

Community Action Team, Inc.

OAP with Vision

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SECTION I - MEDICAL, PRESCRIPTION DRUG AND VISION BENEFITS

NOTICE OF GRANDFATHERED PLAN STATUS

This Plan is being treated as a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your coverage may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at the phone number or address provided in your plan documents, to your Employer or plan sponsor or an explanation can be found at http://www.cigna.com/sites/healthcare_reform/customer.html.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a 48 (or 96) hour length of stay.

■ About This Plan

Community Action Team, Inc. (the Employer) has established an Employee Welfare Benefit Plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). As of July 1, 2016, the medical, drug and vision benefits described in this booklet form a part of the Employee Welfare Benefit Plan and are referred to collectively in this booklet section as the Plan. The Employee Welfare Benefit Plan will be maintained pursuant to the medical, drug and vision benefit terms described in this booklet. The Plan may be amended from time to time.

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

The medical, drug and vision benefits described in this booklet are self-funded by the Employer. The Employer is fully responsible for the self-funded benefits. Cigna Health and 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, drug and vision 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, drug and vision 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 Cigna Health and Life Insurance Company 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, Amendment and Termination

The Employer reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other Plan term or condition, and to terminate the whole Plan or any part of it. Contact the Employer for the procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated. No consent of any Plan Member is required to terminate, modify, amend or change the Plan.

Rescission

A Member's health coverage may not be rescinded (retroactively terminated) by Cigna, the Employer or Plan sponsor unless:

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

OPEN ACCESS PLUS MEDICAL BENEFITS SCHEDULE

This Schedule provides a general description of 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.

When you select a network provider, this Plan pays a greater share of the costs than if you select a provider that is not a network provider. For the names of network providers, contact Member Services at the phone number or website address shown on the Member ID card. You are responsible for confirming that a provider is a network provider.

When you receive services from a network provider, remind your provider to utilize network providers for x-rays, lab tests and other services so that the cost may be considered at the network level.

Plan Deductible

The Plan Deductible is the amount of covered medical expenses that must be satisfied (paid by you and/or your Dependents) each calendar year before the Plan begins to pay benefits. Expenses for network services will not apply to the non-network deductible. Expenses for non-network services and services outside the network area will not apply to the network deductible. Expenses incurred for Special Services will always apply to the network deductible even when not performed by a network provider. Any expenses that were incurred in the last three months of a calendar year and used to satisfy the Plan Deductible for that calendar year will also be applied to the Plan Deductible for the next calendar year.

Network Preventive Care - The Plan Deductible does not apply to expenses for Preventive Care services, including lab tests and x-rays, and office visits.

Covered expenses other than Preventive Care - If the Plan Deductible does not apply, as shown below, to a non-network covered expense, then it also does not apply to the covered expense when the expense is incurred outside the network area.

The Plan Deductible applies to all covered expenses except:

- expenses that are subject to the Inpatient Hospital Facility Services Per Admission Deductible
- expenses that are subject to the Outpatient Facility Services Per Admission Deductible
- expenses subject to a copay
- expenses for Network Urgent Care Facility Visits (includes all services rendered as part of the visit)
- expenses for an Emergency Room Visit (includes all services rendered as part of the visit)
- expenses for Network mental health outpatient office visits
- expenses for Network mental health outpatient treatment other than office visits
- expenses for Network chemical dependency outpatient office visits
- expenses for Network chemical dependency outpatient treatment other than office visits
- expenses for Network provider office visits (office services are separate from the office visit)

Note: This refers to office visits other than for, if covered under the Plan, mental health and chemical dependency.

- expenses for surgery performed in a Network provider's office
- expenses for lab tests performed in a Network provider's office
- expenses for lab tests performed in a Non-network Doctor's office
- expenses for x-rays and advanced radiology performed in a Network provider's office
- expenses for x-rays and advanced radiology performed in a Non-network provider's office
- expenses for lab tests performed in a Network and Non-network independent facility
- expenses for lab tests performed in a Network and Non-network outpatient facility
- expenses for x-rays and advanced radiology performed in a Network outpatient facility
- expenses for x-rays and advanced radiology performed in a Non-network outpatient facility

OPEN ACCESS PLUS MEDICAL BENEFITS SCHEDULE - Continued

Individual Calendar Year Deductible

- Network	\$500.00
- Non-network and outside the Network Area	\$500.00

Family Calendar Year Deductible

- Network	\$1,500.00
- Non-network and outside the Network Area	\$1,500.00

Inpatient Hospital Facility Services Per Admission Deductible

This Per Admission Deductible applies to facility charges for each inpatient admission in a Hospital or other facility, and must be satisfied before the Plan begins paying benefits for inpatient facility charges. This Per Admission Deductible is separate from the Plan Deductible, and continues to apply after the Plan Deductible is satisfied.

This Per Admission Deductible does not apply to inpatient ancillary facility charges or inpatient professional services.

This Per Admission Deductible does not apply to Hospice or Skilled Nursing Facility inpatient admissions.

Per Admission

- Network	None
- Non-network and outside the Network Area	\$500.00

Outpatient Facility Services Per Admission Deductible

This Per Admission Deductible applies to facility charges for each outpatient facility admission for outpatient surgery. Facility charges include: operating room, recovery room, procedures room, treatment room and observation room. This Per Admission Deductible must be satisfied before the Plan begins paying benefits for outpatient facility admissions for outpatient surgery. This Per Admission Deductible is separate from the Plan Deductible, and continues to apply after the Plan Deductible is satisfied.

This Per Admission Deductible does not apply to outpatient ancillary facility charges or outpatient professional services.

This Per Admission Deductible does not apply to non-surgical outpatient procedures.

Per Admission

- Network	None
- Non-network and outside the Network Area	\$500.00

Medical Management Program

Ineligible Expense Penalty per claim	\$250.00
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Out-of-Pocket Maximum

Coinsurance amounts paid by you and your covered Dependents for network services accumulate toward the Network Out-of-Pocket Maximum.

Coinsurance amounts paid by you and your covered Dependents for non-network services and services outside the network area accumulate toward the Non-network and Services outside the Network Area Out-of-Pocket Maximum.

The following expenses do **not** accumulate toward the Out-of-Pocket Maximums:

- expenses not covered under this Plan.
- expenses the Plan pays at 100%.
- expenses used to satisfy the Plan Deductible.

OPEN ACCESS PLUS MEDICAL BENEFITS SCHEDULE - Continued

- expenses used to satisfy the Inpatient Hospital Facility Services Per Admission Deductible.
- expenses used to satisfy the Outpatient Facility Services Per Admission Deductible.
- medical expense copays.
- prescription drug benefit expenses.
- Medical Management Ineligible Expense Penalty.
- Vision Benefit expenses.

The Individual Calendar Year Out-of-Pocket Maximum for Network must be met before covered expenses for network services will be payable at 100% for the remainder of that calendar year.

The Individual Calendar Year Out-of-Pocket Maximum for Non-Network and Services outside the Network Area must be met before covered expenses for non-network and services outside the network Area will be payable at 100% for the remainder of that calendar year.

If the Family Calendar Year Out-of-Pocket Maximum for Network is met, then covered expenses for network services for all covered family Members, even those who have not yet met the Individual Calendar Year Out-of-Pocket Maximum for Network, will be payable at 100% for the remainder of that calendar year.

If the Family Calendar Year Out-of-Pocket Maximum for Non-Network and services outside the Network Area is met, then covered expenses for non-network and services outside the network Area for all covered family Members, even those who have not yet met the Individual Calendar Year Out-of-Pocket Maximum for Non-Network and services outside the Network Area, will be payable at 100% for the remainder of that calendar year.

Plan Deductible, Inpatient Hospital Services Per Admission Deductible and Outpatient Facility Services Per Admission Deductible continue to apply after the Out-of-Pocket Maximum has been met.

Medical expense copays continue to apply after the Out-of-Pocket Maximum has been met.

Individual Calendar Year Out-of-Pocket Maximum

- Network	\$3,000.00
- Non-Network and Services outside the Network Area	\$5,000.00

Family Calendar Year Out-of-Pocket Maximum

- Network	\$9,000.00
- Non-Network and Services outside the Network Area	\$15,000.00

Benefit Maximum(s)

The benefit maximum(s) shown here are per person, per calendar year, unless otherwise noted.

Home Health Care	100 visits
Skilled Nursing Facility	100 days
Outpatient Occupational, Speech and Hearing Therapy	40 visits
Outpatient Physical Therapy	40 visits
Acupuncture Treatment	\$600.00
Chiropractic Services	20 visits
Transplant Services - Approved Travel Expenses (maximum is per transplant)	\$10,000.00
Cardiac Rehabilitation	36 visits

Lifetime Benefit Maximum(s)

OPEN ACCESS PLUS MEDICAL BENEFITS SCHEDULE - Continued

Lifetime Maximum Benefit per Member for all Covered Expenses Unlimited

Copays for Covered Expenses

A copay is an amount you and/or your Dependents (the Member) pays for care at the time of service.

- Mental Health - Network Outpatient Office Visits (such as individual and group psychotherapy, medication management)	\$20.00
- Chemical Dependency - Network Outpatient Office Visits (such as individual and group psychotherapy, medication management)	\$20.00
- Preventive Care Network Office Visits	\$20.00
- Network Chiropractic Services	\$20.00
- Network Outpatient Physical Therapy	\$20.00
- Network Outpatient Speech, Hearing and Occupational Therapy	\$20.00
- Network Urgent Care Facility Visit (includes all services rendered as part of the visit)	\$20.00 per day and per provider
- Emergency Room Visit (includes all services rendered as part of the visit, and this copay is waived if the visit is immediately followed by an inpatient admission)	\$100.00
- Other Network Office Visits - Primary Care	\$20.00
- Other Network Office Visits - Speciality Care	\$20.00

The Other Network Office Visits copay does not apply to office visits for acupuncture, and non-network urgent care facility visits.

Coinsurance for all Covered Expenses

A coinsurance is a percentage of the Maximum Reimbursable Charge for Covered Expenses that a Member is required to pay under the Plan. The Plan's percentage is shown here.

	NETWORK	NON-NETWORK
Mental Health - Inpatient	80%	60%
Mental Health - Outpatient		
- Office Visits (such as individual, family and group psychotherapy, medication management)	100%	60%
- All Other Outpatient Services (such as partial hospitalization, intensive outpatient services)	80%	60%
Chemical Dependency - Inpatient	80%	60%
Chemical Dependency - Outpatient		
- Office Visits (such as individual, family and group psychotherapy, medication management)	100%	60%
- All Other Outpatient Services (such as partial hospitalization, intensive outpatient services)	80%	60%
Preventive Care		
- Preventive Care Office Visits	100%	60%
- Preventive Care Services other than lab tests and x-rays	100%	60%
- Preventive Care lab tests and x-rays ordered as part of Preventive Care and performed in a provider's office	100%	60%
- Preventive Care lab tests and x-rays ordered as part of Preventive Care and performed in an independent or outpatient facility	100%	60%
Office Visits and Office Services		

OPEN ACCESS PLUS MEDICAL BENEFITS SCHEDULE - Continued

	NETWORK	NON-NETWORK
- Office Visits		
* Primary Care	100%	60%
* Specialist Care	100%	60%
- Lab Tests performed in the provider's office		
* Primary Care	80%	60%
* Specialist Care	80%	60%
- X-rays performed in the provider's office		
* Primary Care	80%	60%
* Specialist Care	80%	60%
- Advanced Radiology (such as MRI, MRA, PET, CT-Scan and nuclear medicine) performed in the provider's office		
* Primary Care	80%	60%
* Specialist Care	80%	60%
- Office Surgery		
* Primary Care	80%	60%
* Specialist Care	80%	60%
- Other Office Services (such as diagnostic services, allergy injections)		
* Primary Care	80%	60%
* Specialist Care	80%	60%
Outpatient Facility Services for outpatient surgery, including operating room, recovery room, procedures room, treatment room and observation room		
- Outpatient Facility	80%	60%
- Outpatient Ancillary Facility Charges	80%	60%
- Outpatient Professional Services - Surgeon	80%	60%
- Outpatient Professional Services - Other (including but not limited to Radiologist, Pathologist, Anesthesiologist, other Hospital-Based Doctors)	80%	60%
Outpatient Lab Tests ordered as part of an Office Visit or outpatient care and performed in an:		
- Independent Facility	80%	60%
- Outpatient Facility	80%	60%
Outpatient X-rays ordered as part of an Office Visit or outpatient care and performed in an outpatient facility	80%	60%
Outpatient Advanced Radiology (such as MRI, MRA, PET, CT-Scan and nuclear medicine) ordered as part of an Office Visit or outpatient care and performed in an outpatient facility	80%	60%
Inpatient Hospital		
- Inpatient Facility	80%	60%
- Inpatient Ancillary Facility Charges	80%	60%
- Inpatient Professional Services - Surgeon	80%	60%
- Inpatient Professional Services - Radiologist, Pathologist, Anesthesiologist, other Hospital-Based Doctors	80%	60%
- Inpatient Professional Services - Doctor Visits/Consultations	80%	60%

OPEN ACCESS PLUS MEDICAL BENEFITS SCHEDULE - Continued

	NETWORK	NON-NETWORK
Urgent Care Facility Visit (includes all services rendered as part of the visit)	100%	60%
Emergency Room Visit (includes all services rendered as part of the visit)	100%	100%
Ambulance Services	80%	80%
Medical specialty drugs (cost of drug only) administered under the supervision of a health care professional in these locations:		
- Inpatient Hospital	Same as Inpatient Hospital benefit	Same as Inpatient Hospital benefit
- Outpatient Facility	80%	60%
- Doctor/Physician Office	80%	60%
- Member's Home	80%	60%
Home Health Services	80%	60%
Skilled Nursing Facility	80%	60%
Hospice Care		
- Inpatient Hospice	Same as Inpatient Hospital	Same as Inpatient Hospital
- Outpatient Hospice	Same as Home Health Care	Same as Home Health Care
Contraceptives	Based on place and type of service	Based on place and type of service
Family Planning	Based on place and type of service	Based on place and type of service
Durable Medical Equipment	80%	60%
Chiropractic Services	100%	60%
Acupuncture Treatment	80%	60%
Outpatient Speech, Hearing and Occupational Therapy	100%	60%
Outpatient Physical Therapy	100%	60%
Transplant Services		
- Approved Travel Expenses to and from certain designated Network facilities	100%	Not Covered
- Transplant Services		
* Designated Network facilities	80%	Not Covered
* Other Network facilities	Not Covered	Not Covered
* Non-network facilities	Not Covered	Not Covered
Other Covered Expenses	80%	60%

Covered Expenses incurred outside the Network service area

Covered Expenses incurred outside the Network service area are payable at the percentage shown below:

OPEN ACCESS PLUS MEDICAL BENEFITS SCHEDULE - Continued

- Preventive Care Office Visits	80%
- Preventive Care Services other than lab tests and x-rays	80%
- Preventive Care lab tests and x-rays ordered as part of Preventive Care and performed in:	
* a provider's office	80%
* an independent or outpatient facility	80%
- Ambulance Services	80%
- Emergency Room Visit (includes all services rendered as part of the visit)	100%
- Transplant Services	Not Covered
- Other Covered Expenses incurred outside the Network service area	80%

PRESCRIPTION DRUG BENEFITS SCHEDULE

This Schedule provides a general description of 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.

You and your covered Dependent(s) (the Member) may be required to pay a portion of the Covered Expenses for Prescription Drugs and Related Supplies. That portion includes any applicable deductible, copay or coinsurance.

In no event will the applicable copay or coinsurance paid by you and your covered Dependent(s) for the Prescription Drug or Related Supply exceed the amount paid by the Plan or the Pharmacy's Usual and Customary (U&C) charge. Usual and Customary (U&C) means the established Pharmacy retail cash price, less all applicable customer discounts the Pharmacy usually applies to its customers, regardless of the customer's payment source.

FDA-approved prescription and over-the-counter (OTC) tobacco cessation medications covered under this Plan and required as part of preventive care (details at www.healthcare.gov), when prescribed by a Doctor for tobacco use cessation and purchased from a Network Pharmacy are covered at 100% not subject to any deductible, copay or coinsurance. This includes generic medications, and some brand name medications when certain criteria are met. A written prescription is required.

Copays

A copay is the amount you and your covered Dependent(s) are required to pay for covered Prescription Drugs and Related Supplies charges under this Plan.

A charge is the amount charged by Cigna to the Plan when the Pharmacy is a Network Pharmacy, and it means the actual billed charges when the Pharmacy is not a Network Pharmacy.

If the cost of a Prescription Drug or Related Supply is less than the copay, then you and your covered Dependent(s) pay 100% of the cost.

If a Prescription Drug or Related Supply is not covered, then you and your covered Dependent(s) are responsible for 100% of the cost. A Prescription Drug or Related Supply that is not covered may be available at a discounted price when the ID card is shown at a Network Pharmacy.

The Plan utilizes a tiered Prescription Drug List structure to benefits, and the status of a Prescription Drug or Related Supply within the List structure is subject to change.

When you and your covered Dependent(s) purchase covered Prescription Drugs or Related Supplies from a retail Network Pharmacy, you and your covered Dependent(s) pay any applicable deductible, copay or coinsurance at the time of purchase and do not need to submit a claim form.

Retail Network Pharmacy - up to a 30-day supply

This includes a nationwide network of retail Network Pharmacies.

	Amount Member pays
Tier 1 - Generic drugs on the Prescription Drug List	\$10.00 copay
Tier 2 - Preferred Brand Name drugs on the Prescription Drug List	\$20.00 copay
Tier 3 - Non-Preferred Brand Name drugs on the Prescription Drug List	\$40.00 copay

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

A Non-Network Pharmacy is a Pharmacy that is not a Network Pharmacy. You and your covered Dependent(s) must pay the Pharmacy 100% of the cost at the time of purchase and submit a claim for reimbursement. Reimbursement for covered expenses will be 50% of the Network Pharmacy cost less the Network Pharmacy applicable copay or coinsurance.

90-Day Retail Network Pharmacy - up to a 90-day supply

PRESCRIPTION DRUG BENEFITS SCHEDULE - Continued

This offers the convenience of obtaining a larger supply of certain covered maintenance Prescription Drugs and Related Supplies when a prescription is filled at a designated retail Network Pharmacy. This option is available only after a 30-day prescription is filled for the same Prescription Drug or Related Supply. This option is not available for prescriptions that must be filled according to the Specialty Pharmacy provision. For more information or to locate a designated Pharmacy, contact Member Services at the phone number or website on the ID card.

Amount Member pays

Tier 1 - Generic drugs on the Prescription Drug List	\$30.00 copay
Tier 2 - Preferred Brand Name drugs on the Prescription Drug List	\$60.00 copay
Tier 3 - Non-Preferred Brand Name drugs on the Prescription Drug List	\$120.00 copay

Mail Order Pharmacy (Home Delivery) - up to a 90-day supply

This offers the convenience of obtaining home delivery of certain covered maintenance Prescription Drugs and Related Supplies through designated mail order Pharmacies. For more information or to locate a designated Pharmacy, contact Member Services at the phone number or website on the ID card.

Amount Member pays

Tier 1 - Generic drugs on the Prescription Drug List	\$20.00 copay
Tier 2 - Preferred Brand Name drugs on the Prescription Drug List	\$40.00 copay
Tier 3 - Non-Preferred Brand Name drugs on the Prescription Drug List	\$80.00 copay

Specialty Pharmacy

Certain covered drugs, commonly referred to as “high-cost” specialty drugs, are drugs that require special handling. A covered prescription may be filled one time at a Retail Network Pharmacy, subsequent refills **must** be filled at a designated specialty Network Pharmacy. The copay for specialty drugs will mirror either the Retail Network Pharmacy copay or the Mail Order Drug copay. The way the prescription is written by the Doctor (*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 copay.

VISION BENEFITS SCHEDULE

This Schedule provides a general description of vision 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.

Vision Benefit expenses are not subject to, nor do they apply to, Deductible(s) described on the MEDICAL BENEFITS SCHEDULE.

Eye Exam	Plan pays 100% up to \$60.00 per consecutive 24-month period
Lenses and Frames	
- Lenticular Lenses	Plan pays 100% up to \$192.00 per consecutive 24-month period
- Single Vision Lenses	Plan pays 100% up to \$120.00 per consecutive 24-month period
- Bifocal Lenses	Plan pays 100% up to \$138.00 per consecutive 24-month period
- Trifocal Lenses	Plan pays 100% up to \$150.00 per consecutive 24-month period
- Contacts prescribed for certain medical conditions	Plan pays 100% up to \$360.00 lifetime benefit maximum

ELIGIBILITY

■ Eligible Employees

For the purpose of medical, drug and vision 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 20.0 hours per week.

■ Eligible Dependents

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.

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. However, if you are eligible to be covered as an Employee’s Dependent child because you are under age 26, then you are eligible to be covered as either an Employee or as an Employee’s Dependent child.

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

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

Eligible Dependents are:

- your legal spouse.
- a child under age 26.

Child

“Child” means:

- your natural child.
- your stepchild.
- 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.

Handicapped/Disabled Child

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 intellectual disability; and depends on you for financial support.

“Physical handicap/intellectual disability” 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
- intellectual disabilities 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.

ELIGIBILITY - Continued

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, if you meet the Service definition in ELIGIBILITY on that day, or if due to your health status you do not meet the Service definition on that day.

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.

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.

Your eligible Dependent is not a late applicant if you did not apply to cover the Dependent 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 Dependent. If you apply within 31 days of the date the court order is issued, coverage will start on the court ordered date.

Special Enrollment Rights

For medical, prescription drug, and vision 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 and will not be considered a late applicant.

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, prescription drug, and vision 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

WHEN COVERAGE BEGINS & ENDS - Continued

- 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.

- 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 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.
- 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.

■ 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 last day of the calendar month in which your Service ends.
- The date you are no longer eligible for reasons other than end of your Service.
- The due date of the first contribution toward your coverage that you or the Employer fails to make.

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

- The date your coverage ends.
- The date you cease to be eligible for Dependent coverage.
- The date your Dependent ceases to be an eligible Dependent.

WHEN COVERAGE BEGINS & ENDS - Continued

- The due date of the first contribution toward Dependent coverage that you or the Employer fails to make.

Extension of Medical and Prescription Drug Benefits

A Member who is Totally Disabled on the date he or she becomes ineligible for continuation coverage or coverage under COBRA, including a Member who declines COBRA, may still be eligible for extended benefits for the disabling condition only. These benefits are extended:

- During the course of that Total Disability.
- Under the same benefit provisions as if coverage had not ended.
- Upon termination of the Member's coverage under this Plan, for 90 days, as long as this Plan is still in force.

Benefits for Prescription Drugs and Related Supplies will be payable under the Medical Benefit and not the Prescription Drug Benefit.

You do not have to pay for extended 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, CONTINUATION OF COVERAGE - FMLA and CONTINUATION OF COVERAGE - COBRA.

■ 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 months 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?

When you select a network provider, this Plan pays a greater share of the costs than if you select a provider that is not a network provider. For the names of network providers, contact Member Services at the phone number or website address shown on the Member ID card. You are responsible for confirming that a provider is a network provider.

When you receive services from a network provider, remind your provider to utilize network providers for x-rays, lab tests and other services so that the cost may be considered at the network level.

See “Medical Management Program” for information about pretreatment authorization.

You and your covered Dependents are encouraged, but are not required, to select a Primary Care Physician (PCP) in the network. The PCP provides care and can assist with arranging and coordinating care. You and your covered Dependents may obtain covered services from providers who are designated as specialists without getting PCP approval. To select or change a PCP, contact Member Services at the phone number or website address shown on the Member ID card.

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 Visit through Stabilization if the services are approved by Medical Management.

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.

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

Medical Management Program

Medical Management will review and make an authorization determination for urgent, concurrent and prospective medical services, and prescription drug treatment 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 or the care to be provided, and if admitted to a Hospital, the appropriate length of stay.

As used in this provision “you” refers to the covered Member.

Network providers are responsible for contacting the Medical Management Program for pretreatment authorization.

If the provider is not a network provider - The provider must contact the Medical Management Program for pretreatment authorization. You must make sure that treatment is approved by the Medical Management Program. Without pretreatment authorization, an ineligible expense penalty (see MEDICAL SCHEDULE) will be applied to the claim.

You should contact Member Services at the phone number shown on the ID card prior to receiving non-emergency services and supplies, to determine if pretreatment authorization is required, and for more information about services and supplies that require pretreatment authorization.

Pretreatment authorization is not required prior to receiving care for an Emergency Medical Condition. After care is provided for an Emergency Medical Condition, Medical Management must be contacted within 48 hours.

Pretreatment authorization is required for Hospital admissions for childbirth. However, it is not necessary to obtain preauthorization for the 48/96-hour length of stay portion of the admission.

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

- Air ambulance, when used for non-Emergency Medical Conditions.
- Durable medical equipment, based on type of equipment.
- Genetic testing.
- Home health care (including IV therapy).
- Hospital admissions.
- Partial hospitalization programs.
- Outpatient advanced radiology, such as MRI, MRA, PET, CT-Scan and nuclear medicine.
- 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.
- Renal dialysis.
- Skilled nursing facilities.
- Transplant services.

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

Care Management and Care Coordination Services

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

Additional Programs

The Plan may offer, or arrange for various entities to offer, programs, discounts, benefits or other consideration to Members for the purpose of promoting general health and well being. Contact Member Services at the phone number or website address shown on the Member ID card for more information.

■ **What's Covered? (Covered Expenses)**

The MEDICAL BENEFITS SCHEDULE shows deductibles and copays, as well as any Plan maximums and Plan coinsurance payment percentages. Services must be Medically Necessary as defined in the GLOSSARY. Unless otherwise noted for a particular service or supply, the service or supply must be required as a result of symptoms of Illness. Expenses are covered only if incurred while the Member is covered for these medical benefits.

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.

Maximum Reimbursable Charge

When the provider is a network provider - The covered expense amount is determined based on a fee agreed upon with the provider.

When the provider is not a network provider - The amount payable for a covered expense is determined based on the Maximum Reimbursable Charge. The Maximum Reimbursable Charge is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or
- an Employer-selected percentage of a schedule developed by Cigna that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic market.

The percentile used to determine the Maximum Reimbursable Charge is the 110th percentile.

In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or
- the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna.

The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to any applicable deductibles, copayments and coinsurance amounts.

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

Some providers forgive or waive the cost share obligation (such as any deductible, copay, coinsurance) that this Plan requires you to pay. Waiver of your required cost share obligation can jeopardize your coverage under this Plan. For more details, see the BENEFIT LIMITATIONS section.

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

Emergency Room Visit

Emergency Room

If you need care for an Emergency Medical Condition, go to the nearest medical facility. Pretreatment authorization is not required prior to receiving care for an Emergency Medical Condition. After care is provided for an Emergency Medical Condition, Medical Management must be contacted within 48 hours.

Inpatient Hospital Care immediately following an Emergency Room Visit

Inpatient care for an Emergency Medical Condition includes both Hospital and Doctor charges for initial medical screening examination as well as Medically Necessary treatment which is immediately required to Stabilize the Member's condition.

Inpatient care before the Member's condition is Stabilized - When care is provided in a non-network Hospital or by a non-network Doctor, charges for inpatient care through Stabilization will be payable at the network Hospital coinsurance level and the network Doctor coinsurance level if the care is approved by Medical Management. When care is provided in an out-of-area Hospital, charges for inpatient care through Stabilization will be payable at the Network coinsurance level.

Inpatient care after the Member's condition is Stabilized - Inpatient Hospital and Doctor charges incurred after the Member's condition is Stabilized are determined based on the ***network status of the provider*** and:

- After Stabilization in a non-network or an out-of-area Hospital, if the Member elects to be transferred to a network Hospital, then covered charges will be payable at the network Hospital coinsurance level and network Doctor coinsurance level. Any transportation costs associated with this transfer will be payable at the network Ambulance coinsurance level.
- After Stabilization in a non-network Hospital, if the Member elects to continue to stay in a non-network Hospital, then covered Hospital charges will be payable at the non-network Hospital coinsurance level and:
 - if the Member elects to transfer care to a network Doctor associated with the non-network Hospital, then covered Doctor charges will be payable at the network Doctor coinsurance level.
 - if the Member elects to continue to receive care from a non-network Doctor associated with the non-network Hospital, then covered Doctor charges will be payable at the non-network Doctor coinsurance level.
- After Stabilization in an out-of-area Hospital, if the Member elects to continue to stay in an out-of-area Hospital, then covered Hospital and Doctor charges will be payable at the Services Outside the Network Area coinsurance level.
- If the Member is admitted to a network Hospital and is under the care of a non-network Doctor, then covered Hospital charges will be payable at the network Hospital coinsurance level and:
 - if the Member elects to transfer care to a network Doctor associated with the network Hospital, then covered Doctor charges will be payable at the network Doctor coinsurance level.
 - if the Member elects to continue to receive care from a non-network Doctor associated with the network Hospital, then covered Doctor charges will be payable at the non-network Doctor coinsurance level.

Note: The Member's representative may make on the Member's behalf the elections referred to above.

Urgent Care

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

Inpatient 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 facility services and Doctor's professional services may be considered separate from other Hospital care. See the MEDICAL BENEFITS SCHEDULE for more information.

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

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 Services

The Plan covers Doctor office visits and services provided during the office visit or as a result of the office visit. The following are considered separate from the office visit:

- Surgery performed in the office or an outpatient facility, such as but not limited to a Free-Standing Surgical Facility.
- Lab tests or x-rays performed in the office or in an independent or outpatient facility.
- Advanced radiology, such as MRI, MRA, PET, CT-Scan and nuclear medicine, performed in the office or in an outpatient facility.
- Other office services such as diagnostic services, medical supplies, injections, allergy testing and treatment.

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.

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. Immunizations and booster shots for the purpose of travel or to protect against occupational hazards and risks are not covered.
- Pelvic exams, Pap smears and mammograms.
- Prostate specific antigen (PSA) screening.
- Colorectal cancer screening.

Breast Reconstruction and Breast Prostheses

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

Reconstructive Surgery

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

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

Maternity Coverage

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.

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

Contraceptives

The Plan covers FDA-approved contraceptives prescribed for birth control, and administered or provided by a Doctor. This includes fitting of contraceptives.

See the PRESCRIPTION DRUG BENEFIT for information on coverage of contraceptives purchased from a licensed pharmacy.

Family Planning

The Plan covers tubal ligations and vasectomies. Elective abortions are also covered.

Infertility Testing

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

Mental Health

The Plan covers mental health services. Mental health services are services that are required to treat a disorder that impairs behavior, emotional reaction or thought processes.

In determining benefits payable, charges made for treatment of any physiological conditions related to mental health will not be considered to be charges made for mental health treatment.

Inpatient - The Plan covers services that are provided by a Hospital while you or your Dependent (the Member) is confined in a Hospital for the treatment and evaluation of mental health. Inpatient mental health treatment includes Residential Treatment Services.

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

A Mental Health Residential Treatment Center is an institution which: specializes in the treatment of psychological and social disturbances that are a result of mental health conditions; provides a subacute, structured, psychotherapeutic treatment program, under Doctor supervision; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center. A person is considered confined in a Mental Health Residential Treatment Center when he/she is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Doctor.

Outpatient - The Plan covers services required to treat mental health, when services are provided by a qualified provider while you or your Dependent (the Member) is **not** confined in a Hospital, and services are provided on an outpatient basis in an individual or group setting or Intensive Outpatient Therapy Program. Outpatient mental health treatment includes Partial Hospitalization Services.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment provided by a certified/licensed mental health program, in accordance with the laws of the appropriate legally authorized agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling 9 or more hours in a week.

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

Mental Health Partial Hospitalization Services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed mental health program, in accordance with the laws of the appropriate legally authorized agency.

Chemical Dependency

The Plan covers chemical dependency. Chemical dependency is a psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care and treatment.

In determining benefits payable, charges made for treatment of any physiological conditions related to chemical dependency will not be considered to be charges made for chemical dependency treatment.

Chemical Dependency Detoxification Services - The Plan covers detoxification and related medical ancillary services when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Medical Management review, based on the Medical Necessity of each situation, will determine whether such services will be provided in an inpatient or outpatient setting.

Inpatient - The Plan covers services provided for rehabilitation, while you or your Dependent (the Member) is confined in a Hospital, when required for the diagnosis and treatment of abuse of or addiction to alcohol and/or drugs. Inpatient chemical dependency treatment includes Residential Treatment Services.

Residential Treatment Services are services provided by a Hospital for evaluation and treatment of psychological and social functional disturbances that are a result of subacute chemical dependency.

A Chemical Dependency Residential Treatment Center is an institution which: specializes in the treatment of psychological and social disturbances that are a result of chemical dependency; provides a subacute, structured, psychotherapeutic treatment program, under Doctor supervision; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center. A person is considered confined in a Residential Treatment Center when he/she is a registered bed patient in a Residential Treatment Center upon the recommendation of a Doctor.

Outpatient - The Plan covers rehabilitation services required to treat abuse of or addiction to alcohol and/or drugs, when services are provided by a qualified provider while you or your Dependent (the Member) is **not** confined in a Hospital, and services are provided on an outpatient basis in an individual or group setting or Intensive Outpatient Therapy Program. Outpatient chemical dependency treatment includes Partial Hospitalization Services.

A Chemical Dependency Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment provided by a certified/licensed chemical dependency program, in accordance with the laws of the appropriate legally authorized agency. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling 9 or more hours in a week.

Partial Hospitalization Services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed chemical dependency program, in accordance with the laws of the appropriate legally authorized agency.

Chiropractic Services

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

Alternative Care

The Plan covers expenses for certain services that typically fall outside of traditional medical care, including office visits to a naturopathic physician and acupuncture treatment.

Coverage for naturopathic physician services is limited to office visit charges. Any additional services such as special tests or nutritional supplements are not covered.

Acupuncture treatment is covered when rendered by a licensed provider. Coverage does not include additional charges such as needles, suction cups or herbs.

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

Home Health Services

The Plan covers home health services when the Member requires skilled care, is unable to obtain the required care as an ambulatory outpatient and does not require confinement in a Hospital or other health care facility.

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

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

Home Health Services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Health Care Professional.

Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations. Physical therapy provided in the home is subject to the Home Health Services benefit limitation described in the MEDICAL BENEFITS SCHEDULE. Outpatient occupational, speech and hearing therapy provided in the home is subject to the Home Health Services benefit limitations described in the MEDICAL BENEFITS SCHEDULE.

As used in this provision, "Other Health Care Professional" means an individual other than a Doctor who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses. Other Health Professionals do not include providers such as certified first assistants, certified operating room technicians, certified surgical assistants/technicians, licensed certified surgical assistants/technicians, licensed surgical assistants, orthopedic physician assistants and surgical first assistants.

Hospice Care

The Plan covers Medically Necessary hospice care services provided under a hospice care program, and prescribed by a Doctor for a Member who has been diagnosed with a Terminal Illness.

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 prescribed physical therapy rehabilitation that is performed by an appropriate health care provider; and that is part of a therapy program designed to improve lost or impaired physical function or reduce pain resulting from Illness, Injury, congenital defect or surgery; and is expected to result in significant improvement over a clearly defined period of time; and the program is individualized, and there is documentation outlining quantifiable, attainable treatment goals.

Outpatient Occupational, Speech and Hearing Therapy

The Plan covers prescribed occupational, speech and hearing therapy rehabilitation that is performed by an appropriate health care provider; and that is part of a therapy program designed to improve lost or impaired function or reduce pain resulting from Illness, Injury, congenital defect or surgery; and is expected to result in significant improvement over a clearly defined period of time; and the program is individualized, and there is documentation outlining quantifiable, attainable treatment goals.

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

Cardiac Rehabilitation

The Plan covers Phase II cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when Medically Necessary. Phase II is an outpatient program following an inpatient Hospital discharge. The Phase II program must be Doctor-directed with active treatment and EKG monitoring.

Phase III and Phase IV cardiac rehabilitation is not covered. Phase III follows Phase II and is generally conducted at a recreational facility primarily to maintain the patient's status achieved through Phases I and II. Phase IV is an advancement of Phase III which includes more active participation and weight training.

Transplant Services

The Plan covers charges that are approved by Medical Management for human organ and tissue transplant services, including solid organ and bone marrow/stem cell procedures. This coverage is subject to the following conditions and limitations.

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

Transplant services received at a designated network facility are payable at the network level shown on the SCHEDULE.

As used in this provision, a "designated network facility" is specifically contracted with Cigna for the transplant services provided.

Transplant services received at any other facility are not covered.

As used in this provision, "any other facility" is non-network or outside the network area, or a network facility that is not specifically contracted with Cigna for the transplant services provided.

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

Transplant Travel Services - Charges for certain non-taxable travel expenses incurred in connection with certain approved transplants, may be covered under the Plan subject to conditions and limitations. Transplant travel benefits are not available for cornea transplants. Contact Medical Management for more information about the travel benefit. Medical Management must be notified before the travel benefit is utilized.

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:

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

- 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

The Plan covers routine patient care costs related to a qualified clinical trial when:

- the Member is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and
- the referring health care professional is participating in the trial and has concluded that the Member's participation in such trial would be appropriate based on the Member meeting the conditions described above, or the Member provides medical and scientific information establishing that participation in such trial would be appropriate based on the Member meeting the conditions described above.

Clinical trials conducted by providers who are not network providers will be covered at the network level if there are no network providers participating in the trial that are willing to accept the Member as a patient, or the clinical trial is conducted outside the Member's state of residence. As used here, "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

The clinical trial must meet the following requirements:

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

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

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

Routine patient care costs do not include:

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

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

Orthognathic Surgery

The Plan covers orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone can not correct, provided:

- the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
- the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease; or
- the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

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

Obesity Treatment

The Plan covers charges made for medical and surgical services for the treatment or control of clinically severe (morbid) obesity as defined below and if the services are demonstrated, through existing peer reviewed, evidence based, scientific literature and scientifically based guidelines, to be safe and effective for the treatment or control of the condition.

Clinically severe (morbid) obesity is defined by the National Heart, Lung and Blood Institute (NHLBI) as a Body Mass Index (BMI) of 40 or greater without comorbidities, or a BMI of 35-39 with comorbidities.

The following are specifically excluded:

- medical and surgical services to alter appearances or physical changes that are the result of any medical or surgical services performed for the treatment or control of obesity or clinically severe (morbid) obesity.
- weight loss programs or treatments, whether or not they are prescribed or recommended by a Doctor or under medical supervision.

Miscellaneous Medical Services and Supplies

- Charges made by a Hospital on its own behalf for outpatient medical care and treatment.
- Charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- Charges made on its own behalf, by an Other Health Care Facility, for medical care and treatment.
- Charges made by a Doctor for professional services.
- Charges for nursing services.
- Charges for medical specialty drugs that are infusion or injectable medications ordered or prescribed by a Doctor and administered under the supervision of a health care professional. These medications include, but are not limited to, hemophilia factor and supplies, enzyme replacements and intravenous immunoglobulin.
- 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.
- 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.

PRESCRIPTION DRUG BENEFITS

■ What's Covered? (Covered Expenses)

If you and your covered Dependent(s) (the Member), while covered by the Plan, incur expenses for Pharmacy charges for Medically Necessary Prescription Drugs or Related Supplies prescribed by a Doctor, the Plan will provide coverage for those eligible expenses shown on the PRESCRIPTION DRUG BENEFITS SCHEDULE and as described in this booklet.

Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy is subject to the applicable copay or coinsurance shown on the PRESCRIPTION DRUG BENEFITS SCHEDULE, after you and your covered Dependent(s) satisfy any applicable deductible.

The drug benefit includes coverage of contraceptives.

Coverage also includes eligible Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your covered Dependent(s) by a licensed dental services provider for the prevention of infection or pain in conjunction with a dental procedure.

When a prescription is issued for covered Medically Necessary Prescription Drugs or Related Supplies as part of Emergency Services and that prescription cannot reasonably be filled by a Network Pharmacy, the prescription will be covered as if filled by a Network Pharmacy.

Each Prescription Order is limited:

- up to the consecutive day supply shown in the PRESCRIPTION DRUG BENEFITS SCHEDULE, unless limited by the drug manufacturer's packaging; or
- to a dosage and/or dispensing limit as determined by the P&T Committee.

If a brand name drug is dispensed when a generic equivalent is available, then you must pay 100% of the difference between the brand name price and the generic price, plus the appropriate brand name drug copay. This applies even if the prescribing Doctor has written "Dispense as Written (DAW)" on the prescription.

The Plan may offer, or arrange for various entities to offer, programs, discounts, benefits or other consideration to Members for the purpose of promoting clinically appropriate prescription drug use. Contact Member Services at the phone number or website address shown on the Member ID card for more information.

Contact Member Services at the phone number or website shown on the ID card to obtain a list of Network Pharmacies, and to access the Prescription Drug List. Information about whether a particular drug is covered, and current drug pricing and generic alternatives is accessible through the website shown on the ID card.

Coverage for certain Prescription Drugs and Related Supplies requires your Doctor to obtain authorization prior to prescribing. Prior authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for a specific condition. If your Doctor wishes to request coverage for Prescription Drugs or Related Supplies for which prior authorization is required, your Doctor may call or complete the appropriate prior authorization form to request a prior authorization for coverage of the Prescription Drugs or Related Supplies. Your Doctor should make this request before writing the prescription.

If the request is approved, the Doctor will receive confirmation. The authorization will be processed in the claim system to allow coverage for those Prescription Drugs or Related Supplies. The length of the authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When the Doctor advises you that coverage for the Prescription Drugs or Related Supplies has been approved, you should contact the Pharmacy to fill the prescription(s).

If the request is denied, you and the Doctor will be notified that coverage for the Prescription Drugs or Related Supplies is not authorized. If you disagree with a coverage decision, you may appeal that decision according to the Plan's appeals process by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

PRESCRIPTION DRUG BENEFITS - Continued

If you have questions about a specific prior authorization request, you may call Member Services at the phone number on the ID card.

All drugs newly approved by the Food and Drug Administration (FDA) are designated as either non-Preferred or non-Prescription Drug List drugs until the P&T Committee clinically evaluates the Prescription Drug for a different designation. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

The Plan utilizes a tiered Prescription Drug List structure to benefits as shown on the PRESCRIPTION DRUG BENEFITS SCHEDULE, and the status of a Prescription Drug or Related Supply within the List structure is subject to change.

VISION BENEFITS

■ What's Covered? (Covered Expenses)

All providers, including any facilities, must be licensed in accordance with the laws of the appropriate legally authorized agency, and acting within the scope of such license.

Vision Benefit

The Plan covers routine refractions (eye exams), and eyeglass lenses, frames and contact lenses prescribed to correct vision, provided by a licensed ophthalmologist, licensed optometrist or a licensed or qualified dispensing optician.

Maximum amounts payable include the cost of tinting, photograying, hardening of eyeglass lenses, scratch resistant coating.

BENEFIT LIMITATIONS

General Limitations and Exclusions

No amount will be payable for:

- 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. For example, if Cigna determines that a provider is waiving or has waived, discounted, reduced, or forgiven any portion of its charges and/or any portion of deductible, copay, coinsurance amount(s) you are required to pay for a Covered Expense without Cigna's express consent, then Cigna in its role as benefits administrator shall have the sole discretion to: (i) deny the payment of benefits in connection with the Covered Expense; or (ii) reduce the benefits in proportion to the amount of the deductible, copay or coinsurance amount(s) waived, discounted, forgiven or reduced; regardless of whether the provider represents that you remain responsible for any amounts that the Plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost-sharing payment(s) prior to the payment of any benefits under the Plan. This exclusion includes, but is not limited to, charges of a provider who has agreed to charge you, or has charged you, based upon what you would be required to pay out-of-pocket for treatment provided by another that provider or some other benefit level not otherwise applicable to the treatment received.
- charges arising out of, or relating to, any violation of a healthcare-related state or federal law, or which themselves are a violation of a healthcare-related state or federal law.
- treatment of an Illness or Injury which is due to war, declared or undeclared, riot or insurrection.
- services, drugs and supplies that are not Medically Necessary.
- charges for or in connection with experimental or non-conventional procedures or treatment methods not approved by the American Optometric Association or the appropriate vision specialty society.
- care for health conditions required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if the Member is legally entitled to such treatment and facilities are reasonably available.
- charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Illness.
- expenses for care provided through or by a public program, to the extent that a Member is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- to the extent of the exclusions imposed by any certification requirement (such as Medical Management requirements) shown in this Plan.
- expenses incurred outside the United States other than expenses for medically necessary urgent or emergent care while temporarily traveling abroad.
- charges made by any covered provider who is a member of your family or your Dependent's family.
- for or in connection with an Injury or Illness arising out of, or in the course of, any employment for wage or profit.
- charges made by a Doctor or other health care provider for broken appointments, phone calls, email or internet evaluations unless otherwise specified as covered under the Plan.
- unless otherwise covered in this Plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Doctor and listed as covered in this Plan.
- health care expenses for the infant child of a Dependent, unless the infant child is otherwise eligible under this Plan.

BENEFIT LIMITATIONS - Continued

Medical Benefit Limitations and Exclusions

No amount will be payable for:

- any amount that is more than the Maximum Reimbursable Charge.
- 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 inter-current 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 gastrostomy; oral hygiene, skin and nail care, toilet use, routine enemas; nasal oxygen applications, dressing changes, maintenance of in-dwelling bladder catheters, general maintenance of colostomy, ileostomy, gastrostomy, tracheostomy and casts.
- any unproven or investigational services and supplies, including all related services and supplies. Unproven or investigational services and supplies are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, treatments, procedures, drugs and biologics or devices that are determined by Cigna to be:
 - not demonstrated by the weight of existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the sickness, condition, Injury or Illness for which its use is proposed; or
 - not currently the subject of active investigation because prior investigations and/or studies failed to establish proven efficacy and/or safety; or
 - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use, except for accepted off-label use of drugs and biologics, consistent with Cigna policy; or
 - substantially confined to use in the research setting; or
 - the subject of review or approval by an Institutional Review Board for the proposed use, except as specifically provided in the “Clinical Trials” benefit provision; or
 - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the “Clinical Trials” benefit provision.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one’s appearance including Idiopathic Short Stature Syndrome. However, reconstructive surgery and therapy are covered as provided in the “Reconstructive Surgery” benefit.
- the following are excluded from coverage regardless of clinical indications (except as may be covered under the “Reconstructive Surgery” benefit): macromastia or gynecomastia surgeries; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- treatment of TMJ disorders and craniofacial muscle disorders.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental Injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as described in the “Obesity Treatment” benefit.

BENEFIT LIMITATIONS - Continued

- infertility testing (except as described in the Infertility Testing provision), infertility services, infertility drugs, surgical or medical treatment programs for infertility, including in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- reversal of male or female voluntary sterilization procedures.
- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasm, and premature ejaculation.
- non-medical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back to school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or intellectual disabilities.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" benefits.
- private Hospital rooms and/or private duty nursing except as provided in the "Home Health Services" benefit.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Illness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- aids, devices or other adaptive equipment that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- treatment by acupuncture, except as described in the "Alternative Care" benefit provision.
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Medical Management review opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.

BENEFIT LIMITATIONS - Continued

- enteral feedings, supplies and specially formulated medical foods that are prescribed and non prescribed, except as specifically provided in the “Enteral Nutrition” benefit.
- massage therapy.
- all non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this Plan.

Prescription Drug Benefit Limitations and Exclusions

No amount will be payable for:

- non-prescription or over-the-counter (OTC) drugs and supplies, unless specifically listed in the Plan as a covered benefit.
- a drug class in which at least one of the drugs is available over-the-counter (OTC) and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee.
- therapeutic devices and appliances, unless specifically listed in the Plan as a covered benefit.
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA, unless the drug is recognized for the treatment of the particular indication in the standard reference compendia (AHFS or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in peer-reviewed English language bio-medical journals.
- drugs, devices and supplies for cosmetic purposes.
- 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.
- anti-obesity drugs and formulas.

BENEFIT LIMITATIONS - Continued

Vision Benefit Limitations and Exclusions

No amount will be payable for:

- charges in excess of the usual and customary charge for the service or materials.
- safety glasses.
- radial keratotomy, lasik, laser and other refractive surgery.
- medical or surgical treatment of the eye.
- artificial eyes.
- eyeglass lenses and frames specifically made for sunglasses.

CLAIMS & LEGAL ACTION

■ How To File Claims

As used in this provision, any reference to “you” or “your” refers to the covered Member, and also refers to a representative or provider designated by you to act on your behalf.

A claim form can be requested from the Plan Administrator, through the website address or by calling Member Services at the phone number shown on your ID card. Complete and accurate claim information is necessary to avoid claim processing delays.

Timely Filing of Claims

Cigna will consider claims for coverage, other than Network coverage, under the Plan when proof of loss (a claim) is submitted within 180 days after expenses are incurred. If expenses are incurred on consecutive days, such as for a Hospital confinement, the limit will be counted from the last date expenses are incurred. If the claim is not submitted within the specified time period, it will not be considered valid and will be denied.

Medical Benefits

When using a network provider, you do not need to file a claim if you present your ID card. The network provider will file the claim. When using other providers, claims can be submitted by the provider if the provider is willing and able to file on your behalf. If the provider is not submitting on your behalf, you must send the completed claim form and itemized bills to the address shown on the claim form.

Vision Benefits

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

Prescription Drug Benefits

A prescription given to a pharmacist is not a claim for benefits under the Plan. A claim for Prescription Drugs and Related Supplies may be submitted if all or a portion of the cost of a Prescription drug or Related Supply is paid by you when the Prescription Drug or Related Supply is dispensed, and you want to request reimbursement for the amount paid. Benefits will be processed subject to Plan provisions.

■ Claim Determinations and Appeal Procedures

As used in this provision: (a) any reference to “you” or “your” refers to the covered Member, and also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted; and (b) “Physician/Doctor Reviewers” are licensed Physicians/Doctors depending on the care, service or treatment under review.

Medical Necessity Determinations

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

Certain services and benefits require prior authorization. You or your representative (typically your health care provider) must request prior authorization according to the procedures described in this provision, in the MEDICAL MANAGEMENT PROGRAM section of this Plan booklet, and in the health care provider’s network participation documents as applicable.

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

CLAIMS & LEGAL ACTION - Continued

Pre-Service Determinations

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

If the determination periods above would seriously jeopardize your life or health, 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 care; then Cigna will make the preservice determination on an expedited basis. Cigna's Physician/Doctor reviewer will defer to the determination of the treating Doctor regarding whether an expedited determination is necessary. Cigna will notify you or your representative of an expedited determination within 72 hours after receiving the request.

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

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

Concurrent Determinations

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

Post-Service Determinations

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

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that apply to the determination:

- information sufficient to identify the claim.
- the specific reason or reasons for the adverse determination.
- reference to the specific Plan provisions on which the determination is based.

CLAIMS & LEGAL ACTION - Continued

- a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary.
- a description of the Plan's review procedures and the applicable time limits, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal, if applicable.
- upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on Medical Necessity, experimental treatment or other similar exclusion or limit.
- information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeals process.
- in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

COMPLAINTS and APPEALS - Cigna has a process for addressing your concerns.

Start with Customer Service

If you have a concern regarding a person, a service, the quality of care, contractual benefits you may call Customer Service at the phone number shown on your ID card, explanation of benefits or claim form and explain your concern to a Customer Service representative. You may also express that concern in writing.

Customer Service will make every effort to resolve the matter on your initial contact. If more time is needed to review or investigate your concern, a response will be provided to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

Internal Appeals Procedure

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

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

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

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

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

If you are dissatisfied with the internal appeal, you may request that your appeal be referred to an independent review organization, as described in the External Review Procedure provision.

CLAIMS & LEGAL ACTION - Continued

External Review Procedure

If you are not fully satisfied with the decision of Cigna's internal appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization (IRO). The IRO is composed of persons who are not employed by Cigna or any of its affiliates. A decision to request an external review to an IRO will not affect the claimant's rights to any other benefits under the Plan. There is no charge for you to initiate an external review. Cigna and your benefit plan will abide by the decision of the IRO.

To request a review, you must notify Cigna's Appeals Coordinator within 4 months of receipt of Cigna's appeal review denial. Cigna will then forward the file to a randomly selected IRO. The IRO will render a decision within 45 days.

When requested, and if a delay would be detrimental to your medical condition, as determined by Cigna's Physician reviewer; or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility; the external review will be completed within 72 hours.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include:

- information sufficient to identify the claim.
- the specific reason or reasons for the adverse determination.
- reference to the specific Plan provisions on which the determination is based.
- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined below.
- a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to bring a civil action under ERISA Section 502(a), if applicable.
- upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that was based on Medical Necessity, experimental treatment or other similar exclusion or limit.
- information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeals process. A final notice of an adverse determination will include a discussion of the decision.

"Relevant Information" means any document, record or other information that:

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

Legal Action

If your Plan is governed by ERISA, you have the right to bring a civil action under ERISA Section 502(a) if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the appeal processes, as applicable. Legal action must be taken for network expenses within 3 years after a claim is submitted, and for expenses other than network expenses within 3 years after proof of claim is required under the Plan.

CLAIMS & LEGAL ACTION - Continued

■ What If a Member Has Other Coverage? (Coordination of Benefits)

This Coordination of Benefits provision applies if you or any one of your Dependents is covered under more than one Plan, and determines how benefits payable from all Plans will be coordinated. Claims should be filed with each Plan.

As used in this provision, references to “you” or “your” refers to each covered Member.

This provision does not apply to your Prescription Drug Benefits.

Under this provision, total payments from the Primary and Secondary Plans will never be more than the expenses actually incurred.

Definitions

For the purpose of this provision, the following terms have the meanings described here:

- “Plan” means any of the following that provides health care benefits, services or treatment:
 - this Plan.
 - group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including Closed Panel coverage.
 - coverage under Medicare and other governmental benefits as permitted by law, except Medicaid and Medicare supplement policies.
 - health care benefits coverage of group, group-type and individual automobile contracts.

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

- “Closed Panel Plan” means a Plan that provides health care benefits primarily in the form of services or supplies through a panel of employed or contracted providers, and that limits or excludes benefits provided outside of the panel, except in the case of emergency or if referred by a provider within the panel.
- “Primary Plan” means the Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.
- “Secondary Plan” means a Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.
- “Allowable Expense” means a necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

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

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- The difference between the cost of a private Hospital room and a semiprivate Hospital room, unless the patient’s stay in a private Hospital room is Medically Necessary, is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan’s fee arrangement is the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

CLAIMS & LEGAL ACTION - Continued

- “Claim Determination Period” means a calendar year, but does not include any part of a year during which you are not covered under this Plan or any date before this provision or any similar provision takes effect.
- “Reasonable Cash Value” means an amount which a duly licensed provider of health care services or supplies usually charges patients and which is within the range of fees usually charged for the same service or supply by other health care providers located within the immediate geographic area where the health care service or supply is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this provision will always be the Primary Plan.

If the Plan has a coordination of benefits rule consistent with this provision, the first of the following rules that applies to the situation is the one to use:

- The Plan that covers you as an enrollee or an employee is the Primary Plan and the Plan that covers you as a dependent is the Secondary Plan.
- If you are a dependent child whose parents are not divorced or legally separated, the Primary Plan is the Plan that covers the parent whose birthday falls first in the calendar year as an enrollee or employee.
- If you are the dependent of divorced or separated parents, benefits for the Dependent are determined in the following order:
 - first, if a court decree states that one parent is responsible for the child’s health care expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
 - then, the Plan of the parent with custody of the child;
 - then, the Plan of the spouse of the parent with custody of the child;
 - then, the Plan of the parent not having custody of the child; and
 - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee’s dependent) is the Primary Plan and the Plan that covers you as a laid-off or retired employee (or as that employee’s dependent) is the Secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph does not apply.
- The Plan that covers you under a right of continuation provided by federal or state law is the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee’s dependent) is the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph does not apply.
- If one of the Plans determines the order of benefits based on the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rule determines the order of benefits.

If none of the above rules determine the order of benefits, the Plan that has covered you for a longer period of time is the Primary Plan.

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

Effect on the Benefits of This Plan

The Coordination of Benefits provision is applied throughout each Claim Determination Period.

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

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

- the Allowable Expenses that were not reimbursed under the other Plan; or
- the amount this Plan would have paid if there were no other coverage.

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.

When the Coordination of Benefits 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.

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan and the benefit payments this Plan actually paid as the Secondary Plan, will be recorded as a benefit reserve for you.

As each claim is submitted, the following will be determined: this Plan's obligation to cover services and supplies under this Plan; whether a benefit reserve has been recorded for you; and whether there are any unpaid eligible Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, the benefit reserve recorded for you will be used to pay up to 100% of the total of all eligible Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

Recovery of Excess Benefits

If this Plan pays charges for benefits that should have been paid by the Primary Plan, or if this Plan pays charges in excess of those for which this Plan is obligated to pay, this Plan has the right to recover the actual payment made or the Reasonable Cash Value of any services.

This Plan may seek recovery from any person to, or for whom, or with respect to whom, such services or supplies were provided or such payments made by any insurance company, health care plan or other organization. If requested, you must execute and deliver to this Plan any such instruments and documents as determined necessary to secure the right of recovery.

Right to Receive and Release Information

Without consent or notice to you, information may be obtained from you, and information may be released to any other Plan with respect to you, in order to coordinate your benefits pursuant to this provision. You must provide any information requested in order to coordinate your benefits pursuant to this provision. This request may occur in connection with a submitted claim; if so you will be advised that the "other coverage" information, including an explanation of benefits paid under another Plan, is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim may be denied. If the requested information is subsequently received, the claim will be processed.

■ How Will Benefits Be Affected By Medicare? (Medicare Eligibles)

Under federal law, Medicare Secondary Payer (MSP) Rules, including those described below, do not apply to domestic partners and spouses who do not meet the definition of spouse under federal law and who are covered under a group health plan when Medicare coverage is due to age. For these individuals, Medicare is the Primary Plan and this Plan is the Secondary Plan. However, when Medicare coverage is due to disability, the Medicare Secondary Payer Rules apply.

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

When this Plan is secondary according to Medicare Secondary Payer (MSP) Rules, this Plan will assume the amount payable under:

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

This Plan will pay as Secondary Plan as permitted by the Social Security Act of 1965, as amended, for the following persons who are covered under this Plan:

CLAIMS & LEGAL ACTION - Continued

- A former Employee or the former Employee's Dependent if the person is eligible for Medicare and the person's coverage under this Plan is continued for any reason as provided in this Plan.
- An Employee or the Employee's Dependent if the person is eligible for Medicare due to disability, when the Employer has fewer than 100 employees according to MSP rules.
- An Employee or the Employee's Dependent if the person is eligible for Medicare due to age, when the Employer has fewer than 20 employees according to MSP rules.
- A covered person who is eligible for Medicare due to End Stage Renal Disease (ESRD) after that person is eligible for Medicare for 30 months.

■ Expenses For Which A Third Party May Be Responsible

This Plan does not cover:

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

■ Subrogation/Right of Reimbursement

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

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

■ Lien of the Plan

By accepting benefits under this Plan, a Participant:

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

CLAIMS & LEGAL ACTION - Continued

■ Additional Terms

No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the Plan. The Plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.

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

The Plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine" or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

No Participant hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine" or "Attorney's Fund Doctrine".

The Plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.

The Plan hereby disavows all equitable defenses in the pursuit of its right of recovery. The Plan's subrogation or recovery rights are neither affected nor diminished by equitable defenses.

In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the Plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs and other expenses. The Plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his/her reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.

Any reference to state law in any other provision of this Plan shall not be applicable to this provision, if the Plan is governed by ERISA. By acceptance of benefits under the Plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Plan, including but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

Participants must assist the Plan in pursuing any subrogation or recovery rights by providing requested information.

■ Payment of Benefits

As used in this provision, any reference to "you" or "your" refers to the covered Member, and also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

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

Plan payment may be made to you for the cost of any covered expenses even if benefits have been assigned. When benefits are paid to you or your Dependents, you or your Dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or is not able to give a valid receipt for any payment due, such payment may be made to the person's legal guardian. If no request for payment has been made by the person's legal guardian, Plan payment may be made to the person or institution appearing to have assumed custody and support of the person.

CLAIMS & LEGAL ACTION - Continued

When a Plan participant passes away, and notice is received that an executor of the estate has been established, benefit payments for unassigned claims should be made payable to the executor.

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

Recovery of Overpayment

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

■ Other Information a Member Needs to Know

Legal Actions

A Member may bring a legal action to recover under the Plan. For legal actions not related to the Plan's Appeals Procedure, 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.

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

Custodial Services

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

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

Dependent

See ELIGIBILITY.

Doctor/Physician

A person licensed to practice medicine or osteopathy. This also includes any other practitioner of the healing arts if the practitioner performs a service within the scope of his or her license and for which this Plan provides coverage.

Emergency Medical Condition

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

Emergency Services

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.

Employee

See ELIGIBILITY.

Employer

- Community Action Team, Inc.; 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.

Free-Standing Surgical Facility

An institution which meets all of the following requirements:

- has a medical staff of Doctors/Physicians, nurses and licensed anesthesiologists.
- maintains at least two operating rooms and one recovery room.
- maintains diagnostic laboratory and x-ray facilities.
- has equipment for emergency care.
- has a blood supply.
- maintains medical records.
- has agreements with Hospitals for immediate acceptance of patients who need inpatient Hospital confinement.

GLOSSARY - Continued

- is licensed in accordance with the laws of the appropriate legally authorized agency.

Hospice Facility

An institution or part of it which primarily provides care for Terminally Ill patients; is accredited by the National Hospice Organization; meets established Medical Management standards; and fulfills any licensed requirements of the state or locality in which it operates.

Hospital

An institution:

- licensed as a hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Doctors; and provides 24-hour service by registered graduate nurses; or
- which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO); or
- which specializes in treatment of mental health or substance use or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

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

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.

Maximum Reimbursable Charge

See WHAT'S COVERED? (Covered Expenses).

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 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; 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;

GLOSSARY - Continued

- 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.

Network Pharmacy

A retail Pharmacy with which Cigna has contracted to provide prescription services to Members, or a designated home delivery Pharmacy with which Cigna has contracted to provide home delivery prescription services to Members. A home delivery Pharmacy is a Pharmacy that provides prescription services through mail order.

Other Health Care Facility

An institution other than a Hospital or hospice facility. Examples include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities.

Patient Protection and Affordable Care Act of 2010

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).

Pharmacy

A retail Pharmacy or a home delivery Pharmacy.

Pharmacy & Therapeutics (P&T) Committee

A committee of Cigna network providers, Medical Directors and Pharmacy Directors which regularly reviews Prescription Drugs and Related Supplies for safety and efficacy. The P&T Committee evaluates Prescription Drugs and Related Supplies for potential addition to or deletion from the Prescription Drug List and may also set dosage and/or dispensing limits on Prescription Drugs and Related Supplies.

Plan

The medical, drug and vision benefits described in this booklet.

Prescription Drug

A drug which has been approved by the Food and Drug Administration for safety and efficacy; certain drugs approved under the Drug Efficacy Study Implementation review; or drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

Prescription Drug List

A listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

GLOSSARY - Continued

Prescription Order

The lawful authorization for a Prescription Drug or Related Supply by a Doctor who is duly licensed to make such authorization within the course of such Doctor's professional practice or each authorized refill thereof.

Related Supplies

Diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under PRESCRIPTION DRUG BENEFITS, and spacers for use with oral inhalers.

Service

See ELIGIBILITY.

Sickness

A physical illness.

Stabilize

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 individual from the facility.

Terminal Illness

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

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, prescription drug, and vision 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, Prescription Drug, and Vision Coverage

Under USERRA, you are eligible to elect continued medical, prescription drug, and vision 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, prescription drug, and vision 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

USERRA RIGHTS AND RESPONSIBILITIES - Continued

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.

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.

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 RIGHTS UNDER FEDERAL LAW - COBRA

COBRA continuation coverage is a temporary extension of coverage under the Plan, and was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Under this federal law, you and/or your covered Dependents (a covered Member) if a COBRA qualified beneficiary, must be given the opportunity to continue Plan coverage when there is a "qualifying event" that would result in loss of coverage under the Plan. The law permits continuation of the same Plan coverage under which the qualified beneficiary was covered on the day before the qualifying event, unless the qualified beneficiary moves out of the Plan's coverage area or the Plan is no longer available. If coverage options are available, a qualified beneficiary has the same options to change coverage as others who are covered under the Plan.

COBRA continuation coverage is available for you and your covered Dependents for up to 18 months from the date of the following qualifying events if the event would result in a loss of coverage under the Plan:

- your termination of employment for any reason, other than gross misconduct.
- your reduction in work hours.

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

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

CONTINUATION RIGHTS UNDER FEDERAL LAW - COBRA - Continued

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

The following individuals are not qualified beneficiaries for the purposes of COBRA continuation coverage: domestic partners, spouses who do not meet the definition of spouse under federal law, and children (such as stepchildren, grandchildren) who have not been legally adopted by you. Although these individuals do not have an independent right to elect COBRA continuation coverage, if you elect COBRA continuation coverage for yourself you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation coverage terminates. The provisions "Secondary Qualifying Events" and "Medicare Extension for Dependents" are not applicable to these individuals.

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage, or within the disability extension period. Under no circumstances with COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan.

Disability Extension

If, after electing COBRA continuation coverage due to your termination of employment or reduction in work hours, you or one of your Dependents is determined by the Social Security Administration (SSA) to be totally disabled under Title II or XVI of the SSA, you and all of your Dependents who have elected COBRA continuation may extend such continuation for an additional 11 months, for a maximum of 29 months from the initial qualifying event.

To qualify for the disability extension, both of the following requirements must be satisfied:

- SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
- a copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

If the SSA later determines that the individual is no longer disabled, you must notify the Plan Administrator within 30 days after the date the final determination is made by SSA. The 11-month disability extension will terminate, for all individuals covered under the extension, on the first day of the month that is more than 30 days after the date the SSA makes a final determination that the disabled individual is no longer disabled.

All causes for "Termination of COBRA Continuation Coverage" will also apply to the disability extension period.

Medicare Extension

When the qualifying event is your termination of employment or reduction in work hours, and you became covered under Medicare (Part A, Part B or both) within the 18 months before the qualifying event, the maximum COBRA continuation period for you is 18 months from the date of your termination of employment or reduction in work hours, and for your Dependents the maximum continuation period is 36 months from the date you became covered under Medicare.

CONTINUATION RIGHTS UNDER FEDERAL LAW - COBRA - Continued

Termination of COBRA Continuation Coverage

COBRA continuation coverage will terminate when any of the following occurs:

- the end of the COBRA continuation period of 18, 29 or 36 months; as applicable.
- failure to pay the required cost of coverage as described in “COBRA Premiums”.
- cancellation of the Employer’s Plan.
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under Medicare (Part A, Part B or both).
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage. In such a situation, COBRA continuation coverage will continue until the earlier of: the date the condition becomes covered under the other plan or the occurrence of any of the events listed above.
- after the date the qualified beneficiary qualifies as described in “Disability Extension”, the beneficiary is no longer disabled.
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving COBRA continuation (e.g., fraud).

Employer Notice Requirements

The Employer is required to provide the following notices:

- **Initial Notice** - An initial notice of COBRA continuation rights must be provided within 90 days after Plan coverage begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA election notice.
- **Election Notice** - COBRA continuation coverage will be offered to qualified beneficiaries only after the Employer’s representative or Plan Administrator has been timely notified that a qualifying event has occurred, and must be provided to you and/or your Dependents within the timeframe required by COBRA.

When the qualifying event is termination of employment, reduction of employment hours or the Employee’s death, a COBRA continuation election notice must be provided to you and/or your Dependents:

- if the Plan provides that the COBRA continuation coverage period starts upon the loss of coverage, within 44 days after loss of coverage under the Plan.
- if the Plan provides that the COBRA continuation coverage period starts upon the occurrence of a qualifying event, within 44 days after the qualifying event occurs.

Electing COBRA Continuation Coverage

The COBRA continuation election notice will list the individuals who are eligible for COBRA continuation coverage, and provide information about the applicable cost of coverage. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election in writing no later than the due date stated in the election notice. If written notice is mailed, it must be post-marked no later than the due date stated in the election notice. If you do not make proper notification by the due date stated in the election notice, you and your Dependents will lose the right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed election form before the due date.

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. COBRA continuation coverage may be elected for only one, several, or for all Dependents who are qualified beneficiaries. Parents may elect to continue coverage on behalf of their Dependent children. You or your spouse may elect COBRA continuation on behalf of all the qualified beneficiaries. You are not required to elect COBRA continuation coverage in order for your Dependents to elect COBRA continuation coverage.

CONTINUATION RIGHTS UNDER FEDERAL LAW - COBRA - Continued

Cost of COBRA Continuation Coverage

Each qualified beneficiary may be required to pay the entire cost of COBRA continuation coverage. The amount may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member. The cost during the 11-month disability extension may not exceed 150% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated active Employee or family member.

For example: If the Employee alone elects COBRA continuation, the Employee or family member will be charged 102% (or 150%, if applicable) of the active Employee cost of coverage. If the spouse or one Dependent child alone elects COBRA continuation coverage, the individual will be charged 102% (or 150%, if applicable) of the active Employee cost of coverage. If more than one qualified beneficiary elects COBRA continuation coverage, they will be charged 102% (or 150%, if applicable) of the applicable family cost of coverage.

The first COBRA continuation coverage payment must be made no later than 45 calendar days after the date of your election (if mailed, this is the date the election notice is postmarked). 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 first payment is not made within the 45-day period, all COBRA continuation rights under the Plan will be lost. Claims incurred during the period covered by the initial payment period will not be processed until the payment is made.

After the first payment is made, the qualified beneficiary is required to pay for each subsequent period of coverage. If payment is made on or before its due date, coverage under the Plan will continue for that coverage period without any break.

A grace period of 30 days after the first day of the coverage period will be given to make each periodic payment. Coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if payment is received after the due date, coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If required payment is received before the end of the grace period, coverage will be reinstated back to the beginning of the coverage period. This means that any claim(s) submitted while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated. If payment is not made before the end of the grace period for that coverage period, all rights to COBRA continuation under the Plan will be lost.

You Must Give Notice of Certain Qualifying Events

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

- your divorce or legal separation.
- your child no longer qualifies as a Dependent under the Plan.
- the occurrence of a secondary qualifying event as described in “Secondary Qualifying Events” (this notice must be received prior to the end of the initial 18-month or 29-month COBRA period). See “Disability Extension” for additional notice requirements.

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

CONTINUATION RIGHTS UNDER FEDERAL LAW - COBRA - Continued

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. Coverage is subject to the Plan's notice and/or application process for active Employees adding a new Dependent. Only your newborn or adopted Dependent child is a qualified beneficiary for the purpose of continuing COBRA coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. Any other Dependent added while your coverage is being continued is not a qualified beneficiary for the purpose of continuing COBRA coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary 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.

EFFECT OF SECTION 125 TAX REGULATIONS ON THIS PLAN

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

Coverage Elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if your Employer agrees and you enroll for or change coverage within 31 days of the following:

- the date you meet the Special Enrollment criteria described in "Special Enrollment Rights"; or
- the date you meet criteria described in the following provisions.

Change of Status

A change in status is defined as:

- a change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation; or
- a change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent; or
- a change in employment status of Employee, spouse or Dependent child due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite; or
- changes in employment status of Employee, spouse or Dependent child resulting in eligibility or ineligibility for coverage; or
- a change in residence of Employee, spouse or Dependent child to a location outside of the Employer's network service area; or
- changes which cause a Dependent child to become eligible or ineligible for coverage.
- a reduction the Employee's work hours to below 30 hours per week, even if it does not result in the employee losing eligibility for the Employer's Plan coverage **and** the Employee, spouse or Dependent child intend to enroll in another plan that provides minimum essential coverage (MEC) **and** the new MEC coverage is effective no later than the 1st day of the 2nd month following the month that includes the date the original coverage is revoked.
- enrollment in a marketplace qualified health plan (QHP) when the Employee is eligible for the marketplace's special enrollment period or the Employee wants to enroll in the QHP during the marketplace's open enrollment period **and** disenrollment from the Employer's Plan corresponds to the intended enrollment of the Employee, spouse or Dependent child in the QHP **and** the QHP coverage is effective beginning no later than the day immediately following the last day of the Employer's Plan coverage.

Court Order

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

EFFECT OF SECTION 125 TAX REGULATIONS ON THIS PLAN - Continued

Medicare or Medicaid Eligibility/Entitlement

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

Change in Cost of Coverage

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

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

Changes in Coverage of a Spouse or Dependent Child Under Another Employer's Plan

You may make a coverage election change if the plan of your spouse or Dependent child:

- incurs a change such as adding or deleting a benefit option; or
- allows election changes due to Special Enrollment, Change in Status, Court Order, Medicare or Medicaid Eligibility/Entitlement; or
- this Plan and the other plan have different periods of coverage or open enrollment periods.

ERISA GENERAL INFORMATION

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

The name of the Plan is: Community Action Team, Inc.

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

Community Action Team, Inc.

124 N. 18th St.

St. Helens, OR 97051

503-397-3511

The Employer Identification Number (EIN) is: 93-0554156

The Plan Number assigned by the Employer is: 501

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

The name, address and ZIP code of the designated agent for service of legal process is: Employer named above

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

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 health benefits described in this booklet are self-funded by the Employer. The Employer is fully responsible for the self-funded benefits. Cigna provides contract administration by processing claims and provides other services to the Employer related to the self-funded benefits. Cigna does not insure nor guarantee the self-funded benefits.

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

ERISA GENERAL INFORMATION - Continued

The preceding pages set forth the Plan's eligibility requirements, termination provisions and a description of the circumstances that may result in disqualification, ineligibility, or denial or loss of benefits.

Procedures to be followed in presenting claims for benefits and what to do when claims are denied in whole or in part are described in CLAIMS & LEGAL ACTION.

Plan Type

The Plan is a health care benefit plan.

Plan Trustee(s)

A list of the Trustee(s) of the Plan, if any, including name, title and address, is available upon request to the Plan Administrator.

Collective Bargaining Agreement(s)

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and whether a particular employer or employee organization is a sponsor. A copy of the agreement, if any, is available for examination upon written request to the Plan Administrator.

STATEMENT OF ERISA RIGHTS

As a plan participant 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 the following:

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 plan 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.

Continue Group Health Plan Coverage

If a group health plan is subject to COBRA, you may be eligible to continue health care coverage for yourself or your 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 the documents governing the plan or the rules governing COBRA continuation coverage rights.

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 the 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 the 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.

STATEMENT OF ERISA RIGHTS - Continued

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 documents governing the plan or the latest annual report from the plan and do not receive them within 30 days, you may file suit in 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 the 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.

SECTION II - LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

INTRODUCTION

■ Notices

Coverage for Residents of Certain Other States

If you are a resident of a state other than Oregon and the life insurance and accidental death & dismemberment insurance laws of the state in which you reside require the Plan to provide coverage in excess of what is described in this booklet, the Plan will be administered to comply with such law(s).

■ About This Plan

Community Action Team, Inc. (the Employer) has established an Employee Welfare Benefit Plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). As of July 1, 2016, the Life Insurance and Accidental Death & Dismemberment (AD&D) benefits described in this booklet form a part of the Employee Welfare Benefit Plan and are referred to collectively in this booklet section as the Plan. The Employee Welfare Benefit Plan will be maintained pursuant to the Life Insurance and AD&D benefit terms described in this booklet. The Plan may be amended from time to time.

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

If on the date shown above you are not Actively at Work, see “Will My Coverage Change?” in WHEN COVERAGE BEGINS & ENDS for details as to when a change in coverage will become effective.

The Life Insurance and AD&D benefits described in this booklet are fully insured by Life Insurance Company of North America (LINA) (referred to as LINA or Company in this booklet), 1601 Chestnut Street, Philadelphia, Pennsylvania 19192.

This booklet becomes your certificate of insurance for Life Insurance and AD&D benefits only if you complete the appropriate application forms and are approved for coverage by LINA.

Defined terms are capitalized and have specific meaning with respect to Life Insurance and AD&D benefits, see GLOSSARY.

Discretionary Authority

Life Insurance Company of North America (LINA), as the claims administrator for Life Insurance and AD&D benefits, has the discretionary authority, subject to review by state insurance regulatory agencies and courts of competent jurisdiction, to determine benefit eligibility, construe the terms of the Plan and resolve any disputes which may arise with regard to the rights of any person under the terms of the Plan, including but not limited to eligibility for participation and claims for benefits.

Plan Modification, Amendment and Termination

The Employer reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other Plan term or condition, and to terminate the whole Plan or any part of it. Contact the Employer for the procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated. No consent of any Plan Member is required to terminate, modify, amend or change the Plan.

LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS SCHEDULE

This Schedule provides a general description of Life Insurance and Accidental Death & Dismemberment 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.

Group Policy No. 00181103GL

LIFE INSURANCE BENEFITS

All Employees \$20,000.00

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

The amount of AD&D Benefit that an Employee may receive is based on a Principal Sum. The amount of the Principal Sum is equal to the amount of Standard Life Insurance.

AD&D Benefit for the Loss of:	Amount Payable
Life	Principal Sum
Both hands or both feet or sight of both eyes	Principal Sum
One hand and one foot	Principal Sum
One hand or one foot and sight of one eye	Principal Sum
One hand or one foot	1/2 of Principal Sum
Sight of one eye	1/2 of Principal Sum

Loss of hands and feet means permanent dismemberment by severance through or above the wrist or ankle joints. Loss of sight means total and permanent loss of sight beyond remedy by surgical or other means.

REDUCTIONS IN LIFE INSURANCE AND AD&D BENEFIT

The amount of an Employee's Life Insurance and AD&D Benefit in effect at the time the Employee reaches age 65 will reduce by 35% at age 65, 55% at age 70, 70% at age 75, 80% at age 80 and 85% at age 85.

ELIGIBILITY

■ Eligible Employees

For the purpose of Life Insurance and Accidental Death & Dismemberment 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 20.0 hours per week.

WHEN COVERAGE BEGINS & ENDS

■ When Will Coverage Begin?

The definition of Employee 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; and
- Be Actively at Work on the eligibility date.

■ 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.

Late applicants must provide the Company with Proof of Good Health at their own expense. Coverage for a late applicant will begin on the date the Company approves Proof of Good Health.

■ 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.

If you are an active Employee and you are not Actively at Work when either of these changes occurs, the change in your coverage will not take place until you return to work with the Employer for one full day.

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 the Employer fails to make.

■ Can I Continue or Convert 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 Life Insurance during an Illness, Approved Leave of Absence or Temporary Layoff

If your Service ends due to Illness, Life Insurance will continue for 12 months after your Service ends.

If you are continuously covered under this provision and this group life policy terminates before you are eligible to qualify for coverage under the provision "What If I Become Disabled? (Waiver of Premium)", you must convert to an individual life insurance policy within 31 days in order to continue your life insurance.

If your Service ends due to approved leave of absence or temporary layoff, Life Insurance will continue for 31 days after the date your Service terminates.

Your coverage will end sooner than stated above if you and/or your Employer fails to pay for this continuation coverage.

There is no continuation for AD&D benefits.

WHEN COVERAGE BEGINS & ENDS - Continued

Continuation of Coverage under Federal Laws and Regulations

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

Conversion of Life Insurance Benefits

If all or part of your group term life insurance ends, you may apply for an individual life insurance policy.

Proof of Good Health is not required. You must apply for the life conversion coverage within 31 days after your life insurance coverage ends.

The policy will be one of LINA's standard conversion policies and will not contain a disability benefit or an accidental death benefit. The amount of coverage chosen can never be more than your current amount of insurance. The amount of the premium will depend on your age and class of risk.

You are allowed 31 days to apply for the individual policy. If you die within this period, your beneficiary will receive a death benefit. The amount of this benefit will be the maximum amount of group term life insurance which you would have been eligible to convert under this provision.

However, if the amount of your insurance had been reduced during this 31-day period because of age or retirement, the death benefit will be the amount of your group term life insurance before the reduction. This death benefit is payable even if you had not applied for an individual policy.

Employee Conversion of Life Insurance Benefits

If the group policy is still in force, you may convert all or part of your insurance to an individual policy if your coverage ends. If your coverage reduces due to age or retirement you may convert up to the amount of the reduction.

If the group policy is terminated or amended you may convert your life insurance if all or part of your coverage ends. However:

- You must have been insured under the group policy for at least five consecutive years; and
- The amount of the individual policy will be the lesser of \$10,000.00 and the current amount of your group term life insurance.

If your insurance is being continued under the disability benefit, you may convert your coverage if your coverage ends or reduces due to age or retirement. You may convert this coverage even if the group policy is not in force.

Conversion of AD&D Benefits

Conversion coverage is not available for AD&D benefits.

■ 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 months after the date your coverage ended.

On the date you return to Service, coverage will be on the same basis as that provided for any other active Employee 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.

LIFE INSURANCE BENEFITS

■ Standard Life Insurance

If you die from any cause while covered under the life insurance Plan, your amount of standard life insurance will be paid to your beneficiary. The amount is shown in the LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS SCHEDULE.

■ How Do I Name a Beneficiary?

A beneficiary is the person who will receive payment of the life insurance amount if you die. You should name a beneficiary when you first apply for insurance. Unless legally restricted, you can change the beneficiary at any time by giving written notice. The beneficiary's consent is not required unless the designation of the beneficiary is irrevocable.

Naming or changing a beneficiary must be in writing, signed by you and filed with your Employer.

If a named beneficiary dies before you, the amount of the life insurance that beneficiary would have received will be paid to any remaining named beneficiaries who survive you, unless you have specified otherwise on your application or state law does not allow this.

When there are two or more named beneficiaries the life insurance will be divided in equal shares, unless you have specified otherwise.

Subject to state law, if no named beneficiary survives you or if you have not named a beneficiary, the amount of insurance will be paid to your surviving spouse; if none, then to your surviving child or children; if none, then to your surviving parent or parents; if none, then to your surviving brothers or sisters; if none, then to your estate.

■ How Will Benefits Be Paid?

Proof of death must be sent to LINA. LINA will pay the amount of insurance (the death benefit) to the beneficiary.

- If any person has incurred expenses related to your last illness or death, LINA can deduct up to \$500.00 from the death benefit to pay the person who incurred these expenses.
- The life insurance will be paid to the beneficiary. Prior to your death, you may elect to have your life insurance paid to your beneficiary in any manner to which LINA agrees.
- If you do not elect an optional payment method prior to your death, then after your death the beneficiary may elect to have the life insurance paid to him or her in any manner to which LINA agrees.

Payments will not be made more than once a year unless each payment is at least \$25.00.

■ What If I Become Disabled? (Waiver of Premium)

After you have been Totally Disabled for 9 consecutive months, insurance for yourself may be continued without further premium payment. To qualify for this benefit:

- You must become Totally Disabled while insured under this life insurance Plan;
- Your Total Disability must continue without interruption for at least 9 months;
- You must be under age 60 when you become Totally Disabled;
- You must send proof of your Total Disability to LINA within 12 months of the start of the disability.

If you were continuously covered under the provision "Continuation of Life Insurance During an Illness, Approved Leave of Absence or Temporary Layoff" when you qualified for this disability waiver of premium benefit, you will be notified of the date when you will no longer be required to pay life insurance premium.

LIFE INSURANCE BENEFITS - Continued

If you have converted to an individual policy because this group life policy terminated or the continuation benefit ended during your qualifying period, you must surrender it. See the provision "Conversion of Life Insurance Benefits" in WHEN COVERAGE BEGINS & ENDS. All premiums paid for the individual policy after you have been Totally Disabled for 9 months will be returned. If you die during this 9 month period, the amount of insurance will be paid under either this life insurance Plan or the individual policy but *not* under both.

If you qualify for this disability waiver of premium benefit, you must send proof of the continuance of your Total Disability to LINA when requested.

The amount of life insurance continued will be the amount in effect under this Plan on the date you became disabled. However, the amount of insurance may reduce or terminate due to age or retirement according to the provisions of the Plan that were in effect on the date you became Totally Disabled.

This life insurance Plan does not have to be in force at the time of death for life insurance to be paid.

Your disability waiver of premium benefit will terminate:

- On the date you recover from your Total Disability; or
- If you do not send LINA proof of the continuance of your Total Disability when requested.

■ Is the Amount of My Insurance Reduced As I Grow Older?

Your amount of standard life insurance will be reduced according to the LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS SCHEDULE - REDUCTIONS IN LIFE INSURANCE AND AD&D BENEFIT.

■ Life Insurance Benefits If Terminally Ill

Any Accelerated Benefit that you receive may be treated as taxable income and may affect your eligibility for Medicaid or other government benefits or entitlements. You should consult your personal tax and/or legal advisor before you apply for an Accelerated Benefit.

If you are terminally ill, you may apply to receive a portion of your life insurance as an Accelerated Benefit. In order to do this, you must be covered under this Plan and you must give LINA satisfactory proof of having a Qualifying Medical Condition.

Qualifying Medical Condition means you are terminally ill, with a life expectancy of 6 to 24 months. In considering a request for an Accelerated Benefit, LINA at its expense, may require that you be examined by a Doctor of its choice.

To apply for an Accelerated Benefit you must:

- contact your Employer for the appropriate application form; and
- send your application to LINA along with a statement from your Doctor certifying the Qualifying Medical Condition.

For purposes of this benefit, the Doctor cannot be:

- yourself; or
- a person who is part of your immediate family (your parent, spouse, sibling or child); or
- a person who lives with you.

The request for an Accelerated Benefit must be made by the terminally ill insured person. However, if he or she is legally incapacitated or a minor child, the request must be made by a person with legal authority to act on the insured person's behalf.

You may request an Accelerated Benefit of up to 50% of the amount of your life insurance to a maximum of \$100,000.00. The minimum Accelerated Benefit is \$1,000.00.

The amount of the Accelerated Benefit available to you will be based on the amount of life insurance coverage provided to you by LINA under this Plan when you request the Accelerated Benefit.

LIFE INSURANCE BENEFITS - Continued

For any life insurance scheduled to be reduced within 36 months of the date of application for the Accelerated Benefit, the amount of the Accelerated Benefit will be based on the reduced amount.

The Accelerated Benefit will be paid in a lump sum and is available only one time while covered by LINA. If you recover from your Qualifying Medical Condition after receiving an Accelerated Benefit, LINA will not ask you for a refund of the Accelerated Benefit. However, your amount of life insurance will be reduced as described below.

After payment of the Accelerated Benefit, the amount of your life insurance coverage under this Plan will be reduced by the amount of the Accelerated Benefit. If the Accelerated Benefit amount is equal to or exceeds the amount of life insurance in force at the time of your death, no additional amounts of life insurance will be payable upon your death.

Anyone approved for an Accelerated Benefit may also be approved for disability waiver of premium. (See “What If I Become Disabled? (Waiver of Premium)”) Anyone already on disability waiver of premium when approved for an Accelerated Benefit, will continue on premium waiver.

No Accelerated Benefit will be paid if:

- All or part of your insurance must be paid to your children or your spouse or former spouse as part of a court approved divorce decree, separate maintenance agreement, or property settlement agreement.
- You are married and live in a community property state, unless you provide us with a signed statement from your spouse consenting to payment of the Accelerated Benefit.
- You have made an assignment of all or part of your life insurance, unless you provide LINA with a signed statement from your assignee consenting to payment of the Accelerated Benefit.
- You have filed for bankruptcy, unless you provide LINA with written approval from the bankruptcy court for payment of the Accelerated Benefit.
- You have previously received an Accelerated Benefit while covered under this Plan.

■ Other Information About Life Insurance

Absolute Assignment

You can transfer all your rights of ownership in your life insurance. This is known as absolute assignment. LINA is not responsible for the validity or effect of any assignment.

To assign your life insurance, notify your Employer, who will contact LINA for an assignment form. LINA will not recognize an assignment until the original assignment form has been noted at its Executive Offices.

Collateral Assignment

You cannot assign your insurance as collateral for a loan.

Proof of Age

Before benefits are paid, LINA may request proof of age. An adjustment may be made if:

- The Member’s age was misstated; and
- A different premium rate would have been charged for the person’s true age.

The difference between the premiums actually paid, and those that should have been paid, will be calculated. Any difference will be paid:

- By your Employer to LINA, if the age was understated; and
- By LINA to your Employer, if the age was overstated.

AD&D BENEFITS

Your AD&D benefits are payable if you are Injured while covered under this AD&D Plan and suffer a loss:

- Within 180 days of the Injury; and
- As a result of the Injury.

The amount of AD&D benefits that you may receive is based on a Principal Sum. The amount of your Principal Sum is equal to the amount of your Standard Life Insurance. (See "Standard Life Insurance" in LIFE INSURANCE BENEFITS.) LINA will pay all or part of the Principal Sum according to the AD&D Benefit shown in the LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS SUMMARY.

Only one of the amounts, the largest, will be paid for all Injuries that result from any one accident.

Loss of hands and feet means permanent dismemberment by severance through or above the wrist or ankle joints. Loss of sight means total and permanent loss of sight beyond remedy by surgical or other means.

If you die, the benefit will be paid to the beneficiary you name for life insurance. If you suffer any other loss, the benefit will be paid to you.

To claim AD&D benefits, written proof of loss must be sent to LINA as soon as reasonably possible. In any case, the proof required must be given no later than 15 months from the date of loss unless the claimant was legally incapable of doing so.

Your amount of AD&D Principal Sum is subject to the same age-based reductions as your life insurance.

AD&D BENEFIT LIMITATIONS

No amount will be payable for any loss caused by or in connection with:

- Intentionally self-inflicted Injury.
- War or any act relating to war.
- Any form of disease.
- Physical or mental infirmity.
- The medical or surgical treatment of a disease or infirmity.
- Suicide.
- Voluntary ingestion of known ptomaine.
- Bacterial infections, except bacterial infections resulting from Injury within 180 days of the accident.
- Commission of a felony.

CLAIMS & LEGAL ACTION

■ How To File Claims

A claim for benefits 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 and appeals.

All claim forms include instructions on how to complete and submit a claim. Claim forms may be requested from the Plan Administrator. 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.

Disability Waiver of Premium Benefits

To apply for disability waiver of premium benefits, the Plan Administrator, Member and the Member's Doctor must complete the Waiver of Premium Disability Claim Report. The Plan Administrator will submit the report to LINA for processing.

Claims for which determination of disability is involved will be processed within 30 days of the date received by LINA. 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
- 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 requested information is not provided within this time period, the Member should consider the claim to be denied.

However, this denial will be reconsidered if the information is subsequently received. If the necessary information is received within the 45-day period, a decision will be made within 30 days of the date the information is received, unless a decision still cannot be made. If this is the case, the above notification process will be repeated within the 30-day decision period.

The Member will again have 45 days from receipt of the notice to provide the requested information. If the information is received within the 45-day period, a decision will be made within 30 days of the date the information is received, unless the Member agrees to a longer period of time.

Life Insurance and Accidental Death & Dismemberment Benefits

For life insurance and accidental death claims, the beneficiary must request a claim form from the Plan Administrator, complete the form and return it with the certified proof of death to the Plan Administrator, who will submit to LINA for processing.

To apply for accelerated benefits, the Plan Administrator, Member and the Member's Doctor must complete the Accelerated Living Request form. The Plan Administrator will submit the form to LINA for processing.

For accidental dismemberment and loss of sight claims, the Member must request a claim form from the Plan Administrator, complete the form and return it with the accident or police report to the Plan Administrator, who will submit to LINA for processing.

Life insurance and accidental death & dismemberment claims will be processed or acknowledged within 30 days of the date received by LINA. If a claim decision cannot be made within the initial 30-day period because of special circumstances, LINA will notify the beneficiary and may request an extension of up to 90 days. Every 45 days after the initial notification, LINA will notify the Member or beneficiary in writing of the reason(s) for the extension, whether additional information is required and why this information is needed, and the date that LINA expects to make a claim decision. Claim decisions will not exceed the above time frames unless the beneficiary agrees to a longer period of time. Once the decision is made, LINA will either pay the allowable amount of insurance to the beneficiary(ies) or send written notice of benefits denied.

CLAIMS & LEGAL ACTION - Continued

■ If A Claim Is Denied

If benefits are denied, in whole or in part, LINA will send the Member or beneficiary a written or electronic notice within the established time periods described in "How To File Claims". The denial may be appealed 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 right to bring civil action by the Member or beneficiary under ERISA Section 502(a) after required Plan appeals have been exhausted.

If the denial involves a disability claim, 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 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 upon request and at no charge.

LINA will respond to any pertinent inquiry regarding status of a claim within 30 days. LINA will respond to an inquiry from the Department of Consumer and Business Services regarding status of a claim within 20 days. The denial may be appealed as described below.

Appeal of a Disability Waiver of Premium 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 by submitting a written request to the address shown on the adverse determination letter 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.

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 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.

The decision on the appeal will be made within 45 days of the date the appeal is received. If special circumstances require it, the time period may be extended up to an additional 45 days provided that within the initial 45-day review period the Member is informed of the special circumstances and the date a decision is expected. If the special circumstances include the need for additional information from the Member in order for a decision to be made, the necessary information will be requested. The Member will have 45 days from the date the request is received to provide the information. If the requested information is not provided within this time period, the appeal may be denied. If the additional information is received within the 45-day period, a decision on the appeal will be made within 45 days of the date the information is received, unless the Member agrees to a longer period of time.

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.

CLAIMS & LEGAL ACTION - Continued

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.

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).

Appeal of a Life Insurance or Accidental Death & Dismemberment Claim Denial

After receiving notice of a claim denial, in whole or in part, the Member, beneficiary, or Authorized Representative can appeal a claim denial by submitting a written request to the address shown on the adverse determination letter within 60 days of the date the denial notice is received.

An appeal includes the right to review and request copies of relevant documents, free of charge, and to submit issues and comments in writing.

The appeal request should include the following information:

- The name of the Member, Employee and the deceased; and
- The Member's group plan number and claim number, as shown on the adverse determination letter; and
- Any relevant information in support 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.

The decision on the appeal will be made within 60 days of the date the appeal is received. If special circumstances require it, the decision may be extended up to an additional 60 days provided the Member or beneficiary is informed of the special circumstances within the initial 60-day review period.

Two appeals are required before the Member or beneficiary 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.

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

The Member or beneficiary 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).

■ Other Information a Member Needs to Know

Incontestability

After the Plan has been in force for 2 years, its validity can only be contested due to non-payment of premiums. During the first 2 years a Member is covered under this Plan, only a written statement signed by the Member can be used to contest the validity of the coverage. After the Member's coverage has been in force for 2 years during the Member's lifetime, no statement by the Member can be used to contest the validity of the Member's coverage.

CLAIMS & LEGAL ACTION - Continued

Proof of Claim

Send written claim to LINA as soon as reasonably possible. A written claim must be submitted no later than 15 months from the date the claim is incurred, unless the claim can not be filed for legal reasons.

Benefit Payments

The death benefit will be paid to the beneficiary(ies).

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.

Conformity with Statutes

This Plan is amended to comply with the minimum requirements of the state in which this Plan is delivered.

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.

Autopsy

The Company may have an autopsy performed unless prohibited by law.

GLOSSARY

Actively at Work

Employment on an active and full-time basis at the Employer's usual place of business.

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
- State law requires such practitioner to be covered.

Eligibility Waiting Period

The eligibility waiting period is the period of employment or membership with the group that a prospective enrollee must complete before coverage begins.

Employee

See ELIGIBILITY.

Employer

- Community Action Team, Inc.; 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.

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, unless required by state law, 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 or pregnancy. 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.

Member

An Employee who has enrolled for coverage under the terms of this plan.

Plan

The Life Insurance and AD&D benefits described in this booklet.

Proof of Good Health

Written evidence that the person meets LINA's general underwriting standards. Such evidence includes but is not limited to medical evidence.

Service

See ELIGIBILITY.

GLOSSARY - Continued

Totally Disabled and Total Disability

Being under the care of a Doctor and prevented by Illness from working for pay or profit in any job for which you are or may become suited by reason of education, training or experience.

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.

“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 Life Insurance Benefits

If you are covered under the Employer’s Plan for life insurance and the Plan includes continuation of life insurance benefits for an approved leave of absence, then you are eligible for this continuation when you take a leave for Uniformed Service. Continuation of such coverage is subject to the same conditions, limitations and payment provisions that apply to continuation of life insurance benefits for any other approved leave of absence. No continuation is available for AD&D benefits.

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.

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. See the Plan Administrator with questions about FMLA leave.

EFFECT OF SECTION 125 TAX REGULATIONS ON THIS PLAN

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

Coverage Elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if your Employer agrees and you enroll for or change coverage within 31 days of the date you meet criteria described in the following provisions.

Change of Status

A change in status is defined as:

- a change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation; or
- a change in employment status of Employee due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite; or
- changes in employment status of Employee resulting in eligibility or ineligibility for coverage; or

EFFECT OF SECTION 125 TAX REGULATIONS ON THIS PLAN - Continued

Change in Cost of Coverage

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

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

ERISA REQUIRED INFORMATION LIFE INSURANCE AND AD&D BENEFITS

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

The name of the Plan is: Community Action Team, Inc.

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

Community Action Team, Inc.

124 N. 18th St.

St. Helens, OR 97051

503-397-3511

The Employer Identification Number (EIN) is: 93-0554156

The Plan Number assigned by the Employer is: 501

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

The name, address and ZIP code of the designated agent for service of legal process is: Employer named above

The cost of the Plan is paid by the Employer.

The life insurance and AD&D benefits described in this booklet are fully insured by Life Insurance Company of North America (LINA). LINA provides contract administration for Life Insurance and AD&D benefits.

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

The preceding pages set forth the Plan's eligibility requirements, termination provisions and a description of the circumstances that may result in disqualification, ineligibility, or denial or loss of benefits.

Procedures to be followed in presenting claims for benefits and what to do when claims are denied in whole or in part are described in CLAIMS & LEGAL ACTION.

Plan Type

The Plan is a Life Insurance and Accidental Death & Dismemberment benefit plan.

Plan Trustee(s)

A list of the Trustee(s) of the Plan, if any, including name, title and address, is available upon request to the Plan Administrator.

Collective Bargaining Agreement(s)

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and whether a particular employer or employee organization is a sponsor. A copy of the agreement, if any, is available for examination upon written request to the Plan Administrator.

STATEMENT OF ERISA RIGHTS

As a plan participant 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 the following:

STATEMENT OF ERISA RIGHTS - Continued

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 plan 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.

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 the 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 documents governing the plan or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in 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.