- Non-network	50%
Outpatient Speech, Hearing and Occupational Therapy	
- Network	100%
- Services outside the Network Area	80%
- Non-network	50%
Outpatient Physical Therapy	
- Network	100%
- Services outside the Network Area	80%
- Non-network	50%
Ambulance Expenses	
- Network	80%
- Services outside the Network Area	80%
- Non-network	80%
Transplant Expenses	
- Travel Expenses to and from a Transplant Network facility	100%
- Other Transplant Expenses	
* Transplant Network facility	80%
* Other Network facilities	Not Covered
* Services outside the Network Area	Not Covered
* Non-network	Not Covered
Other Covered Expenses	
- Network	80%
- Services outside the Network Area	80%
- Non-network	50%
Out-of-Pocket Maximum for Network Services	
Individual	\$5,000.00
Family	\$10,000.00
Out-of-Pocket Maximum for Non-Network Services and Services outside the Network Area	
Individual	\$8,000.00
Family	\$16,000.00
Calendar Year Benefit Maximum	
Home Health Care	60 visits
Skilled Nursing Facility	60 days
Outpatient Occupational, Speech and Hearing Therapy	20 visits
Outpatient Physical Therapy	20 visits

OPEN ACCESS PLUS MEDICAL BENEFITS SUMMARY - Continued

Lifetime Benefit Maximum

Transplant Travel Expenses to and from a Transplant Network facility. Certain travel expenses are limited to a daily maximum. See the "Transplants" benefit provision for more details.

\$10,000.00

Maximum Benefit for all Covered Expenses

Lifetime benefit per Member

Unlimited

PRESCRIPTION DRUG BENEFITS SUMMARY

This summary provides a general description of your prescription drug benefits. It does not list all benefits. The Plan contains limitations and restrictions that could reduce the benefits payable under the Plan. Please read the entire booklet for details about your benefits.

Retail Network Pharmacy - up to a 30-day supply

Tier 1 - Generic Drug copay	100% after \$15.00 copay
Tier 2 - Lowest Brand Name Drug copay	100% after \$40.00 copay
Tier 3 - Highest Brand Name Drug copay	100% after \$70.00 copay

Non-network Pharmacy - up to a 30-day supply

Member must pay 100% of drug cost at time of purchase and submit a claim for reimbursement. Reimbursement will be 50% of the network pharmacy cost after the copay.

Ninety-day Retail Network Pharmacy Program - 80 to 90-day supply

Tier 1 - Generic Drug copay	100% after \$45.00 copay
Tier 2 - Lowest Brand Name Drug copay	100% after \$120.00 copay
Tier 3 - Highest Brand Name Drug copay	100% after \$210.00 copay

Mail Order Drug Program - up to a 90-day supply

Tier 1 - Generic Drug copay	100% after \$30.00 copay
Tier 2 - Lowest Brand Name Drug copay	100% after \$80.00 copay
Tier 3 - Highest Brand Name Drug copay	100% after \$140.00 copay

Specialty Pharmacy Program - for certain high-cost drugs

The copay for Specialty drugs will mirror either the Retail Network Pharmacy or Mail Order Drug Program copays. The way the prescription is written by the physician (*i.e., 30-day supply or 90-day supply*) will dictate the copay. A 30-day supply will require a Retail Network Pharmacy copay. A 90-day supply will require a Mail Order Drug Program copay.

ELIGIBILITY

■ Eligible Employees

For the purpose of medical and drug benefits, an eligible Employee is a person who is in the Service of the Employer and is a resident of the United States.

Service

“Service” means work with the Employer on an active, full-time and full pay basis for at least 24.00 hours per week.

■ Eligible Dependents

It is your responsibility to notify the Employer when a covered Dependent is no longer eligible for coverage.

The cost of Dependent health coverage (premium) is usually exempt from federal income tax. Generally, if you can claim an individual as a dependent for purposes of federal income tax, then the premium for that dependent’s health coverage will not be taxable to you as income. However, if you cover an individual as a Dependent and the individual does not meet the federal definition of dependent, the premium may be taxable to you as income. If you have questions concerning your specific situation, you should consult your own tax consultant or attorney.

Your Dependents must live in the United States to be eligible for coverage.

Eligible Dependents are:

- your legal spouse.
- an unmarried child, as defined below.

The following applies if you and your spouse are eligible to be covered as Employees: A person who is eligible as an Employee will not be considered as an eligible Dependent. An eligible Dependent child may be considered as a Dependent of only one Employee.

The following applies if you are eligible to be covered as an Employee and as a Dependent child of another Employee: A person who is eligible as an Employee will not be considered as an eligible Dependent.

Child

“Child” means:

- your natural child.
- your stepchild.
- a natural child of your covered minor Dependent.
- your adopted child. This includes a child placed with you for adoption.

“Placed for adoption” means the assumption and retention of a legal obligation for the total or partial support of a child in anticipation of the adoption of such child. The child’s placement is considered terminated upon the termination of such legal obligation.

- a child who is recognized under a medical child support order as having a right to enrollment under the Plan.
- a foster child.

The child must meet the age requirement described below and depend on you for financial support. The support requirement does not apply to a child who is recognized under a medical child support order as having a right to enrollment under the Plan.

Dependent Child Age Requirement

The child is under age 26.

Handicapped/Disabled Child

ELIGIBILITY - Continued

The age limit does not apply to a child who becomes disabled, or became disabled, before reaching the age limit and who cannot hold a self-supporting job due to a permanent physical handicap or mental retardation.

“Physical handicap/mental retardation” means permanent physical or mental impairment that is a result of either a congenital or acquired illness or injury leading to the individual being incapable of independent living.

“Permanent physical or mental impairment” means:

- a physiological condition, skeletal or motor deficit; or
- mental retardation or organic brain syndrome.

A non-permanent total disability where medical improvement is possible is not considered to be a “handicap” for the purpose of this provision. This includes substance abuse and non-permanent mental impairments.

At reasonable intervals, but not more often than annually, the Plan may require a Doctor’s certificate as proof of the child’s disability.

Medical Child Support Order

A medical child support order is a *qualified* medical child support order (QMCSO) or a *qualified* national medical support notice issued by a state court or administrative agency that requires the Plan to cover a child of an Employee, if the Employee is eligible for benefits under the Plan.

When the Employer receives a medical support order, the Employer will determine whether the order is “qualified”.

If the order is determined to be qualified, and if you are eligible to receive benefits under this Plan, then your Dependent child will be covered, subject to any applicable contribution requirements. Your Employer will provide your Dependent child with necessary information which includes, but is not limited to, a description of coverages and ID cards, if any. Upon request, your Employer will provide at no charge, a description of procedures governing medical child support orders.

WHEN COVERAGE BEGINS & ENDS

■ When Will Coverage Begin?

The definition of Employee or Dependent in ELIGIBILITY will determine who is eligible for coverage under the Plan.

Coverage will begin on the first day of the month coinciding with or next following the date you satisfy any eligibility waiting periods required by the Employer.

Before coverage can start, you must:

- Submit an application within 31 days after becoming eligible;
- Pay any required contribution.

Coverage for a newly acquired Dependent will begin on the date you acquire the Dependent if you are covered and if you apply for coverage within 31 days after acquiring the new Dependent.

If the Dependent is an adoptive child, coverage will start:

- For an adoptive newborn, from the moment of birth if the child's date of placement is within 31 days after the birth; and
- For any other adoptive child, from the date of placement.

■ What If I Don't Apply On Time?

You are a late applicant under the Plan if you don't apply for coverage within 31 days of the date you become eligible for coverage. Your Dependent is a late applicant if you elect not to cover a Dependent and then later want coverage for that Dependent.

Medical and Prescription Drug Benefits

A late applicant may apply for coverage only during an open enrollment period. The Plan Administrator can tell you when the open enrollment period begins and ends. Coverage for a late applicant who applies during the open enrollment period will begin on the first day of the month following the close of the open enrollment period.

Special Enrollment Rights

For medical and drug benefits, if you or your eligible Dependent experience a special enrollment event as described below, you or your eligible Dependent may be entitled to enroll in the Plan outside of a designated enrollment period.

If you are already enrolled for coverage at the time of a special enrollment event, within 31 days of the special enrollment event, you may request enrollment in a different medical and drug benefit option, if any, offered by the Employer and for which you are currently eligible.

A special enrollment event occurs if:

- You did not apply for coverage for yourself or your eligible Dependent within 31 days of the date you were eligible to do so because at the time you or your eligible Dependent was covered under another health insurance plan or arrangement and coverage under the other plan was lost as a result of:
 - Exhausting the maximum period of COBRA coverage; or
 - Loss of eligibility for the other plan's coverage due to legal separation, divorce, cessation of dependent status, death of a spouse, termination of employment or reduction in the number of hours of employment; or
 - Loss of eligibility for the other plan's coverage because you or your eligible Dependent no longer resides in the service area; or
 - Loss of eligibility for the other plan's coverage because you or your eligible Dependent incurs a claim that meets or exceeds the lifetime maximum for that plan; or
 - Termination of benefits for a class of individuals and you or your eligible Dependent is included in that class; or
 - Termination of the employer's contribution for the other plan's coverage.

You must have stated in writing that the other health coverage was the reason you declined coverage under this Plan, but only if the Employer required such a statement and notified you of the consequences of the requirement when you declined coverage.

WHEN COVERAGE BEGINS & ENDS - Continued

- You did not apply for coverage for yourself or your eligible Dependent within 31 days of the date you were eligible to do so because at the time you or your eligible Dependent was covered under a state Medicaid or Children's Health Insurance Program (CHIP) plan, and such coverage terminates due to a loss of eligibility. In this situation, you may request coverage for yourself and/or any affected eligible Dependent not already enrolled in this Plan. Coverage must be requested within 60 days of the date Medicaid or CHIP coverage terminated.
- You did not apply for coverage for yourself or your eligible Dependent within 31 days of the date you were eligible to do so and you or your eligible Dependent later becomes eligible for employment assistance under a state Medicaid or CHIP plan that helps pay for the cost of this Plan's coverage. In this situation, you may request coverage for yourself and/or any affected eligible Dependent not already enrolled in this Plan. Coverage must be requested within 60 days of the date the Member is determined to be eligible for such assistance.
- You did not apply to cover your spouse or a Dependent child within 31 days of the date you became eligible to do so and later are required by a qualified court order to provide coverage under this Plan for that person.
- You did not apply to cover yourself or an eligible Dependent within 31 days of the date you became eligible to do so and later experience a change in family status because you acquire a Dependent through marriage, birth or adoption. In this case, you may apply for coverage for yourself, your spouse and any newly acquired Dependents.

If you apply within 31 days of the date:

- Coverage is lost under the other plan, as described above, coverage will start on the day after coverage is lost under the other plan.
- A court order was issued, coverage will start on the court ordered date.
- You acquire a new Dependent, coverage will start:
 - In the case of marriage, on the date of marriage.
 - In the case of birth or adoption, on the date of birth, adoption or placement for adoption.

If you apply within 60 days of the date Medicaid or CHIP coverage is terminated or within 60 days of the date the Member is determined to be eligible for employment assistance under a state Medicaid or CHIP plan, coverage will start no later than the first day of the month following receipt of your enrollment request.

■ What If I Was Covered for Health Benefits Under the Employer's Prior Plan?

A Member who had similar coverage for health benefits under the Employer's prior plan on the date of its termination will be covered under this Plan on the Plan effective date.

Any waiting period under this Plan will be reduced by the part of the waiting period that had been satisfied under the prior plan.

"Health benefits" mean medical and prescription drug benefits.

If a Member was on COBRA or any other continuation coverage or extension of benefits under the prior plan and that plan terminated, coverage will be provided for that Member until the earlier of:

- The date on which coverage would end under the terms of the Plan; or
- The last day of the period for which coverage would have been provided had the prior plan not terminated.

If a Member was covered under any extension of benefits under the prior plan, the benefits provided under this Plan will be the same as those provided by the prior plan, less any amount paid under the prior plan.

If you were on Family and Medical Leave on the effective date of this Plan and you were covered under the Employer's prior plan on the date of its termination, then you will become covered for the benefits provided under this Plan as of its effective date.

WHEN COVERAGE BEGINS & ENDS - Continued

Medical Deductible Credits

Any amount a Member has already paid toward the calendar year medical deductible for Network services under the prior medical plan will be applied to this Plan's calendar year deductible for Network services. The amount a Member has already paid toward the calendar year medical deductible for Non-network services under the prior medical plan will be applied to this Plan's calendar year deductible for Non-network services. If the prior medical plan applied one calendar year deductible to all services, then the amount a Member has already paid toward such calendar year medical deductible will be applied to this Plan's calendar year deductible for Network services.

Special Benefits for Pre-Existing Conditions

These benefits apply if a Member would not be eligible for coverage under the Plan because of the pre-existing conditions limitation and is not eligible for benefits under the prior plan because expenses were incurred after termination of that plan.

The amount of benefits will be the lesser of the amount that would have been paid under the prior plan if it had stayed in force and the amount that would have been paid under this medical Plan if it did not have a pre-existing conditions limitation.

Any length of time a Member has already satisfied toward the pre-existing conditions limitation waiting period of the prior plan will be carried over to this medical Plan.

■ Will My Coverage Change?

If the Employer amends the benefits or amounts provided under the Plan, a Member's coverage will change on the effective date of the amendment. If a Member changes classes, coverage will begin under the new class the first day of the month coinciding with or next following the date the Member's class status changes.

All claims will be based on the benefits in effect on the date the claim was incurred.

■ When Will My Coverage End?

Your coverage will end on the earliest of the following dates:

- The date the Employer terminates the benefits described in this booklet.
- The date you are no longer eligible or the last day of the month coinciding with or next following the date your Service ends.
- The due date of the first contribution toward your coverage that you or the Employer fails to make.
- The date Loss of Residence occurs.

Your Dependent coverage will end on the earliest of the following dates:

- The date your coverage ends; or
- The date Loss of Residence occurs; or
- The date your Dependent is no longer eligible for benefits; or
- The due date of the first contribution toward Dependent coverage that you or the Employer fails to make.

A Certificate of Creditable Coverage (CCC) will be sent when coverage for a Member ends. In addition, a CCC may be requested from the Plan Administrator at any time while a Member is covered under the Plan and up to 24 months after coverage ends.

■ Can I Continue My Coverage If I Become Ineligible?

If you become ineligible for coverage under the Plan, you may be able to continue coverage for certain benefits.

Continuation of Coverage under Federal Laws and Regulations

If coverage would otherwise terminate under this Plan, you and your Dependents may be eligible to continue coverage under certain federal laws and regulations. See USERRA RIGHTS AND RESPONSIBILITIES and CONTINUATION OF COVERAGE - COBRA.

WHEN COVERAGE BEGINS & ENDS - Continued

■ Can Coverage Be Reinstated?

If your coverage ended because of termination of your Service, you may be eligible for reinstatement of coverage if you return to Service within 3 month(s) after the date your coverage ended. On the date you return to Service, coverage for you and your eligible Dependents will be on the same basis as that provided for any other active Employee and his or her Dependents as of that date. However, any restrictions on your coverage that were in effect before your reinstatement will still apply.

See USERRA RIGHTS AND RESPONSIBILITIES for information about reinstatement of coverage upon return from leave for military service.

OPEN ACCESS PLUS MEDICAL BENEFITS

■ How Does the Plan Work?

The plan includes a nationwide **Open Access Plus Network** of Hospitals and Doctors and a Medical Management Program. For the names of network providers, contact Member Services at the phone number or access the on-line directory at the website address shown on the Member ID card.

Network providers will submit Members' claims and take care of getting Medical Management approval when necessary. When a non-network provider is used, the Member will need to file their own claim and make sure treatment is approved by Medical Management. See "Medical Management (MM) Program" for information about pretreatment authorization.

Benefits received from network providers are payable at a higher level than benefits received from non-network providers. Members are responsible for confirming that a provider is a network provider.

Members are encouraged, but are not required, to select a Primary Care Physician (PCP) in the Open Access Plus network. The PCP provides care and can assist with arranging and coordinating care. Members may obtain covered services from providers who are designated as specialists without getting PCP approval. By involving the PCP in health care decisions, Members receive the continuity that a personal PCP can provide. To select or change a PCP, contact Member Services at the phone number or website address shown on the Member ID card.

If a Member is traveling and needs care for a non-Emergency Medical Condition, contact Member Services for help in locating a network provider. Since the network is nationwide, the Member may be able to see a network provider and receive a higher level of benefits. If a Member is outside the network area, benefits will be payable as shown in OPEN ACCESS PLUS MEDICAL BENEFITS SUMMARY.

Special Services

The following non-network services are payable at the network level:

- Services of a non-network provider such as, but not limited to: inpatient consultations, neonatology, x-rays and lab tests, radiology, anesthesiology and other specialists over whom the Member has no control in selecting after admission, when the Member is admitted for inpatient or outpatient care in:
 - a network facility.
 - a non-network facility, if the admission and the provider's services are approved by Medical Management, and the authorization indicates that the services are payable at the network level.
- Services of a non-network assistant surgeon, surgical assistant or any other non-network provider who is qualified to assist during surgery, if the surgery is performed by a network Doctor in a network facility. The use of an assistant during surgery must be appropriate for the type of surgery rendered.
- Inpatient care provided in a non-network Hospital or by a non-network Doctor immediately following Emergency Room Care through stabilization if the services are approved by Medical Management.

Supplemental Network

Members who use a non-network provider may reduce their out-of-pocket expenses by choosing a provider participating in a supplemental network. This supplemental network is available to Members who choose a provider outside the primary network. Call Member Services for the names of providers who are participating in the program. Certain claims from non-network providers who are not in the supplemental network may, however, qualify for negotiation. Providers that participate in the supplemental network or agree to negotiate are considered non-network providers under the Plan. The Member is responsible for pretreatment authorization for all services and supplies that require pretreatment authorization.

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

Transitional Care for Members upon Termination of a Provider from the Network

If a Member's provider ceases to be a network provider for reasons other than quality-related reasons, fraud, or failure to adhere to CIGNA's policies and procedures, coverage may continue for a specified period of time for treatment in progress for a Member who is:

- in her second or third trimester of pregnancy; or
- receiving care for end-stage renal disease and dialysis; or
- receiving outpatient mental health treatment; or
- terminally ill, with anticipated life expectancy of six months or less; or
- undergoing an active course of treatment for which changing to a different provider would be likely to cause significant risk of harm to the Member's health; or
- undergoing chemotherapy or radiation therapy for treatment of cancer; or
- a candidate for a solid organ or bone marrow transplant.

Contact Member Services to obtain a Transition of Care Request Form. The Transition of Care Request Form must be received by CIGNA within 60 days of the provider's termination date. If your request is approved, care provided will be subject to the same copays, deductibles, coinsurance and limitations as care given by a network provider.

Medical Management (MM) Program

Medical Management will review and make an authorization determination for urgent, concurrent and prospective medical services, and prescription drugs for Members covered under the Plan. Medical Management will also review the medical necessity of services that have already been provided.

Medical Management will determine the medical necessity of the care, the appropriate location for the care to be provided, and if admitted to a Hospital, the appropriate length of stay.

If a pretreatment request does not follow the Medical Management procedures, the provider will be notified of the established procedures no later than 5 days after receipt of the request.

Network providers are responsible for contacting the MM Program for pretreatment authorization.

If the provider is not a network provider - The provider must contact the MM Program for pretreatment authorization. The Member must make sure that treatment is approved by the MM Program. Without pretreatment authorization, an ineligible expense penalty (see MEDICAL SUMMARY) will be applied to the claim. The ineligible expense penalty amount cannot be applied toward the calendar year deductible or out-of-pocket maximum.

Certain services and supplies require pretreatment authorization, including, but not limited to:

- Air ambulance, when used for non-Emergency Medical Conditions.
- Durable medical equipment charges over \$500.
- Genetic testing.
- Home health care (including IV therapy).
- Hospital admissions, including partial hospitalization programs for mental health treatment.
- Outpatient high technology radiology (examples include: CAT scans, PET scans and MRIs).
- Outpatient surgery, except for surgery performed in a Doctor's office.
- Prescription drugs that need to be reviewed for Medical Necessity. This includes, but is not limited to:
 - certain drugs that are used for specialized medical treatment, to ensure that the drugs are used appropriately; and
 - certain drugs that have multiple uses, to ensure that the drug is used according to acceptable medical practice and FDA guidelines.

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

- Renal dialysis.
- Skilled nursing facilities.
- Transplant evaluations.

For more information about services and supplies that require pretreatment authorization, contact Member Services at the phone number on the ID card.

Medical Management will review and render an authorization determination as described below.

- **Urgent Care Requests**

For an urgent care request, MM will notify the Member and the provider of the authorization decision:

- no later than 24 hours after receipt of a request involving concurrent care, if the request is made at least 24 hours prior to the expiration of the previously approved care; and
- no later than 72 hours after receipt of any other urgent care request.

If MM does not have all the information needed to process an urgent care request, MM will notify the Member or provider within 24 hours after receipt of the request and give details as to what additional information is required. The requested information should be provided within 48 hours or the authorization request may be denied. MM will notify the Member and provider of the authorization decision within 48 hours after the requested information has been received.

MM will provide either verbal or written notice of the decision. When verbal notice is provided, a written notice will be sent within 3 days.

- **Non-urgent Care Requests**

For a non-urgent care request, MM will notify the Member and provider of an authorization decision no later than 15 days after receipt of the request. If an authorization decision cannot be made within the 15-day period, an extension of up to 15 days may be requested. If additional information is needed, the Member or provider will be notified within the initial 15-day period and given details as to what information is required. The requested information should be provided within 45 days after receipt of the request or the authorization request may be denied.

An authorization decision will be made no later than 15 days after MM receives the requested information, unless the Member or provider agrees to a voluntary extension of time.

Medical Management will send the Member and the provider written notice of all authorization determinations.

If previously authorized benefits are reduced or terminated, MM will send notice of this decision *prior* to any reduction or termination of benefits.

If a Member receives notice of an adverse determination, in whole or in part, the Member or the Member's Authorized Representative can appeal the decision.

An "Authorized Representative" means a person authorized in writing by the Member or a court of law to represent the Member's interests for claim submission, pretreatment and appeal requests. The Member's spouse, parent (if Member is a minor) and health care provider will be automatically recognized as the Member's Authorized Representative for pretreatment requests, claim submissions and appeals. For requests involving urgent care, any health care professional with knowledge of a Member's medical condition will be automatically recognized as the Member's Authorized Representative for pretreatment requests and appeals.

"Adverse determination" means a determination of non-approval, in whole or in part, of a pretreatment or claim payment request.

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

If the MM decision is an adverse determination, the Member will be sent written notice that will include the reason(s) for the denial, reference to the Plan provision(s) on which the denial is based, whether additional information is needed to process the request and why the information is needed, the appeal procedures and time limits, including procedures and time limits for urgent care appeals, and the Member's right to bring civil action under ERISA Section 502(a) after required Plan appeals have been exhausted.

The adverse determination notice will also specify:

- whether an internal rule, guideline, protocol or other criterion was relied upon in making the adverse decision and that this information is available to the Member upon request and at no charge; and
- that an explanation of the scientific or clinical judgment for a decision based on medical necessity, experimental treatment or a similar limitation is available to the Member upon request and at no charge.

Appeal of Medical Management Decision

Appeal of a Medical Management decision should be requested within 180 days after receipt of an adverse determination. You have the right to review and/or request copies of relevant documents, free of charge, and to submit written comments, documents and issues.

One level of appeal must be completed for appeals involving urgent care and two levels of appeal must be completed for all other appeals involving a MM adverse determination, before a Member may bring civil action under ERISA for an adverse determination. (See STATEMENT OF ERISA RIGHTS.) The appeal review will consider written comments, documents and any other information submitted by the Member, Authorized Representative or Doctor, regardless of whether the documentation was reviewed as part of the initial determination.

• Level I Appeal

The first appeal level is an internal review by MM. Upon receipt of an initial appeal of a denied request for medical services, MM will assign the review to a board certified Physician Reviewer who is in the same or similar specialty that typically manages the service under review and *who was not involved in the prior adverse determination and is not a subordinate of the individual who made the prior determination.*

The Member and the provider or other Authorized Representative will be sent written notice of an appeal determination:

- no later than 72 hours after receipt of an appeal involving urgent care; and
- no later than 15 days after receipt of an appeal involving non-urgent care; and
- no later than 30 days after receipt of an appeal involving services that have already been provided.

If the appeal decision upholds an adverse determination, and you decide to appeal the decision, you may proceed to Level II. For appeals involving urgent care, Level II is voluntary.

• Level II Appeal

If the first level internal review denies authorization, in whole or in part, a second level appeal review may be requested. The second level appeal is an external review by an independent review entity and is binding on the Plan. The written request for external review must be submitted to Medical Management within 60 days after receipt of the first level appeal determination. An external review will be provided at no cost to the Member.

A Doctor or a group of Doctors in the same or similar specialty that typically manage the service under review and who is not affiliated with Medical Management will conduct the external review.

The Member and the provider will be sent a written notice of the external review determination:

- no later than 15 days after receipt of the second level appeal request for preauthorization of services; and
- no later than 30 days after receipt of the second level appeal request for authorization of services that have already been provided.

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

If the external review results in a denial of the requested service, the Member has the right to bring civil action under ERISA Section 502(a) after required Plan appeals have been exhausted.

Members will be sent written notice of an adverse determination upon completion of a Level I appeal and upon completion of a Level II appeal. The notice will include:

- the reason(s) for the determination;
- reference to the Plan provision(s) on which the determination is based;
- the Member's right to review and request copies of all relevant documents, free of charge;
- whether an internal rule, guideline, protocol or other criterion was relied upon in making the adverse decision and that this information is available to the Member upon request and at no charge;
- that an explanation of the scientific or clinical judgment for a decision based on medical necessity, experimental treatment or a similar limitation is available to the Member upon request and at no charge.

The notice will also include the Member's right to bring civil action under ERISA Section 502(a) after required Plan appeals have been exhausted.

Appeal of an adverse determination involving urgent care may be submitted either orally or in writing and will be expedited.

Medical Outreach Program

The Medical Outreach Program includes various initiatives to assist Members to manage their health concerns and to stay healthy. The Medical Outreach Program includes:

- A Disease Management Program;
- A Care Management Program; and
- A Health Management Program.

A Member may call the toll-free Member services telephone number or access the website shown on his or her ID card for more information about these Programs.

Disease Management Program

If this Plan participates in the Disease Management (DM) Program, Members have access to educational materials and individualized care plans designed to help a Member manage a chronic medical condition such as pain, asthma, diabetes, coronary disease and chronic lung disease. The DM Program also provides services and support for Members with conditions classified as Oncology, End Stage Renal Disease (ESRD) and Neonatology. The DM Program is staffed by specially trained nurses who are available 24 hours a day, 7 days a week.

Members who may benefit from the DM Program are identified through a variety of means, such as medical and/or pharmacy claims, health risk assessments, preauthorization, physician referrals and self referrals. Each enrolled Member will receive tailored educational material depending on the Member's condition. The care managers in the DM Program will assist in setting clinical goals and monitor adherence to goals. Based on the severity of the condition, the care managers will schedule ongoing telephonic contact or home care visits by trained professionals. The Member's Doctor will be able to access the information provided to Members.

A Member may call the toll-free Member services telephone number or access the website shown on his or her ID card to confirm that this Plan participates in the DM Program and to access the DM Program.

There are no additional out-of-pocket expenses for these services obtained through the DM Program. If this Plan includes a Lifetime Maximum, then any costs associated with the Member's participation in the DM Program will not be applied to the Maximum Benefit for All Covered Expenses.

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

Care Management Program

The Care Management (CM) Program manages the care of Members with serious Illnesses. Under the CM Program, if a Member requires inpatient care, such as surgery followed by long term medical care, a case manager who will work on behalf of the Member is assigned to the Member.

The case manager will help to coordinate and provide the most appropriate care in the most cost-effective manner. This includes handling the pretreatment authorization process, providing concurrent review for continued stay as an inpatient in a Hospital, discharge planning and post-discharge follow-up by the clinical staff to ensure that the Member is receiving proper care and support outside of a Hospital setting.

Members who may benefit from the CM Program are identified through a variety of means, such as the pretreatment authorization process and medical claims. Generally, Members may choose to participate in the CM Program.

If a Member chooses to participate in the CM Program and if a Member and the Member's Physician decide that the recommended alternative treatment plan is right for the Member, it will be covered on the same basis as the care and treatment for which it is substituted.

Members with certain serious Illnesses must participate in the CM Program.

A Member may call the toll-free Member Services telephone number or access the website shown on his or her ID card to find out more about participation in the CM Program.

Health Management Program

The Health Management (HM) Program offers online health and wellness services, programs and other resources that enable Members to more easily and effectively obtain information about health-related topics. This includes the latest medical advances and a variety of information about eating a healthy diet and exercise support and smoking cessation.

Calendar Year Deductible and Copay

A calendar year deductible is the amount of covered medical expenses that must be satisfied before the Plan begins to pay benefits.

Network expenses will not apply to a non-network deductible and non-network expenses will not apply to a network deductible. Any expenses incurred for Special Services will always apply to network deductible even when not performed by a network provider.

A copay is an amount a Member pays for care at the time of service.

■ What's Covered? (Covered Expenses)

OPEN ACCESS PLUS MEDICAL BENEFITS SUMMARY shows deductibles and copays, as well as any Plan maximums and Plan coinsurance payment percentages. Members are responsible for any remaining coinsurance percentage amount of covered expenses, deductible and copay amounts.

Allowable Covered Expenses

Benefits are subject to allowable covered expense guidelines.

When the provider is a network provider - The allowable covered expense is determined using a set fee schedule. Members are not responsible for amounts over the scheduled amount for covered expenses.

When the provider is not a network provider - The allowable covered expense is based on the average contracted rates (ACR) for network providers in the area where the care is provided. However, for out-of-area covered expenses and for the following non-network services, the allowable covered expense is determined by usual and customary charge (U&C) guidelines:

- Services by an assistant surgeon when the surgery is performed by a network Doctor in a network Hospital.
- Services by an anesthesiologist when the surgery is performed in a network Hospital.

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

- Services of a radiologist or pathologist in a network Hospital.
- Services received as an inpatient in a Hospital following Emergency Room Care until the Member's Emergency Medical condition is stabilized.

Members are responsible for amounts over ACR and U&C. Covered Emergency Room Care and ambulance services are not subject to ACR or U&C.

ACR is the average contracted rate for network providers in the area where the care is provided. The covered amount for each service and supply will be the lesser of the fee usually charged by a provider and the ACR for that service or supply.

U&C for each service and supply received is the lesser of the fee usually charged by a provider and the fee usually charged by other providers in the same geographical area for the same services and supplies.

Services must be Medically Necessary as defined in the GLOSSARY. Unless otherwise noted for a particular service, services must be required as a result of symptoms of illness. All providers, including facilities, must be licensed in accordance with the laws of the appropriate legally authorized agency, and acting within the scope of such license. Expenses are covered only if incurred while the Member is covered for these medical benefits.

Emergency Care

Emergency Room Care

If you need care for an Emergency Medical Condition, go to the nearest medical facility. Coverage for an Emergency Medical Condition is available 7 days a week, 24 hours a day. This includes care received outside of the United States, required to stabilize the Member's condition for return to the United States. Pretreatment authorization is not required prior to receiving care in an emergency room.

Inpatient Hospital Care immediately following Emergency Room Care

Inpatient care for an Emergency Medical Condition includes both Hospital and Doctor's charges for initial medical screening examination as well as Medically Necessary treatment which is immediately required to stabilize the Member's condition. After care is provided for an Emergency Medical Condition, Medical Management must be contacted within 48 hours.

When care is provided in a non-network Hospital or by a non-network Doctor, the inpatient services and supplies received in the Hospital and the Doctor's charges are paid at the network level through stabilization if the services are approved by Medical Management.

When care is provided in an out-of-area Hospital, the inpatient services and supplies received in the Hospital and the Doctor's charges will be covered at the Services Outside the Network Area level shown in OPEN ACCESS PLUS MEDICAL BENEFITS SUMMARY.

After the Member's condition is stabilized, the Member or his/her Authorized Representative will be presented with the options described below. The inpatient Hospital and Doctor's charges incurred after the Member's condition is stabilized, are determined based on the *network status of the provider*. If:

- the Member elects to be transferred to a network Hospital after stabilization in a non-network Hospital or in an out-of-area Hospital, then the benefits will be paid at the network Hospital and Physician payment percentage shown in OPEN ACCESS PLUS MEDICAL BENEFITS SUMMARY. Any transportation costs associated with this transfer will be paid at the network level.
- the Member elects to continue to stay in a non-network Hospital and:
 - receives treatment from a non-network Doctor after stabilization of the Emergency Medical Condition, then the benefits will be payable at the non-network Hospital and Physician payment percentage shown in OPEN ACCESS PLUS MEDICAL BENEFITS SUMMARY.

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

- receives treatment from a network Doctor after stabilization of the Emergency Medical Condition, then the benefits will be payable at the non-network Hospital and network Physician payment percentage shown in OPEN ACCESS PLUS MEDICAL BENEFITS SUMMARY.
- the Member elects to continue to stay in an out-of-area Hospital, then benefits will be payable at the Services Outside the Network Area level shown in OPEN ACCESS PLUS MEDICAL BENEFITS SUMMARY.
- the Member is admitted to a network Hospital and is under the treatment of a non-network Doctor, and if:
 - the Member elects to transfer care to a network Doctor associated with the network Hospital, then the benefits will be payable at the network Physician payment percentage shown in OPEN ACCESS PLUS MEDICAL BENEFITS SUMMARY.
 - the Member elects to continue to receive care from a non-network Doctor associated with a network Hospital, then the benefits will be payable at the non-network Physician payment percentage shown in OPEN ACCESS PLUS MEDICAL BENEFITS SUMMARY.

Urgent Care

If you need urgent care, you may seek care from an Urgent Care Facility.

Hospital Care

The Plan covers semi-private room and board and ICU expenses, as well as supplies and services, such as surgery and x-rays and lab tests.

Certain services, such as x-ray and lab tests and Physician charges for surgery, may be considered separate from other Hospital care. See OPEN ACCESS PLUS MEDICAL BENEFITS SUMMARY for more information.

Skilled Nursing Facility

The Plan covers semi-private care, including room and board, in a licensed skilled nursing facility. Care must be such that it requires the skills of technical or professional personnel, is needed on a daily basis and cannot be provided in the patient's home or on an outpatient basis. Care must be required for a medical condition which is expected to improve significantly in a reasonable period of time and the Member must continue to show functional improvement.

Office Visits and Office Services

The Plan covers Doctor office visits and services provided during an office visit, including medical supplies.

Certain office services, such as medical supplies, surgery, x-rays and lab tests, as well as allergy testing, treatment and injections, are considered separate from the office visit. See OPEN ACCESS PLUS MEDICAL BENEFITS SUMMARY for more information.

Primary Care includes Preventive Care and care rendered by Doctors who agree to serve as Primary Care Physicians. In general, Primary Care Physicians include Doctors in the fields of General Practice, Family Practice, Pediatrics and Internal Medicine. OB/GYNs are also included. Members may determine a provider's classification by using the member web site or by calling Member Services.

The Office Visit copay does not apply to non-network providers and services of some Specialists, such as Physical Therapists. These services are subject to payment as shown in OPEN ACCESS PLUS MEDICAL BENEFITS SUMMARY.

Preventive Care

The Plan covers the following preventive care services:

- Routine physical exams by a Doctor. This includes x-ray and lab services if part of a physical exam, necessary immunizations and booster shots.
- Pelvic exams, Pap smears and mammograms.
- Prostate specific antigen (PSA) screening.
- Colorectal cancer screening.

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

Post-Mastectomy Coverage

The Plan covers reconstruction of the breast on which a mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications related to all stages of mastectomy, including lymphedemas.

Treatment is to be determined by the attending Doctor, in consultation with the patient. Benefits will be payable on the same basis as for similar treatment covered under the Plan.

Reconstructive Services and Surgery

The Plan covers reconstructive services and surgery, including but not limited to treatment of covered newborn children's congenital defects and birth abnormalities, when the reconstruction meets **one** of the following primary purposes:

- When the primary purpose is to restore large skin defects due to a port wine stain.
- When the primary purpose is to relieve severe physical pain caused by an abnormal body structure.
- When the primary purpose is reconstruction following a mastectomy. See "Post-Mastectomy Coverage".
- When the primary purpose is to:
 - treat a functional impairment caused by an abnormal body structure; or
 - restore the Member's normal appearance, regardless of whether a functional impairment exists;

when the abnormality results from a documented Illness that occurred within the preceding 12 months.

Subsequent procedures integral or linked to the covered reconstruction that cannot be performed within the 12-month period due to medical considerations, may be covered after the 12-month period if documented planning for these procedures takes place within 12 months of the Illness.

"Functional impairment" means an impairment that interferes with normal bodily function. For the purpose of this provision, interference with psychological function or well-being is not considered to be a functional impairment.

Certain types of reconstructive services and surgeries may not be covered under the Plan. See BENEFIT LIMITATIONS.

Maternity Coverage

The Plan includes Great Beginnings which is a Maternity Support Program (the GB Program) that will assist Members to identify the care they need during their pregnancy and avoid risks related to their pregnancy. Members who may benefit from the GB Program are identified through a variety of means, such as review of medical claims, preauthorization requests, physician referrals and self referrals. An enrolled Member will receive educational materials and a medical assessment. The care managers in the GB Program will work with the Member and the attending Doctor and provide the care and education necessary during the Member's pregnancy. If it is determined that there are complications and that the pregnancy will qualify as high risk, then the progress of the Member's pregnancy will be followed more intensely and care will be coordinated with the attending obstetrician and perinatologist. All information is confidential and will only be shared with those directly involved in your medical care.

There are no additional out-of-pocket expenses for these services obtained through the GB Program. If this Plan includes a Lifetime Maximum, then any costs associated with the Member's participation in the GB Program will not be applied to the Maximum Benefit for All Covered Expenses.

The Plan covers prenatal, childbirth and postnatal care. Coverage for you and your baby, if dependent coverage is elected, includes a Hospital stay of 48 hours following a normal vaginal delivery and 96 hours following a C-section. The 48/96 hours begin following delivery of the last newborn in case of multiple-births. When delivery takes place outside a hospital, the 48/96 hours begin at the time of inpatient admission. The Hospital stay may be less than the 48-hour or 96-hour minimum if a decision for early discharge is made by the attending Doctor in consultation with the mother.

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

Pre-authorization is not required for the 48/96-hour Hospital stay. However, authorization is needed for a longer stay than as described above.

Family Planning

The Plan covers:

- tubal ligations.
- vasectomies.
- elective abortions.
- FDA-approved prescription contraceptives when prescribed for the treatment of birth control. This includes contraceptives administered or provided by a Doctor, including fitting of contraceptives, and those purchased from a pharmacy. If covered under the prescription drug benefit, coverage will be subject to the provisions of the prescription drug benefit.

Infertility Testing

The Plan covers diagnostic testing for the purpose of diagnosing infertility.

Treatment of Mental Health Conditions and Chemical Dependency

The Plan covers inpatient treatment of mental health conditions, alcoholism, drug addiction and other chemical dependency.

The Plan covers outpatient treatment of mental health conditions, alcoholism, drug addiction and other chemical dependency.

Chiropractic Services

The Plan covers chiropractic service expenses for services related to spinal adjustment.

Home Health Care

The Plan covers home health care visits. Services must be prescribed as an alternative or a follow-up to inpatient Hospital care. The Member must be restricted from leaving home due to a medical condition.

Care must be such that it cannot be learned or performed by the average, non-medically trained person. Care must be provided by technical or professional personnel or by home health aides working along with technical or professional personnel. Care must be required for a medical condition which is expected to improve significantly in a reasonable period of time.

Hospice Care

The Plan covers hospice care if prescribed by a Doctor and the Member's life expectancy is six months or less.

Durable Medical Equipment

The Plan covers durable medical equipment, including orthopedic and prosthetic devices, that are not useful in the absence of an Illness or Injury, not disposable, able to withstand repeated use and appropriate for use in a Member's home.

Coverage includes repair or replacement of covered equipment only when repair or replacement is required as a result of normal usage. Coverage for equipment rental will not exceed the equipment's purchase price.

Physical Therapy

The Plan covers physical therapy rehabilitation that is performed to restore function and prevent disability following acute disease, Injury or loss of body part with the expectation of significant improvement within two months.

Covered therapy includes exercise, heat, cold, electricity, ultrasound and massage to improve circulation, strengthen muscles, encourage return of motion and train Members to perform the activities of daily living.

Massage is covered only when it is part of a covered course of physical therapy and is provided by or under the direct supervision of a physical therapist.

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

Occupational, Speech and Hearing Therapy

The Plan covers outpatient occupational, speech and hearing therapy.

Occupational therapy means rehabilitation to attain the maximum level of physical and psycho-social independence following acute disease, Injury or loss of body part with the expectation of significant improvement within two months. This includes fine motor coordination, perceptual-motor skills, sensory testing, adaptive/assistive equipment, activities of daily living and specialized upper extremity and hand therapies.

Speech therapy means restoration of speech due to impairment following a recent physiological disturbance or Injury, such as CVA, tracheostomy, swallowing disorders, laryngectomy and neuromuscular disease, with the expectation of significant improvement within two months.

Transplants

The Plan covers transplants that have been preauthorized by Medical Management.

Medical Management will direct the patient to the appropriate facility for the patient's specific type of transplant.

Certain types of transplants must be performed in a Transplant Network facility to be covered under the Plan. For more information, contact Member Services at the phone number or website address shown on the Member's ID card.

As used in this Transplant provision, the term "donor" means a person who furnishes an organ or tissue for transplantation. If a human organ or tissue transplant is provided from a donor to a transplant recipient, the following will apply:

- When the donor and recipient are both covered under this Plan - This Plan covers, under the recipient's coverage, eligible transplant expenses incurred by both patients.
- When only the recipient is covered under this Plan - This Plan covers eligible transplant expenses incurred by the recipient. Coverage may also be provided under this Plan for certain donor expenses, but only if such donor expenses are not eligible for coverage under any other coverage available to the donor.
- When only the donor is covered under this Plan - When the donor is covered under this Plan, but the recipient is not, this Plan does not cover transplant expenses of either person.

Travel Expenses

The Plan covers the following:

- Transportation costs and miscellaneous expenses such as lodging, meals and parking incurred for travel to and from a Transplant Network facility, if the site is outside a 50-mile radius from the Member's home. Travel expenses must be preauthorized by Medical Management to be covered under the Plan.

Travel expense coverage will be for the Member (the transplant recipient) and one other individual, or two other individuals if the transplant recipient is a minor, accompanying the Member. While there is no maximum limit to the number of days per trip, miscellaneous expenses such as lodging, meals and parking are limited to \$100 per person, per day. Transportation expenses do not have a daily limit.

Travel coverage, including transportation and miscellaneous expenses, is limited to the Transplant Travel Expenses Lifetime Maximum shown in OPEN ACCESS PLUS MEDICAL BENEFITS SUMMARY.

- If a living donor is used, reimbursement for the donor's Travel Expenses to and from a Transplant Network facility is limited to one trip and \$100 per day for travel and lodging. All living donor travel and lodging charges apply to the Member's Transplant Travel Expenses Lifetime Maximum shown in OPEN ACCESS PLUS MEDICAL BENEFITS SUMMARY.

Travel expenses are not covered if the Member utilizes a facility other than a Transplant Network facility.

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

Enteral Nutrition

Enteral nutrition means medical foods that are specially formulated for enteral feedings or oral consumption. Coverage includes medically approved formulas prescribed by a Physician for the treatment of phenylketonuria (PKU).

The Plan covers enteral nutrition and supplies required for enteral feedings when *all* of the following conditions are met:

- It is necessary to sustain life or health;
- It is used in the treatment of, or in association with, a demonstrable disease, condition or disorder;
- It requires ongoing evaluation and management by a Physician; and
- It is the sole source of nutrition or a significant percentage of the daily caloric intake.

Coverage *does not* include:

- Regular grocery products that meet the nutritional needs of the patient (e.g., over-the-counter infant formulas such as Similac, Nutramigen and Enfamil); or
- Medical food products:
 - Prescribed without a diagnosis requiring such foods;
 - Used for convenience purposes;
 - That have no proven therapeutic benefit without an underlying disease, condition or disorder;
 - Used as a substitute for acceptable standard dietary intervention; or
 - Used exclusively for nutritional supplementation.

Clinical Trials

Services and supplies, such as medications, provided as part of clinical trials are generally not covered under the Plan because they are Experimental, Investigational or Unproven.

However, the Plan covers clinical services, as defined in this provision, when a Member participates in a phase III or IV clinical trial that has been preauthorized by Medical Management for treatment of cancer or other life-threatening illness, if all of the following criteria are met:

- the Member has a current diagnosis that will likely be terminal in less than two years under generally accepted treatment options in the absence of the clinical trial; and
- standard therapies have not been effective in significantly improving the condition or standard therapies are not medically appropriate; and
- the Member must be enrolled in the clinical trial and not be treated off protocol; and
- treatment is provided in a clinical trial that meets certain criteria established by CIGNA. For more information, contact Member Services at the phone number or website address shown on the Member's ID card.

All Plan provisions, including but not limited to pretreatment authorization and Medical Management review, apply to a Member's participation in a clinical trial.

For the purpose of this provision, "clinical services" mean services and supplies that are:

- necessary to administer the service or supply that is the focus of the clinical trial.
- necessary for management of the patient's health within the clinical trial.
- required for the clinically appropriate monitoring of the effects of the focus of the clinical trial (example: blood tests to measure tumor markers).
- required for the prevention, diagnosis or treatment of complications that result from the clinical trial treatment.

Clinical services do not include:

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

- services and supplies that:
 - are excluded from coverage under the Plan in absence of an approved clinical trial.
 - are customarily provided by the trial sponsor at no cost to the patient.
 - are provided solely to determine trial eligibility.
 - are provided solely to satisfy the trial's data collection needs (examples: monthly CT scans for a condition that usually requires a single scan, protocol induced costs).
- costs that are funded by other agencies or research sponsors.
- expenses such as travel, housing, companion expenses that may result from a Member's participation in a clinical trial.
- administrative services (example: statistical analysis).
- charges related to covered services or supplies that have not or cannot be separated from costs related to non-covered services or supplies.

Miscellaneous Medical Services and Supplies

- Nursing services.
- Air or ground ambulance when used to transport a Member:
 - from place of Illness or Injury to the nearest Hospital where appropriate treatment can be provided; and
 - from one Hospital to another, when approved by Medical Management.
- General anesthesia and associated facility charges for dental procedures when determined to be Medically Necessary.
- Custom-designed orthotics when prescribed by a Doctor and required for all normal, daily activities.
- Treatment of Injury to sound/natural teeth within six months after the accident. "Sound/natural" means teeth that are free from defect or disease, and are not artificial. A chewing injury is not considered to be an Injury.
- Services required for the treatment of diabetes and diabetes self-management education programs.

■ Is There a Limit On My Expenses?

The out-of-pocket maximums are shown in OPEN ACCESS PLUS MEDICAL BENEFITS SUMMARY.

Out-of-Pocket Maximum for Network Services

If in any one calendar year the coinsurance an individual Member pays for network services reaches the Individual Out-of-pocket Maximum for Network Services, all other covered network expenses for that individual Member during the rest of that calendar year will be payable at 100%, subject to payment of copays and satisfaction of deductibles for that individual Member.

If in any one calendar year the coinsurance paid for network services on behalf of all family Members reaches the Family Out-of-Pocket Maximum for Network Services, all other covered network expenses for family Members during the rest of that calendar year will be payable at 100%, subject to payment of copays and satisfaction of deductibles.

Out-of-Pocket Maximum for Non-network Services and Services Outside the Network Area

If in any one calendar year the coinsurance an individual Member pays for non-network services and services outside the Network Area reaches the Individual Out-of-pocket Maximum for Non-network Services and Services Outside the Network Area, all other covered non-network expenses and expenses for services outside the Network Area for that individual Member during the rest of that calendar year will be payable at 100%, subject to payment of copays and satisfaction of deductibles for that individual Member.

If in any one calendar year the coinsurance paid for non-network services and services outside the Network Area on behalf of all family Members reaches the Family Out-of-Pocket Maximum for Non-network Services and Services Outside the Network Area, all other covered non-network expenses and expenses for services outside the Network Area for family Members during the rest of that calendar year will be payable at 100%, subject to payment of copays and satisfaction of deductibles.

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

Expenses Excluded from the Out-of-Pocket Maximum

Expenses that are not applied toward the out-of-pocket maximum include expenses:

- for services and supplies not covered under this Plan.
- that are payable at 100%.
- for a Medical Management (MM) Non-Compliance Penalty.
- used to satisfy any deductible or copay amounts.

PRESCRIPTION DRUG BENEFITS

The prescription drug benefits are provided through several programs. The Performance Pharmacy Program uses a nationwide network of participating retail pharmacies. The Ninety-day Retail Network Pharmacy Program offers the convenience of obtaining a three-month supply of medication at designated retail pharmacies. The Mail Order Drug Program offers one mail order pharmacy that can dispense a multiple-month supply of medication and lowers a member's out-of-pocket costs. The Specialty Drug Program uses a small pharmacy network referred to as the Specialty Pharmacy Network (SPN). The SPN covers certain drugs commonly referred to as *high-cost specialty drugs*.

The Tier 2 and Tier 3 drugs are subject to change. Contact Member Services or visit the website shown on the Member ID card for additional information.

Covered drugs and contraceptive devices require the written prescription of a Doctor and approval by the Food and Drug Administration (FDA). Drugs and contraceptive devices must be purchased from a licensed pharmacist or Doctor. Benefits are payable only for drugs required for the treatment of illness or birth control, when received as an outpatient and while covered for these benefits.

New FDA approved drugs are evaluated by the Pharmacy and Therapeutics Committee.

If a prescription drug is not covered under the Plan, it may be available at a discounted price when the Member shows his/her ID card at a participating pharmacy.

Some drugs may have dispensing limits that are primarily based on FDA recommendations. Additionally, some drugs are subject to prior authorization. Coverage for these drugs is dependent upon satisfying Medically Necessary requirements.

The Performance Pharmacy Program

The Performance Pharmacy Program covers charges for prescription drugs, insulin and diabetic supplies, except as specifically excluded under the Plan. Refer to Prescription Drug Benefit Limitations.

Benefits are also payable for contraceptive drugs and devices prescribed for the purpose of birth control.

The Performance Pharmacy Program covers a 30-day supply received in any one purchase.

Covered expenses will be limited to the cost of a generic drug if a generic drug is available. If the Member requests a brand name drug when a generic drug is available, then, in addition to the brand name drug copay, the Member must pay the difference between the cost of the generic drug and the brand name drug.

When a Member shows his/her ID card at a participating pharmacy, the pharmacist will collect the appropriate copay and the Member won't have to file a claim.

If a Member buys drugs at a pharmacy that is not a participating pharmacy, the Member must pay the pharmacist the full price of the drug and file a claim for reimbursement. Reimbursement will be 50% of the network pharmacy cost of the drug, minus the copay amount.

Ninety-day Retail Network Pharmacy Program

For convenience, a Member may elect to have a 90-day supply of maintenance medication filled at a designated retail pharmacy. This option is available **only after the Member has filled a 30-day prescription for the same medication**. To locate a retail network pharmacy that is equipped to fill a 90-day supply of medication, you may contact Member Services or access the website shown on the Member ID card. The minimum supply available under this benefit is an 80-day supply.

PRESCRIPTION DRUG BENEFITS - Continued

Mail Order Drug Program

The Mail Order Drug Program covers costs for home delivery and expenses for prescription maintenance drugs required for treatment of illness. Prescription maintenance drugs are drugs prescribed by the Doctor on an ongoing basis. This includes expenses for diabetic supplies and insulin.

Benefits are also payable for contraceptive drugs and devices prescribed for the purpose of birth control.

With this program, a Member may buy through the mail up to 90-day supplies of insulin and covered maintenance prescription drugs. Ask the Employer for a mail order drug brochure.

Ask the Doctor to prescribe needed medications for a 90-day supply, plus refills. If a Member is presently taking medications, the Member should ask the Doctor for a new prescription.

Covered expenses will be limited to the cost of a generic drug if a generic drug is available. If a Member's prescription is for a brand name drug but a generic equivalent is available, then in addition to the brand name drug copay, the Member must pay the difference between the cost of the generic drug and the brand name drug.

If medication is needed immediately, the Member should ask the Doctor for two prescriptions. The first should be for a 14-day supply that the Member can have filled at a local participating pharmacy. The second prescription should be mailed to the Mail Order Drug Program with the copay.

The Specialty Pharmacy Program

The Specialty Pharmacy Program covers certain drugs commonly referred to as *high-cost specialty drugs*. To receive the network discount for these medications, and lower out-of-pocket costs, these drugs must be obtained by mail through a select group of pharmacies. These pharmacies comprise the Specialty Pharmacy Network (SPN). The SPN specializes in dispensing and delivering drugs that require special handling. Specialty Pharmacies provide additional helpful services, including free courier delivery, Medically Necessary ancillary supplies such as syringes and alcohol swabs, and education programs focused on the disease for which the medication is dispensed. Common conditions that involve treatment with one of the specialty drugs include multiple sclerosis, hepatitis C and rheumatoid arthritis.

With a new Specialty Pharmacy prescription, the Member may contact Member Services, or access the website shown on the Member ID card, to identify the drugs contained on the Specialty Pharmacy list. Members may also access the website or contact Member Services for assistance in locating the Specialty Pharmacy that can be used to obtain medication.

Managed Drug Limit (MDL) Program

The MDL Program helps promote safe, clinically appropriate prescription drug use. With this program there is a limit on the dose amount and days' supply of certain medications. The limits for prescription drugs were developed based on recommendations by the Food and Drug Administration (FDA) and the manufacturer of the prescription drug. If a Doctor prescribes an additional supply of a prescription drug that is on the MDL list, the Pharmacy Prior Authorization (PPA) unit will review the request for Medical Necessity. If a Member has exceeded the limit, the Member must contact the Doctor or Member Services to initiate the authorization process with the PPA unit for additional supply of the prescription drug.

Prior Authorization (PA) Program

The PA program helps to control the cost of prescription drug benefits by requiring certain high-cost drugs to be reviewed for Medical Necessity. This list is reviewed and updated periodically. The Member must make sure to contact their Doctor or Member Services to initiate the authorization process with the PPA unit for the high-cost drugs. To avoid any delay when filling prescriptions, a Member can call Member Services or access the Prior Authorization prescription drug list available at the website shown on the Member ID card.

BENEFIT LIMITATIONS

Pre-Existing Conditions Limitation for Medical Benefits

This provision will *not* apply to a child placed with you for adoption.

A pre-existing condition is an illness or any related condition for which a Member received services, supplies or medication during the 3 months before the enrollment date of the Member under this medical Plan.

A pre-existing condition is not:

- A pregnancy existing on the enrollment date.
- Genetic information.

Benefits are payable for services, supplies and medication received for a pre-existing condition if they are received 12 months after the enrollment date for the Member.

For a late applicant as described in “What If I Don’t Apply On Time?”, benefits will be payable for services, supplies and medication for a pre-existing condition only if they are received on or after the date which is 12 months after the person’s enrollment date.

“Enrollment date” means:

- the first day of coverage; or
- the first day of the eligibility waiting period, if an eligibility waiting period is required by the Employer.

You must apply for coverage for yourself and/or your eligible Dependents within the 31-day period when you are first eligible.

Portability of Coverage

A person will receive credit toward this Plan’s Pre-Existing Condition Limitation periods for the time covered under another health plan, but only if the person was covered, under another health plan that meets the definition of “Creditable Coverage”, within the 63-day period just before his or her enrollment date under this Plan. Any eligibility waiting period that the person must satisfy under this Plan will not be considered in determining the 63-day period. Creditable Coverage information is given to CIGNA by the Employer. For questions regarding the amount of prior Creditable Coverage, contact the Plan Administrator.

If the person was covered:

- For a period of time under Creditable Coverage that is greater than the time periods referred to in the Pre-Existing Conditions Limitation, then the Pre-Existing Conditions Limitation periods will not apply to the person.
- For a period of time under Creditable Coverage that is less than the time periods referred to in the Pre-Existing Conditions Limitation, then the Pre-Existing Conditions Limitation periods will be reduced by the number of consecutive days that the person was covered under Creditable Coverage.

However, for a child who became covered under Creditable Coverage within 31 days of birth, the Pre-Existing Conditions Limitation periods will not apply regardless of how long the child was covered under Creditable Coverage.

If a person enrolled or re-enrolled in COBRA or state continuation coverage, if any, under the extended election period allowed in the American Recovery and Reinvestment Act of 2009 (ARRA), this lapse in coverage will be disregarded for the purpose of determining Creditable Coverage.

Notice for Colorado Residents

If a Member resides in Colorado and:

- The Member’s coverage under this medical Plan has been in force for at least six months; and
- The Member has a pre-existing condition that will not be covered under this Plan because he has not satisfied the periods referred to in this provision;

Then, subject to payment of the required premium, the Member may be eligible for coverage under the Colorado High Risk Health Insurance Act, under the CoverColorado program.

BENEFIT LIMITATIONS - Continued

For further information regarding CoverColorado, please contact:

CoverColorado
425 So. Cherry Street, Suite 160
Glendale, Colorado 80246
303-863-1960 or 1-877-461-3811

Medical Benefit Limitations

No amount will be payable for:

- Custodial care of a Member whose health is stabilized and whose current condition is not expected to significantly or objectively improve or progress over a specified period of time. Custodial care does not seek a cure, can be provided in any setting and may be provided between periods of acute or intercurrent health care needs.

Custodial care includes any skilled or non-skilled health services or personal comfort and convenience services which provide general maintenance, supportive, preventive and/or protective care. This includes assistance with, performance of, or supervision of:

- walking, transferring or positioning in bed and range of motion exercises;
- self-administered medications;
- meal preparation and feeding, by utensil, tube or gastronomy;
- oral hygiene, skin and nail care, toilet use, routine enemas;
- nasal oxygen applications, dressing changes, maintenance of indwelling bladder catheters, general maintenance of colostomy, ileostomy, gastronomy, tracheostomy and casts.
- Special nursing services if those same services could be provided by the regular nursing staff of any Hospital in which the Member is confined.
- Charges by a Doctor for any phone call or interview during which the Member is not examined.
- Confinement, treatment, services or materials for educational or training problems or learning disorders.
- Special education.
- Borderline intellectual functioning treatment.
- Cognitive rehabilitation.
- Outpatient physical, occupational or speech therapy for non-acute injuries, diseases or conditions that are not reasonably expected to result in significant clinical improvement within two months. This includes developmental progress in skills such as sitting, walking, talking and learning that compare unfavorably to measured results from standardized tests of others of the same age.
- Geriatric day care, occupational and recreational therapy for age related cognitive decline (treatment for organic mental disorders).
- Services or supplies which are primarily for the Member's education, training or development of skills needed to cope with an injury or sickness, except as specifically provided in the Plan.
- Any expense or charge, including any membership dues, associated with exercise equipment, health clubs, weight loss clinics or similar programs.
- Work-hardening programs.
- Wilderness programs.
- Travel or transportation expenses, except as specifically provided in the Plan.
- Cosmetic, plastic or reconstructive services or surgery, except reconstructive services and surgery described in "What's Covered?".
- Gene manipulation therapy.

BENEFIT LIMITATIONS - Continued

- The reversal of any sterilization procedure.
- Massage, except when it is part of a covered course of physical therapy and is provided by or under the direct supervision of a physical therapist.
- Services for an exam to determine refraction errors of the eye, including eye exams associated with a medical or post-operative diagnosis, or a surgical procedure to correct refraction errors of the eye, including any confinement, treatment, services or supplies provided in connection with or related to the surgery.
- Eyeglasses, contact lenses, eye exams to assess visual acuity or the fitting of glasses and lenses.
- Care of or treatment to the teeth, gums or supporting structures such as, but not limited to, periodontal treatment, endodontic services, extractions, implants, or any treatment to improve the ability to chew or speak, unless otherwise covered under this Plan.
- Non-prescription/over-the-counter drugs or medicines, unless specifically listed in the Plan as a covered benefit.
- Drugs or medicines that are not approved by the Food and Drug Administration (FDA).
- Programs related to smoking cessation.
- Osteotomy, orthognathic surgery, maxillofacial orthopedics or related treatment for deformities caused by anything other than cancer or trauma.
- Substance related disorders (such as nicotine, caffeine) treatment or programs.
- Treatment for the purpose of weight loss, including but not limited to Bariatric surgery, Gastroplasty, any residual treatment from previous gastro surgery. However, consultation with a licensed dietician for the purpose of weight loss is a covered expense.
- Hearing aids or the fitting of hearing aids, including surgically implanted hearing aids.
- Treatment of temporomandibular disorders and craniofacial muscle disorders.
- Counseling, except as covered under the Plan's mental health and chemical dependency provisions.
- Counseling for educational reasons, IQ testing or other testing.
- Counseling related to consciousness raising.
- Vocational training and counseling.
- Religious counseling.
- Drugs, medicines or insulin which are received as an outpatient.
- Infertility testing, except as described in the Infertility Testing provision.
- Infertility treatment, such as but not limited to any procedure that requires surgical or drug assisted reproductive technology (examples: artificial insemination, in-vitro fertilization, GIFT or ZIFT).
- Chelation therapy, except to treat heavy metal poisoning.
- Examinations or treatment ordered by a court in connection with legal proceedings when such treatment or examinations are not included as a covered expense under the Plan.
- Court ordered treatment (such as parole, probation, custody visit, sex offender).
- Sex transformation procedures, services and supplies.
- Charges made by a Doctor for his or her time on "stand-by" status if he or she performs no actual services except for interventional cardiology procedures (such as angioplasty) and C-sections.
- Purchase or rental of luxury medical equipment when standard equipment is appropriate for the patient's condition (e.g., motorized wheelchairs or other vehicles, bionic or computerized artificial limbs).
- Computerized speech devices or other adaptive equipment that is not primarily restorative in nature.
- Transplants, except as provided in the Transplant benefit provision. Non-human organs and Experimental, Investigational or Unproven transplant services and supplies, and any transplant expenses which are eligible to be paid under any private or public research fund, government program or other funding program, are not covered.
- Home delivery. Pre and postnatal care are covered expenses, but obstetrical services and medical expenses related to home delivery are not covered.

BENEFIT LIMITATIONS - Continued

- Transcutaneous Electrical Nerve Stimulation (TENS) units.
- Enteral feedings, supplies and specially formulated medical foods that are prescribed and non-prescribed, except as specifically provided in the Enteral Nutrition benefits provision.
- Clinical trials, except as provided in the Clinical Trials benefit provision.
- Acupuncture. Related charges, including but not limited to charges for needles, suction cups and herbs, are also not covered.

Prescription Drug Benefit Limitations

No amount will be payable for:

- Therapeutic devices and appliances, except as specifically provided under the Plan.
- Non-prescription or over-the-counter (OTC) drugs and supplies, unless specifically listed in the Plan as a covered benefit.
- Drugs or medicines that are not approved by the Food and Drug Administration (FDA).
- Drugs, devices and supplies for cosmetic purposes.
- The administration of drugs.
- More than one purchase of a drug or insulin during the dosage period recommended by the prescribing Doctor.
- Allergy serums.
- Drugs for treatment of infertility.
- Prescription drugs or supplies for which there is a non-prescription or over-the-counter (OTC) equivalent. An OTC equivalent contains the same chemical(s) as a prescription drug or supply, but has been approved by the Food and Drug Administration (FDA) to be sold OTC.

General Benefit Limitations

No amount will be payable for:

- Services, drugs and supplies, other than contraceptives prescribed for the purpose of birth control, that are not Medically Necessary.
- Experimental, Investigational or Unproven services and supplies. Any service or supply that is integral or linked to an Experimental, Investigational or Unproven service or supply that, in the absence of the Experimental, Investigational or Unproven service or supply, would not be Medically Necessary, is also not covered.
- Any charge not included as a covered expense under the Plan.
- Charges which would not have been made if the Member did not have coverage.
- Charges which the Member is not obligated to pay, or for which the Member is not billed or for which the Member would not have been billed except that they were covered under the Plan.
- Vision therapy or orthoptic treatment.
- Anti-obesity drugs and formulas.
- Broken appointments.
- Care provided by a government health plan. If the Member is entitled to benefits under a state-sponsored medical assistance program, benefits under the Plan will be paid to the state.
- Expenses incurred for care provided by your or your spouse's immediate or extended family.
- Care received for an illness that is a result of war or engaging in a riot or insurrection.
- An Injury that occurs while working for pay or profit.
- An illness for which the Member can receive benefits under any Workers' Compensation or similar law.

CLAIMS & LEGAL ACTION

■ How To File Claims

A claim for benefits and services that have been provided may be filed by a Member, beneficiary or Authorized Representative. An *Authorized Representative* means a person authorized in writing by the Member or a court of law to represent the Member's interests for claim submission, pretreatment requests and appeals.

The Member's spouse, parent (if Member is a minor) and health care provider will be automatically recognized as the Member's Authorized Representative for pretreatment requests, claim submissions and appeals. For requests involving urgent care, any health care professional with knowledge of a Member's condition will also be automatically recognized as the Member's Authorized Representative for pretreatment requests and appeals.

All claim forms include instructions on how to complete and submit a claim. Members can request a claim form from the Plan Administrator or visit the website shown on the Member ID card. Complete and accurate claim information is necessary to avoid claim processing delays. Claim decisions will not exceed the time frames described below, unless the Member, beneficiary or Authorized Representative agrees to a longer period of time.

Health Benefits

Medical Benefits

Members who present their ID card when using a network provider will not have to file a claim. The ID card contains all the information network providers need to directly bill the Company for the balance.

For other services, Members must file a claim. Sign the completed form, attach the itemized bill and mail both to the address on the Member ID card.

An Explanation of Benefits (EOB) will be sent to the Member showing how the claim was paid.

For expenses incurred outside the United States, the Member must pay the bill and file a claim.

Prescription Drug Benefits

A prescription given to a pharmacist is not a claim for benefits under the Plan. A Member may submit a claim for prescription drugs if:

- a copay amount was charged that the Member believes to be incorrect; or
- all or a portion of the cost of a prescription drug or supply is paid by the Member at the time the drug or supply is dispensed and the Member wants to request reimbursement for the amount paid; or
- prescription drugs or supplies are purchased at a pharmacy that is *not* a participating pharmacy.

Claim forms are available from Member Services and from the Employer. If a Member decides to pay full price to purchase a drug or supply, the Member should submit a claim to the prescription drug benefits manager for processing. Benefits will be processed subject to the provisions of the Plan. This includes any deductible, copayment percentage, coverage limitations and benefit maximums.

With the first Mail Order drug order, the Member should complete the member profile form found in the Mail Service brochure. Ask the Employer for a copy of this brochure.

Claim Decisions

Claims for health benefits and services provided to a Member will be processed within 30 days of the date the claim is received by CIGNA. If a decision cannot be made within this time period for reasons beyond the control of the Plan, the Member will be notified of:

- the reasons for the delay;
- any information needed to perfect the claim; and

CLAIMS & LEGAL ACTION - Continued

- the date by which a decision is expected.

The Member will have 45 days from the date the notice is received to provide the requested information. If the information is received within this time period, a decision will be made within 15 days of the date the information is received, unless the Member agrees to a longer period of time. If the requested information is not provided within this time period, the Member should consider the claim to be denied. The claim will be reconsidered if the information is subsequently received.

■ If A Claim Is Denied

If benefits are denied, in whole or in part, CIGNA will send the Member a written or electronic notice within the established time periods described in "How to File Claims". The Member or Authorized Representative may appeal the denial as described below. The adverse determination notice will include the reason(s) for the denial, reference to the Plan provision(s) on which the denial is based, whether additional information is needed to process the claim and why the information is needed, the claim appeal procedures and time limits, and the Member's right to bring civil action under ERISA Section 502(a) after required Plan appeals have been exhausted.

The notice will also specify:

- whether an internal rule, guideline, protocol or other criterion was relied upon in making the claim decision and that this information is available to the Member upon request and at no charge.
- that an explanation of the scientific or clinical judgment for a decision based on medical necessity, experimental treatment or a similar limitation is available to the Member upon request and at no charge.

Appeal of a Health Benefit Claim Denial

After receiving notice of a claim denial, in whole or in part, the Member, the Member's beneficiary, provider or other Authorized Representative can appeal a claim denial by submitting a written request within:

- 180 days of the date the notice of denial of the initial claim is received; or
- 60 days of the date the notice of the initial appeal decision is received.

The appeal request must be submitted to Health Claim Appeal at the address on the adverse determination notice. The appeal request should include the Member's and the Employee's name and identification number, the date of service, address and telephone number of the Member and the provider, and a description of the appeal.

The appeal will be reviewed by an individual who was not involved in the prior adverse determination and who is not a subordinate of the individual who made the prior determination. If the prior determination was based on medical judgment, a health care professional with appropriate training in the field of medicine that is the subject of the claim will be consulted and identified.

In connection with the review, the Member has the right to:

- review and request copies of relevant documents, free of charge; and
- submit issues and comments in writing; and
- have a representative act on his or her behalf in the appeal.

The decision on the appeal will be made within 30 days of the date the appeal is received.

In the case of an adverse decision of an appeal, the notice of the decision will include the information described above for a claim denial.

Two appeals are required before the Member may bring civil action under ERISA Section 502(a) as described in the Statement of ERISA Rights.

Once the required appeals have been exhausted, additional appeals are allowed on a voluntary basis upon request when new and substantial information is provided. Voluntary reviews must be requested within 60 days of the date the notice of the appeal decision is received.

CLAIMS & LEGAL ACTION - Continued

There are no voluntary appeal rights following the required appeal process when the denial was based on medical judgment.

The Member has a right to request information regarding voluntary appeal procedures. Any statute of limitations or other defense based on timeliness is suspended during the time that a voluntary appeal is pending. Voluntary appeals do not need to be exhausted in order to bring civil action under ERISA Section 502(a).

For the purposes of health benefits, “medical judgment” includes but is not limited to Medically Necessity, and Experimental, Investigational or Unproven determinations.

Please see “How Does the Plan Work?” in MEDICAL BENEFITS for information about pretreatment authorization, urgent care and non-urgent care denials and appeals.

■ What If a Member Has Other Health Coverage?

A Member may be covered under more than one health plan. For example, coverage may be under this Plan and also under a group health plan sponsored by the Employee’s spouse’s employer. If this type of duplicate coverage occurs, this Plan uses a method called Coordination of Benefits (COB) to determine which plan pays benefits first on a claim (is primary) and which plan pays second (is secondary). Under COB, total payments from both plans will never be more than the expenses actually incurred.

This COB provision does not apply to your Prescription Drug Benefits.

The benefits provided by the plans listed below are considered in coordinating benefits:

- This Plan;
- Any other group health plan, including automobile fault or no-fault insurance; Health Maintenance Organizations (HMOs); Blue Cross/Blue Shield;
- Any labor-management trustee plan, union welfare plan, employer organization plan or employee benefit organization plan;
- Any government plan or statute providing benefits for which COB is not prohibited by law;
- Any individual automobile no-fault insurance plan.

Which Plan Is Primary?

Certain rules are used to determine which of the plans will be primary. This is done by using the first of the following rules that applies:

- A plan with no COB provision will determine its benefits before a plan with a COB provision.
- A plan that covers a person other than as a Dependent will determine its benefits before a plan that covers the person as a Dependent.
- When a claim is made for a Dependent child who is covered by more than one plan, in most cases the birthday rule will be used to determine the order of benefits. Under the birthday rule:
 - the plan of the parent whose birthday falls earlier in a year will be primary; but
 - if both parents have the same birthday, the plan that covered the parent longer will be primary.

However:

- If the other plan does not have the birthday rule, then the plan that covers the child as a Dependent of the male parent will be primary.
- If the parents are legally separated or divorced, benefits for the child will be determined in this order:
 - * first, the plan of the parent with custody of the child will pay its benefits;
 - * then, the plan of the spouse of the parent with custody of the child will pay its benefits; and
 - * finally, the plan of the parent not having custody of the child will pay its benefits.

CLAIMS & LEGAL ACTION - Continued

However, if there is a court decree stating which parent is responsible for the health care expenses of the child, then a plan covering the child as a Dependent of that parent will be primary.

If a court decree states that the parents have joint custody of the child, but does not specify which parent has responsibility for the child's health care expenses, benefits will be determined on the same basis as for a child whose parents are not separated or divorced.

- A plan that covers a person as:
 - a laid-off or retired employee; or
 - a Dependent of such an employee; or
 - a continuee under a state or Federal law;

will determine its benefits after the benefits of any other plan covering that person as an employee.

If one of the plans does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

- When a claim is made for an Employee's Dependent who is also covered under Medicare and as a retiree under his employer's plan:
 - the plan covering the person as a Dependent will determine its benefits prior to Medicare; and
 - the plan covering the person as a retiree will determine its benefits after Medicare.
- If none of the above rules establishes the order of payment, the plan covering the person for a longer period of time will be primary.

What If This Plan Is Primary?

If this Plan is primary, it will determine its benefits without considering other coverage. The Member should submit the claim first to the Benefit Payment Office listed on the claim form. When the explanation of benefits is received from this Plan, send it, along with the claim and itemized bills, to the secondary plan.

What If This Plan Is Secondary?

Submit the Member's claim first to the primary plan. After the other plan has determined its benefits, send the explanation of benefits from the other plan, along with the Member's claim, to the Benefit Payment Office listed on the claim form.

If this Plan is secondary, it pays the lesser of:

- the allowable expenses that were not reimbursed under the other plan; and
- the amount this Plan would have paid if there were no other coverage.

The COB provision is applied throughout the calendar year.

When the COB provision reduces the benefits payable under this Plan:

- each benefit will be reduced proportionately; and
- only the reduced amount will be charged against any benefit limits under this Plan.

A credit savings may be established if this Plan is secondary. A credit savings is the difference between the benefits this Plan would pay if there were no other coverage and the benefits this Plan actually paid. Credit savings may be used to provide 100% rather than partial payment of allowable expenses that are incurred by the same person within the same calendar year.

Allowable expenses for a Member are any necessary, usual and customary items of expense, at least part of which is covered under at least one of the plans covering the person.

Allowable expenses will not include the difference between the cost of a private Hospital room and a semi-private Hospital room unless the patient's stay in a private Hospital room is Medically Necessary.

CLAIMS & LEGAL ACTION - Continued

When the benefits of a government plan are taken into consideration, the allowable expense is limited to the benefits provided by that plan.

■ How Will Benefits Be Affected By Medicare?

The following applies to you if you are an active Employee and you or your spouse becomes eligible for Medicare **due to age**. You and your Dependents will continue to be eligible for the benefits provided under this medical Plan. This Plan will coordinate benefits with Medicare. If:

- Your Employer employed at least 20 full-time or part-time employees during at least 20 calendar weeks of the preceding or current calendar year, then this medical Plan will be considered the Member's primary coverage, and Medicare will be considered the Member's secondary coverage. This means that benefits under this medical Plan will be payable first, and then Medicare will determine the remaining expenses it will pay.
- Your Employer employed fewer than 20 full-time or part-time employees during at least 20 calendar weeks of the preceding or current calendar year, then Medicare will be considered primary, and this medical Plan will be considered secondary.

The following applies to you if you are an active Employee and you or your Dependents become eligible for Medicare **due to disability**. You and your covered Dependents will continue to be eligible for the benefits provided under this medical Plan. This Plan will coordinate benefits with Medicare. If:

- Your Employer employed at least 100 full-time or part-time employees during 50% or more of the Employer's business days during the previous calendar year, then coverage under this medical Plan will be considered the primary coverage, and Medicare will be considered the secondary coverage. This means that the benefits payable under this medical Plan will be payable first, and then Medicare will determine the remaining expenses it will pay.
- Your Employer employed fewer than 100 full-time or part-time employees during 50% or more of the Employer's business days during the previous calendar year, Medicare will be considered the primary coverage, and coverage under this Plan will be considered the secondary coverage.

If A Member Becomes Eligible for Medicare Due to End-Stage Renal Disease (ESRD)

Under Medicare law, a Member must complete a waiting period, typically three months, before becoming eligible for Medicare solely because of ESRD. During this waiting period, this Plan will pay benefits and Medicare will not pay any benefits.

After the waiting period, for the first 30 months of eligibility for Medicare Part A benefits solely due to ESRD, this Plan will pay its benefits first (primary payer) and Medicare will pay its benefits second (secondary payer). After that, if the Member is still eligible for Medicare due to ESRD, Medicare will be the primary payer and this Plan will be the secondary payer.

In certain circumstances, such as a kidney transplant, the 30-month time frame that this Plan will be the primary payer may be less as defined by the Medicare guidelines for determining primary payer.

If the Member becomes eligible for Medicare due to ESRD after Medicare became the primary payer under any other provision of Medicare law or this Plan, Medicare will be the primary payer and this Plan will be the secondary payer.

Treatment must be rendered in a Medicare-approved facility in order to be covered under this Plan.

A Member is eligible for Medicare when:

- the Member is covered under Medicare; or
- the Member is not covered under Medicare due to:
 - the Member's refusal of Medicare coverage;
 - the Member's voluntary termination of Medicare coverage; or
 - the Member's failure to apply for Medicare coverage.

CLAIMS & LEGAL ACTION - Continued

■ Provision for Subrogation and Right of Recovery

An Other Party may be liable or legally responsible to pay expenses, compensation and/or damages in relation to an Illness incurred by a Member (i.e. a Covered Person). A Covered Person is defined to also include the Member's legal representative.

An Other Party is defined to include, but is not limited to, any of the following:

- the party or parties who caused the Illness;
- the insurer or other indemnifier or guarantor or indemnifier of the party or parties who caused the Illness;
- the Covered Person's own insurer (for example, in the case of uninsured, underinsured, medical payments or no-fault coverage);
- a Workers' Compensation insurer;
- any other person, entity, policy or plan that is liable or legally responsible in relation to the Illness.

Benefits may also be payable under the Plan in relation to the Illness. When this happens, CIGNA may, at its option:

- subrogate, that is, take over the Covered Person's right to receive payments from the Other Party. The Covered Person will transfer to CIGNA any rights he or she may have to take legal action arising from the Illness to recover any sums paid under the Plan on behalf of the Covered Person;
- recover from the Covered Person any benefits paid under the Plan from any payment the Covered Person is entitled to receive from the Other Party.

The Covered Person must cooperate fully with CIGNA in asserting its subrogation and recovery rights. The Covered Person will, upon request from CIGNA, provide all information and sign and return all documents necessary to exercise CIGNA's rights under this provision.

CIGNA will have a first lien upon any recovery, whether by settlement, judgment, mediation or arbitration, that the Covered Person receives or is entitled to receive from any of the sources listed above. This lien will not exceed:

- the amount of benefits paid by CIGNA for the Illness, plus the amount of all future benefits which may become payable under the Plan which result from the Illness. CIGNA will have the right to offset or recover such future benefits from the amount received from the Other Party; or
- the amount recovered from the Other Party.

No Covered Person shall make any settlement which specifically reduces or excludes, or attempts to exclude, the benefits provided by the Plan.

If the Covered Person:

- makes any recovery from any of the sources described above; and
- fails to reimburse CIGNA for any benefits which arise from the Illness;

then:

- the Covered Person will be personally liable to CIGNA for the amount of the benefits paid under this Plan; and
- CIGNA may reduce future benefits payable under this Plan for any Illness by the payment that the Covered Person has received from the Other Party.

CIGNA's first lien rights will not be reduced due to the Covered Person's own negligence; or due to the Covered Person not being made whole; or due to attorney's fees and costs.

For clarification, this provision for subrogation and right of recovery applies to any funds recovered from the Other Party by or on behalf of:

- an Employee's minor covered Dependent;
- the estate of any Covered Person; or

CLAIMS & LEGAL ACTION - Continued

- on behalf of any incapacitated person.

■ Other Information a Member Needs to Know

Proof of Claim

Send written claim to CIGNA as soon as reasonably possible. A Member must submit a written claim no later than 15 months from the date the claim is incurred, unless legally incapable of doing so.

Complaint Process

For concerns or complaints, contact Member Services at the phone number shown on the ID card. Whether the issue involves health care or the administration of coverage, CIGNA's representatives will do what they can to make sure it's addressed. No retaliatory action will be taken by CIGNA against the Member because of a complaint. CIGNA's goal is for the Member to be completely satisfied with the measures taken to resolve the issue. However, if a Member is not satisfied, CIGNA's representatives can help the Member begin the formal complaint process. If the issue is not resolved to the Member's satisfaction, the Member may appeal.

For complaints involving timely claim payment or a denial of a claim see "How To File Claims". For complaints involving a preauthorization determination, see "Medical Management (MM) Program" in MEDICAL BENEFITS.

For all other complaints, including those related to availability, delivery or quality of a health care service, contact Member Services for an explanation of the complaint process.

Legal Actions

A Member may bring a legal action to recover under the Plan. Such legal action may be brought no sooner than 60 days, and no later than 3 years, after the time written proof of loss is required to be given under the terms of the Plan.

Physical Examinations

The Company, at its own expense, has the right to have the person for whom a claim is pending examined as often as reasonably necessary.

Benefit Payments

Benefits will be paid to the Member, if living. If not, benefits will be paid to the Member's estate. If any benefit is payable to the Member's estate or to a person who cannot give a valid release, then CIGNA can pay up to \$1,000.00 to any relative it considers to be entitled to such payment. The Member may request in writing that payments under the Plan be made directly to the person providing the services.

Benefit Payments to a Representative of a Minor

In the case of a minor child who qualifies as a Dependent under the Plan, if the child has a representative who is not covered under the Plan, then the Plan must pay benefits on behalf of that child to the representative. The person must submit proof that he or she is the child's representative and that he or she qualifies to be paid the benefits.

Relationship Between CIGNA and Network Providers

Providers under contract with CIGNA are independent contractors. Network providers are neither agents nor employees of CIGNA, nor is CIGNA, or any employee of CIGNA, an agent or employee of Network providers. CIGNA will not be responsible for any claim or demand on account of damages arising out of, or in any way connected with, any injuries suffered by the Member while receiving care from any Network provider or in any Network provider's facilities.

GLOSSARY

Creditable Coverage

Coverage under a group health plan, individual health insurance coverage, Medicare, Medicaid or other public health plans, TRICARE coverage (formerly known as CHAMPUS) for military personnel and their families, a medical program of the Indian Health Service or of a tribal organization or the Peace Corps, state health benefit risk pools, the Federal Employee Health Benefit Plan (FEHBP) or a State Children's Health Insurance Program (S-CHIP).

Dentist

A person licensed to practice dentistry.

Dependent

See ELIGIBILITY.

Doctor/Physician

A person licensed to practice medicine or osteopathy. This also includes any other practitioner of the healing arts if:

- He or she performs a service within the scope of his or her license and for which this Plan provides coverage; and
- State law requires such practitioner to be covered.

Emergency Medical Condition

The sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson who possesses an average knowledge of health and medicine to believe that immediate medical care is required and that lack of such care could reasonably be expected to result in:

- placing the patient's life in serious jeopardy;
- serious Injury or impairment of bodily functions; or
- serious or permanent dysfunction of any bodily organ or part;
- with respect to a pregnant woman, placing the woman's health, or that of her unborn child, in serious jeopardy.

Employee

See ELIGIBILITY.

Employer

- Cotopaxi School District RE 3; and
- Any affiliated companies listed in the application of the Employer. The Employer may add an affiliated company after the effective date of the Plan. For that company only, the effective date of the Plan will be considered to be the effective date of the amendment that adds that company.

Experimental, Investigational or Unproven

A service or supply, such as medication, that meets any of the following criteria:

- For a service or supply that is subject to Food and Drug Administration (FDA) approval:
 - it does not have FDA approval; or
 - it has FDA approval, but is being used for an indication or at a dosage that is not an accepted off-label use.

An accepted off-label use is a use that is:

- established based on reliable evidence as defined in this provision; or
- is included and favorably recognized for treatment of the indication in at least one of the following publications: DrugDex, Drug Facts and Comparisons, Clinical Pharmacology or other established reference compendia as designated by Medical Management, and the data are sufficiently conclusive as to efficacy to allow recognition of the off-label use; or
- Is being provided pursuant to phase I, II, III or IV clinical trials, unless in the case of phase III or phase IV clinical trials is provided in accordance with the clinical trials coverage described in the Plan; or

GLOSSARY - Continued

- Is being provided pursuant to a written protocol that describes among its primary objectives determination of maximum tolerated dosage, safety, toxicity, effectiveness, or effectiveness compared to conventional alternatives; or
- Is being provided pursuant to a written informed consent used by the treating provider that refers to the service or supply as experimental, investigational, unproven or for research; or
- Is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the Department of Health & Human Services (HHS) and the FDA; or
- Based upon review and analysis of the published peer-reviewed medical literature, the weight of the evidence demonstrates that it is the predominant opinion of independent experts that the service or supply:
 - is substantially confined to use in research settings; or
 - is subject to further research studies or clinical trials, in order to determine maximum tolerated dosage, safety, toxicity, effectiveness, or effectiveness compared to conventional alternatives; or
 - is experimental, investigational, unproven; or
- Is not a covered service or supply as defined under Medicare because it is considered investigational or experimental as determined by HHS/Centers for Medicare & Medicaid Services (CMS); or
- Is not currently the subject of active investigation because prior investigations and/or studies have failed to establish proven efficacy and/or safety.

In making the determination whether a service or supply is Experimental, Investigational or Unproven, Medical Management reserves the right to certify coverage of a service or supply, notwithstanding that the service or supply meets one of the above criteria, if there is reliable evidence as defined in this provision, that would support use of the service or supply as efficacious in the unique circumstances present in a particular case.

For these purposes, “reliable evidence” means evidence of all of the following:

- There are at least two articles in peer-reviewed U.S. scientific medical or pharmaceutical publications supporting use of the service or supply outside the investigational setting; and
- The published articles evidence a well-designed investigation that has been reproduced by non-affiliated authoritative sources with measurable, clinically meaningful results; and
- The investigation evidences that the probable benefits of using the service or supply in the unique circumstances in the particular case in question outweigh the risks associated with such use in situations where conventional alternatives have not or would not be efficacious.

Hospital

An institution licensed as a Hospital by the proper authority of the state in which it is located. An institution recognized as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). This does not include any institution that is used primarily as a place for treatment of alcoholism or substance abuse, a clinic, convalescent home, rest home, home for the aged, nursing home, custodial care facility, or training center.

Illness

An Injury, a sickness, a disease, a bodily or mental disorder, a pregnancy, or any birth defect of a newborn child. Conditions that exist and are treated at the same time or are due to the same or related causes are considered to be one Illness.

Injury

A sudden and unforeseen event from an external agent or trauma, resulting in injuries to the physical structure of the body. It is definite as to time and place and it happens involuntarily or, if the result of a voluntary act, entails unforeseen consequences. It does not include harm resulting from disease.

GLOSSARY - Continued

Loss of Residence

Being outside the United States for more than 60 days. However, a Member will continue to be eligible for the benefits provided under this Plan if he or she is temporarily outside of the United States:

- On vacation;
- To study; or
- To conduct business for your Employer;

For a period of up to, but not exceeding, 60 continuous days.

Medically Necessary/Medical Necessity

Health care services and supplies, such as medication, that a Physician, exercising prudent clinical judgment, provides to a Member for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and are:

- In accordance with generally accepted standards of medical practice; and
- Clinically appropriate, in terms of type, frequency, level, extent, site and duration, and considered effective for the Member's Illness, Injury or disease; and
- Not deemed to be cosmetic or Experimental, Investigational or Unproven as defined in the Plan; and
- Specifically allowed by the licensing statutes which apply to the Physician who provides the service or supply; and
- At least as medically effective as any standard care and treatment; and
- Not primarily for the convenience, psychological support, education or vocational training of the Member, Physician or other health care provider; and
- Not more costly than an alternative service, supply or sequence of services or supplies, and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's Illness, Injury or disease.

For these purposes, "generally accepted standards of medical practice" mean the:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;
- Recommendations of an American Medical Association-recognized Physician specialty society;
- Prevalent practices of Physicians in the relevant clinical area; or
- Any other relevant factors.

Medical Management may require satisfactory proof in writing that any type of service or supply received is Medically Necessary. Medical Necessity will be determined solely by Medical Management, in accordance with the definition above.

Medicare

Title 18 of the United States Social Security Act of 1965 as amended from time to time and the coverage provided under it. This includes coverage provided under Medicare Advantage plans.

Member

An Employee and any covered Dependent.

Plan

The medical and drug benefits described in this booklet.

Service

See ELIGIBILITY.

GLOSSARY - Continued

Totally Disabled and Total Disability

Active Employees

Being under the care of a Doctor and prevented by Illness from performing your regular work.

Dependents

Being under the care of a Doctor and prevented by Illness from engaging in substantially all of the normal activities of a person of the same age and sex who is in good health.

Urgent Care Facility

A freestanding facility which is engaged primarily in providing minor emergency and episodic medical care and which has:

- a Doctor, a registered nurse (R.N.) and a registered x-ray technician in attendance at all times; and
- x-ray and laboratory equipment and a life support system.

You and Your

An Employee.

USERRA RIGHTS AND RESPONSIBILITIES

The federal Uniformed Services Employment and Reemployment Rights Act (USERRA), establishes requirements for Employers and certain Employees who terminate Service with the Employer for the purpose of Uniformed Service. This includes the right to continue the medical and prescription drug coverage that you (the Employee) had in effect for yourself and your Dependents.

“Uniformed Service” means the performance of active duty in the Uniformed Services under competent authority which includes training, full-time National Guard duty and the time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of the assigned duties.

You must notify your Employer verbally or in writing of your intent to leave employment and terminate your Service with the Employer for the purpose of Uniformed Service. The notice must be provided at least 30 days prior to the start of your leave, unless it is unreasonable or impossible for you to provide advance notice due to reasons such as military necessity.

Continued Medical and Prescription Drug Coverage

Under USERRA, you are eligible to elect continued medical and prescription drug coverage for yourself and your Dependents when you terminate Service with the Employer for the purpose of Uniformed Service.

The Employer should establish reasonable procedures for electing continued medical and prescription drug coverage and for payment of contributions. See the Plan Administrator for details.

If you do not provide advance notice of your leave and you do not elect continued coverage prior to your leave

Coverage for you and your Dependents will terminate on the date that coverage would otherwise terminate due to termination of your Service.

However, if you are excused from giving advance notice because it was unreasonable or impossible for you to provide advance notice due to reasons such as military necessity, then coverage will be retroactively reinstated if you elect coverage for yourself and your Dependents and pay all unpaid contributions within the period specified in the Employer’s reasonable procedures.

If you provide advance notice of your leave but you do not elect continued coverage prior to your leave

Coverage for you and your Dependents will terminate on the date that coverage would otherwise terminate due to termination of your Service, when the duration of Uniformed Service is at least 30 days.

However, coverage will be retroactively reinstated if the Employer has established reasonable procedures for election of continued coverage after the period of Uniformed Service begins, and you elect coverage for yourself and your Dependents and pay all unpaid contributions within the time period specified in the procedures.

If the Employer has not established reasonable procedures, then the Employer must permit you to elect continued coverage for yourself and your Dependents and pay all required contributions at any time during the period of continued coverage, and the Employer must retroactively reinstate coverage.

If you elect continued coverage but do not make timely payments for the cost of coverage

If the Employer has established reasonable payment procedures and you do not make payments according to the procedures, then coverage for you and your covered Dependents will terminate as described in the procedures.

Period of Continued Coverage

During a leave for Uniformed Service, the period of continued coverage begins immediately following the date you and your covered Dependents lose coverage under the Plan, and it continues for a maximum period of up to 24 months.

Cost of Continued Coverage

If the period of Uniformed Service is less than 31 days, you are not required to pay more than the amount that you paid as an active Employee for that coverage for continued coverage.

USERRA RIGHTS AND RESPONSIBILITIES - Continued

If the period of Uniformed Service is 31 days or longer, then you will be required to pay up to 102% of the applicable group rate for continued coverage.

COBRA Coverage

If you are entitled to COBRA continuation coverage, then the COBRA coverage period runs concurrently with the USERRA coverage period. In some instances, COBRA coverage may continue longer than USERRA coverage.

Reinstatement of Coverage

Coverage for an Employee who returns to Service with the Employer following Uniformed Service will be reinstated upon request from the Employee and in accordance with USERRA.

Reinstated coverage will not be subject to any exclusion or waiting period, if such exclusion and/or waiting period would not have been imposed had coverage not terminated as a result of Uniformed Service.

For medical coverage, a pre-existing condition limitation may be imposed on an Illness that is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, Uniformed Service. See the Plan Administrator for details.

CONTINUATION OF COVERAGE - FMLA

This provision applies if the Employer is subject to the Family and Medical Leave Act of 1993 (FMLA), as amended. If you are eligible for FMLA leave and if the Employer approves your FMLA leave, coverage under the Plan will continue during your leave. Contributions must be paid by you and/or the Employer. If contributions are not paid, your coverage will cease. If you return to work on your scheduled date, coverage will be on the same basis as that provided for any active Member on that date. If your coverage ends during FMLA leave, a COBRA qualifying event occurs if you do not return to work on the date you are scheduled to return from your FMLA leave. See the Plan Administrator with questions about FMLA leave.

CONTINUATION OF COVERAGE - COBRA

This provision generally explains COBRA continuation coverage, when it may become available to a Member and what a Member needs to do to protect the right to receive it. COBRA continuation coverage, is a temporary extension of coverage under the Plan, and was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

In some circumstances, COBRA requires that Members who lose group Medical and Prescription Drug plan coverage to be given an opportunity to continue that coverage when there is a “qualifying event” that would result in a loss of coverage under the Plan. A “qualified beneficiary” is a person who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, qualified beneficiaries can include the Employee and/or the Employee’s spouse or Dependent children. COBRA continuation coverage must be offered to each qualified beneficiary and the coverage is the same coverage that other Members under the Plan who have not had a qualifying event have. Each qualified beneficiary will have the same rights under the Plan as other Members, including open enrollment and special enrollment rights.

CONTINUATION OF COVERAGE - COBRA - Continued

Right to COBRA Continuation Coverage

- As an Employee, you have a right to choose COBRA continuation coverage, if you lose your coverage due to a reduction in your hours of employment, or due to voluntary or involuntary termination of your employment, for any reason except gross misconduct.
- As a Dependent spouse, you have the right to choose COBRA continuation coverage, if you lose your coverage due to the Employee's death, or the Employee's termination of employment or reduction in hours of employment, as stated above, or due to your divorce or legal separation. If the Employee cancels your coverage in anticipation of your divorce or legal separation and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a qualifying event even though you have lost coverage earlier.
- Your Dependent Child, including alternate recipients under a medical child support order have the right to choose COBRA continuation coverage if the Dependent Child loses coverage due to the reasons stated above or ceases to be an eligible Dependent under the terms of the Plan.

Length of COBRA Continuation Coverage

Generally:

- In the case of loss of coverage due to termination of employment or reduction in hours of Service, coverage may be continued for those who elect continuation coverage, for up to 18 months from the date of the qualifying event.
- In the case of loss of coverage due to your death, divorce or legal separation, or a Dependent Child ceasing to be a Dependent under the terms of the Plan, coverage may be continued for those who elect continuation coverage, for up to 36 months from the date of such event.
- If an Employee becomes entitled to Medicare and later has a qualifying event, which is a termination of employment or reduction of hours, within 18 months of entitlement to Medicare, then the maximum coverage period for the Dependent spouse and children will be 36 months which begins from the date the Employee becomes entitled to Medicare.
- If, after the occurrence of any event described in the Right to COBRA Continuation Coverage above, the Member is allowed to continue coverage under the Plan (whether or not contributions are required) beyond the Plan's termination of coverage provision for any reason other than to comply with the federal law (i.e. state laws mandating continuation coverage or the Plan's special provisions), such continuation period(s) will be used to reduce the maximum length of COBRA continuation coverage period otherwise available to such person under this provision.

Extension of COBRA Continuation Coverage

- ***Disability Extension*** - If you lose coverage because of termination of your employment or reduction in your hours of employment, and if anyone in your family unit is determined under Title II or XVI of the Social Security Act to have been Totally Disabled at any time during the first 60 days of COBRA continuation coverage, then the Totally Disabled Member and other qualified beneficiaries who are entitled to COBRA continuation coverage may extend the continuation for 11 additional months.
- ***Second Qualifying Event*** - If your Dependent:
 - is covered under COBRA because of termination of your employment or reduction in your hours of employment; and
 - while covered under COBRA experiences a second qualifying event, such as a divorce or legal separation or ceasing to be an eligible Dependent;

then such qualified beneficiaries are entitled to up to a maximum of 36 months of COBRA coverage from the date of the first qualifying event.

Health FSA

The maximum COBRA coverage period for a health flexible spending arrangement (Health FSA), if maintained by your Employer, ends on the last day of the Flexible Benefits Plan Year in which the qualifying event occurred.

CONTINUATION OF COVERAGE - COBRA - Continued

Notice Requirements

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator of the Employer or the representative of the Employer has been timely notified that a qualifying event has occurred.

When the qualifying event is termination of employment, reduction of hours of employment or death of the Employee, the Plan Administrator will notify the Employee within 44 days of the later of the date of the qualifying event or the date coverage ends.

Dependents - If your spouse or Dependent children become eligible for COBRA continuation coverage due to divorce or legal separation or end of dependency status, or upon occurrence of a second qualifying event, the Plan Administrator or the representative of the Employer must be notified within 60 days of the first or the second qualifying event. The notice must be provided following Reasonable Notice Procedures, as described below.

If the notice is not provided within 60 days of the qualifying event, your spouse or Dependent children will lose the right to such coverage.

If you have a child or adopt a child while covered under COBRA, and you decide to add the child to your COBRA continuation coverage, then you must notify the Plan Administrator or the representative of the Employer of the birth or adoption within the 30 days of birth, adoption or placement for adoption in order for the child to be considered a COBRA qualified beneficiary. The notice must be provided following Reasonable Notice Procedures, as described below.

Disability Extension - A Member who wishes to continue COBRA continuation coverage under the Disability Extension must notify the Plan Administrator or the representative of the Employer of the Social Security Administration's disability determination within 60 days of such determination and before the end of the initial 18-month COBRA coverage period. If the notice is not provided within the specified timeframe, the qualified beneficiary and the members of the family unit will lose the right to extend COBRA coverage under the Disability Extension.

If the Social Security Administration determines that the qualified beneficiary's disability ceases to exist, then the qualified beneficiary must notify the Plan Administrator or the representative of the Employer of this information within 30 days of such determination.

The notice must be provided following the Reasonable Notice Procedures, as described below.

Reasonable Notice Procedures

Any notice that needs to be provided must be in writing. Oral notice, including notice by telephone, is not acceptable. The qualified beneficiary must mail the notice to the contact person at the address specified below:

Cathy Emig
345 County Rd. 12
Cotopaxi, CO
81223

The notice must be postmarked no later than the last day of the required notice period. Any notice provided must state the name and address of the Employee covered under the Plan and the names and addresses of the qualified beneficiaries, the qualifying event and the date of the qualifying event. If a qualifying event is a divorce, the notice must include a copy of the divorce decree. In case of a disability, the notice must include the name of the disabled qualified beneficiary, the date of disability and a copy of the Social Security Administration's letter of determination of disability or determination that the qualified beneficiary is no longer disabled. The notice must be provided by the qualified beneficiary, spouse or parent, if applicable, or by an authorized representative of the qualified beneficiary.

Election of COBRA Continuation Coverage

When a qualifying event occurs, the Employer or a representative of the Employer must give the qualified beneficiary the necessary

CONTINUATION OF COVERAGE - COBRA - Continued

COBRA election form. The qualified beneficiary must elect coverage in writing within 60 days of being provided a COBRA election notice or the date the qualified beneficiary would lose coverage, whichever is later. To elect coverage, the qualified beneficiary must follow the procedures specified in the Election Form. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. If the qualified beneficiary does not elect coverage within the 60-day election period, the qualified beneficiary will lose the right to elect COBRA continuation coverage. The qualified beneficiary has the right to change a prior rejection of COBRA continuation coverage anytime within the 60-day election period by following the procedures specified in the Election Form. Failure to continue this coverage will affect future rights under federal law, such as the right to purchase individual health insurance policies that do not impose a pre-existing condition exclusion.

Cost of Coverage

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% of the applicable group rate.

If a qualified beneficiary elects to continue coverage, the qualified beneficiary must make the first payment for continuation within 45 days of the election. The qualified beneficiary is responsible for making sure that the amount of the first payment is enough to cover the entire initial period from the date coverage would have otherwise terminated, up to the date the qualified beneficiary makes the first payment. If the qualified beneficiary fails to make the first payment, they will lose the continuation coverage rights under the Plan. Claims incurred during the period covered by the initial payment period will not be processed until the payment is made.

After the qualified beneficiary makes the first payment for continuation coverage, they will be required to pay for continuing the coverage for each subsequent month of coverage; they will be given a grace period of 30 days to make each periodic payment. The coverage will be continued as long as payment for that period is made before the end of the grace period.

The Plan may require payments of up to 150% of the applicable group rate if coverage is extended under the *Disability Extension*.

In some situations, the American Recovery and Reinvestment Act of 2009 (ARRA), as amended, may reduce the COBRA premium. A premium reduction may be available to certain individuals who experience a qualifying event that is an involuntary termination of employment during the period beginning with September 1, 2008, and ending with February 28, 2010, or later date as reflected in federal law. If a qualified beneficiary qualifies for a premium reduction, the qualified beneficiary is responsible for paying 35% of the COBRA premium otherwise due. This premium reduction is available for up to a maximum 15 months. If a qualified beneficiary's COBRA continuation coverage is longer than the maximum number of months, the qualified beneficiary is responsible for the full cost of coverage.

Termination of COBRA Continuation Coverage

The COBRA continuation coverage may terminate before the maximum period of continuation runs out if:

- The required contribution is not paid; or
- After the date of election of COBRA continuation coverage, the qualified beneficiary becomes entitled to Medicare benefits (except for a person whose continuation coverage right derives from the Employer's filing for reorganization under Chapter 11 of the Bankruptcy Code); or
- After the date of election of COBRA continuation coverage, the qualified beneficiary becomes covered under another group health plan that does not impose a pre-existing condition limitation for a pre-existing condition of a qualified beneficiary; or
- After the date the qualified beneficiary qualifies under the *Disability Extension*, the beneficiary is no longer disabled; or
- All of Employer's group health plans are terminated.

The qualified beneficiary must notify the Employer or its representative of the beneficiary's entitlement to Medicare coverage under another group health plan or that the beneficiary is no longer disabled within 30 days of the event. The notice must comply with the Reasonable Notice Procedures, described above. The Employer or its representative will notify the qualified beneficiary of the termination of coverage if it happens prior to the maximum period of COBRA continuation coverage.

CONTINUATION OF COVERAGE - COBRA - Continued

For more information about COBRA continuation of coverage, a Member may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

In order to protect your rights and your Dependent's rights, you should keep the Plan Administrator informed of any changes in the address of family members.

The Trade Act of 2002

The Trade Act of 2002 created a special second COBRA election period for certain displaced workers receiving Trade Adjustment Assistance (TAA) under the Trade Act of 1974. A Member who did not elect COBRA continuation coverage during the initial 60-day election period that was a direct consequence of the TAA-related loss of coverage, may elect COBRA continuation coverage during a second 60-day period that begins on the first day of the month in which the Member is determined to be "TAA-Eligible". The election must be made within 6 months after the date of the TAA-related loss of coverage.

Under the new tax provisions eligible individuals can either take a tax credit or get advance payment of 65% of contributions paid for qualified health insurance, including COBRA continuation coverage. Federal law amended these provisions, including an increase in the amount of the credit to 80% of contributions for coverage before January 1, 2011, and temporary extension of the maximum period of COBRA continuation for eligible individuals.

If you have questions about the new tax provisions you may call the Health Care Tax Credit Customer Contact Center toll free at 1-866-628-4282. TTD/TTY callers may call toll free at 1-866-626-4282.

SECTION II - ERISA

ERISA GENERAL INFORMATION

The following information is required by the Employee Retirement Income Security Act of 1974 (ERISA).

The Plan Sponsor/Employer is Cotopaxi School District RE 3.

The address of the Plan Sponsor/Employer is 345 County Rd. 12, Cotopaxi, CO 81223. The telephone number is 719-942-4131.

The Employer Identification Number (EIN) is 84-6001224. The Plan Number assigned by the Plan Sponsor is 501.

The Plan Administrator is Cathy Emig, Business Manager.

The Agent for Service of Legal Process is Geoffrey Gerk, Superintendent.

Service of legal process may also be made upon the Plan Trustee or the Plan Administrator.

The Plan provides Medical and Prescription Drug Benefits.

The medical and drug benefits described in this booklet are self-funded by the Employer. The Employer is fully responsible for the self-funded benefits. Connecticut General Life Insurance Company (CIGNA) provides Contract Administration by processing claims and providing other services to the Employer related to the self-funded benefits. CIGNA does not insure or guarantee the self-funded benefits.

The eligibility requirements, termination provisions and a description of the circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are described in this booklet.

Contributions are determined by the Employer. Employee contributions, if any, for a time period for which the Employee is not covered under the Plan may be refunded by the Employer. Please see your Plan Administrator for details.

The fiscal records of the Plan are maintained on the basis of Plan years ending November 30.

Procedures to be followed in presenting claims for medical and drug benefits and what to do when claims are denied in whole or in part are described in "How To File Claims" under the MEDICAL AND PRESCRIPTION DRUG BENEFITS SECTION of this booklet.

STATEMENT OF ERISA RIGHTS

As a participant in this 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.

You may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest Annual Report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

You may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- You may 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.

However, Employers with fewer than 100 Participants at the beginning of the Plan Year are not required to:

- **furnish statements of the plan's assets and liabilities and receipts and disbursements or allow examination of the Annual Report; or**
- **furnish copies of the Annual Report or any Terminal Report.**

STATEMENT OF ERISA RIGHTS - Continued

- Continue Group Health Plan Coverage.

You may be eligible to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a COBRA qualifying event. You or your Dependents may have to pay for such coverage. You may review this summary plan description and the documents governing the Plan or the rules governing your COBRA continuation coverage rights.

There may be a reduction or elimination of exclusionary periods of coverage for pre-existing 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 COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for up to 12 months (up to 18 months if you are a late enrollee) after your enrollment date in your coverage.

- Prudent Actions by Plan Fiduciaries.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are 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.

- Enforce Your Rights.

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 without charge copies of documents relating to the decision 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 federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

- Assistance With Your Questions.

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