Vitrue, Inc.
Open Access: In Network
Base Medical Plan
Performance Rx (3 Tier)

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SECTION I - MEDICAL AND PRESCRIPTION DRUG BENEFITS

PATIENT PROTECTION AND AFFORDABLE CARE ACT

■ PATIENT PROTECTION AND AFFORDABLE CARE ACT ENDORSEMENT

The Plan is amended as stated below.

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

Definitions

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

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

"Emergency Care" means, with respect to an Emergency Medical Condition:

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

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

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

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

Lifetime Benefit Maximums - Dollar Limits

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

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

Annual Dollar Limits

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

Rescissions

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

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

PATIENT PROTECTION AND AFFORDABLE CARE ACT - Continued

Extension of Health Dependent Coverage

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

Preventive Care Services

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

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

Notice of Adverse Determination

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

Right to Appeal

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

Except where life or health would be seriously jeopardized, you must first exhaust the internal appeal process set forth in your Plan before your request for an external independent review will be granted.

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

Emergency Care

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

PATIENT PROTECTION AND AFFORDABLE CARE ACT - Continued

Selection of a Primary Care Provider

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

Pre-Existing Conditions Limitation

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

INTRODUCTION

Notices

CIGNA Commitment to Quality

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

Women's Health and Cancer Rights Act

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

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

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

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

Under the federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

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

About This Plan

Vitrue, 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 January 1, 2012, the medical and drug benefits described in this booklet form a part of the Employee Welfare Benefit Plan and are referred to collectively in this booklet as the Plan. The Employee Welfare Benefit Plan will be maintained pursuant to the medical and drug benefit terms described in this booklet. The Plan may be amended from time to time.

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

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

INTRODUCTION - Continued

Discretionary Authority

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

For initial claim determination, the Plan Administrator has the discretionary authority to determine eligibility and to interpret the Plan. For claim appeals, the Plan Administrator has designated 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/Termination

The Employer may:

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

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

OPEN ACCESS PLUS MEDICAL BENEFITS SUMMARY

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

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

Copay Amount for Network Services

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

Chiropractic Services	$35.00
Outpatient Physical Therapy	$35.00
Outpatient Speech, Hearing and Occupational Therapy	$35.00
Other Office Visits	
- Primary Care	$25.00
- Specialist Care	$35.00

The "Other Office Visits" copay does not apply to office visits for outpatient mental health conditions and chemical dependency treatment and preventive care.

Copay Amount for Network Urgent Care Facility Visit (includes all services rendered as part of the visit)	$60.00
Copay Amount for 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

Plan Deductible

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

The Plan Deductible applies to all covered expenses except:

- expenses subject to a copay
- expenses for Network Preventive Care services (including outpatient x-rays and lab tests)

Individual Calendar Year Deductible	$500.00
Family Calendar Year Deductible	$1,500.00

Medical Management Program

Ineligible Expense Penalty per claim	$250.00

Out-of-Pocket Maximum

Plan Deductible and coinsurance amounts paid by you and your covered Dependents accumulate toward the Out-of-Pocket Maximum, except:

- expenses for services and supplies not covered under this Plan.
- expenses for services and supplies that are payable at 100%.
- medical expense copays.
- Medical Management Ineligible Expense Penalty.

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

OPEN ACCESS PLUS MEDICAL BENEFITS SUMMARY - Continued

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

Plan Deductible does not 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	$500.00
Family Calendar Year Out-of-Pocket Maximum	$1,500.00

Benefit Maximum(s)

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

Home Health Care	60 visits
Skilled Nursing Facility	60 days
Outpatient Occupational, Speech and Hearing Therapy	20 visits
Outpatient Physical Therapy	20 visits
Chiropractic Services	20 visits

Lifetime Benefit Maximum

Transplant Services - Approved Travel Expenses	$10,000.00

Maximum Benefit for all Covered Expenses

Lifetime benefit per Member	Unlimited

Coinsurance for all Covered Expenses

Acoinsurance 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.

Home Health Services	
- Network	100%
- Services outside the Network Area	80%
- Non-network	Not Covered
Skilled Nursing Facility	
- Network	100%
- Services outside the Network Area	80%
- Non-network	Not Covered
Outpatient Facility Services for outpatient surgery, including operating room, recovery room, procedures room, treatment room and observation room	
- Network	100%
- Services outside the Network Area	80%
- Non-network	Not Covered
Doctor/Physician charges for Outpatient Facility Services	
- Network	100%
- Services outside the Network Area	80%
- Non-network	Not Covered

OPEN ACCESS PLUS MEDICAL BENEFITS SUMMARY - Continued

Hospice Care	
- Network	100%
- Services outside the Network Area	80%
- Non-network	Not Covered
Preventive Care Services	
- Network	100%
- Services outside the Network Area	100%
- Non-network	Not Covered
Hospital Care (including Mental Health Conditions and Chemical Dependency inpatient treatment)	
- Network	100%
- Services outside the Network Area	80%
- Non-network	Not Covered
Doctor/Physician charges for Hospital care (including Mental Health Conditions and Chemical Dependency inpatient treatment) and inpatient surgery	
- Network	100%
- Services outside the Network Area	80%
- Non-network	Not Covered
Inpatient Hospital X-rays and Lab Tests in a	
- Network Hospital	100%
- Hospital outside the Network Area	80%
- Non-network Hospital	Not Covered
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	
- a Network Doctor's office	100%
- a Network independent lab facility	100%
- a Network outpatient facility	100%
- a Doctor's office outside the Network Area	80%
- an independent lab facility outside the Network Area	80%
- an outpatient facility outside the Network Area	80%
- a Non-network Doctor's office	Not Covered
- a Non-network independent lab facility	Not Covered
- a Non-network outpatient facility	Not Covered
Outpatient X-rays and Lab Tests	
- ordered and performed as part of Preventive Care in	
* a Network provider's office	100%
* a Network independent x-ray or lab facility	100%
* a Network outpatient facility	100%
* a provider's office outside the Network Area	100%
* an independent x-ray or lab facility outside the Network Area	100%
* an outpatient facility outside the Network Area	100%
* a Non-network provider's office	Not Covered
* a Non-network independent x-ray or lab facility	Not Covered

OPEN ACCESS PLUS MEDICAL BENEFITS SUMMARY - Continued

* a Non-network outpatient facility	Not Covered
- other outpatient x-rays and lab tests ordered as part of an Office Visit or outpatient care and performed in	
* a Network provider's office	100%
* a Network independent x-ray or lab facility	100%
* a Network outpatient facility	100%
* a provider's office outside the Network Area	80%
* an independent x-ray or lab facility outside the Network Area	80%
* an outpatient facility outside the Network Area	80%
* a Non-network provider's office	Not Covered
* a Non-network independent x-ray or lab facility	Not Covered
* a Non-network outpatient facility	Not Covered
Durable Medical Equipment	
- Network	100%
- Services outside the Network Area	80%
- Non-network	Not Covered
Office Visits	
- Network	100%
- Services outside the Network Area	80%
- Non-network	Not Covered
Office Services, other than surgery and x-ray and lab tests	
- Network	100%
- Services outside the Network Area	80%
- Non-network	Not Covered
Office Surgery	
- Network	100%
- Services outside the Network Area	80%
- Non-network	Not Covered
Outpatient Mental Health Conditions Treatment (including Office Visits)	
- Network	100%
- Services outside the Network Area	80%
- Non-network	Not Covered
Outpatient Chemical Dependency Treatment (including Office Visits)	
- Network	100%
- Services outside the Network Area	80%
- Non-network	Not Covered
Urgent Care Facility Visit (includes all services rendered as part of the visit)	
- Network	100%
- Services outside the Network Area	80%
- Non-network	Not Covered
Emergency Room Visit (includes all services rendered as part of the visit)	
- Network	100%
- Services outside the Network Area	100%

OPEN ACCESS PLUS MEDICAL BENEFITS SUMMARY - Continued

- Non-network	100%
Chiropractic Services	
- Network	100%
- Services outside the Network Area	80%
- Non-network	Not Covered
Outpatient Speech, Hearing and Occupational Therapy	
- Network	100%
- Services outside the Network Area	80%
- Non-network	Not Covered
Outpatient Physical Therapy	
- Network	100%
- Services outside the Network Area	80%
- Non-network	Not Covered
Ambulance Services	
- Network	100%
- Services outside the Network Area	100%
- Non-network	100%
Transplant Services	
- Approved Travel Expenses	100%
- Transplant Services	
* Designated Network facility	100%
* Other Network facilities	Not Covered
* Facilities outside the Network Area	Not Covered
* Non-network facilities	Not Covered
Other Covered Expenses	
- Network	100%
- Services outside the Network Area	80%
- Non-network	Not Covered

PRESCRIPTION DRUG BENEFITS SUMMARY

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

Covered expenses are subject to the Member cost share described here. If the cost of a drug is less than the Member's share, then the Member pays 100% of the cost of the drug. If a prescription drug is not covered, the Member is responsible for 100% of the cost of the drug. Aprescription drug that is not covered may be available at a discounted price when the Member shows his/her ID card at a network pharmacy.

Prescription drugs required as part of evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force are covered at 100% not subject to any copay, when the prescription is filled at a network pharmacy.

Retail Network Pharmacy - *maximum 30-day supply*

Tier 1 - Generic Drugs	Member pays $15.00 copay
Tier 2 - Preferred Brand Name Drugs	Member pays $40.00 copay
Tier 3 - Non-Preferred Brand Name Drugs	Member pays $70.00 copay

Non-Network Pharmacy - *maximum 30-day supply*

Member must pay the pharmacy 100% of the cost at the time of purchase and submit a claim for reimbursement. Reimbursement will be 50% of the network pharmacy cost less the network pharmacy applicable Member cost share amount.

90-Day Retail Network Pharmacy - *80 to 90-day supply*

Tier 1 - Generic Drugs	Member pays $45.00 copay
Tier 2 - Preferred Brand Name Drugs	Member pays $120.00 copay
Tier 3 - Non-Preferred Brand Name Drugs	Member pays $210.00 copay

Mail Order Pharmacy - *80 to 90-day supply*

Tier 1 - Generic Drugs	Member pays $30.00 copay
Tier 2 - Preferred Brand Name Drugs	Member pays $80.00 copay
Tier 3 - Non-Preferred Brand Name Drugs	Member pays $140.00 copay

Specialty Pharmacy - *for specialty drugs*

Certain covered drugs, commonly referred to as "high-cost" specialty drugs, are drugs that require special handling. Members may fill a specialty drug prescription one time at a retail 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. A30-day supply will require a Retail Network Pharmacy copay. A90-day supply will require a Mail Order Drug Program copay.

ELIGIBILITY

Eligible Employees

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

Service

"Service" means work with the Employer on an active, full-time and full pay basis for at least 40.00 hours per week.

Eligible Dependents

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 or, as defined below, your Domestic Partner.
- an unmarried child, as defined below.

The following applies if you and your spouse or domestic partner are eligible to be covered as Employees: Aperson who is eligible as an Employee may also be considered as an eligible Dependent, if the person meets the Plan's definition of Dependent. An eligible Dependent child may be considered as a Dependent of only one Employee.

The following applies if you are eligible to be covered as an Employee and as a Dependent child of another Employee: Aperson who is eligible as an Employee may also be considered as an eligible Dependent, if the person meets the Plan's definition of Dependent.

Domestic Partner

"Domestic Partner" means the person, regardless of gender, named in the Affidavit of Domestic Partnership that you have submitted to and has been approved by the Employer.

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.
- a child of your covered domestic partner.

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

Dependent Child Age Requirement

The child is under age 26.

Handicapped/Disabled Child

ELIGIBILITY - Continued

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

"Physical handicap/mental retardation" means permanent physical or mental impairment that is a result of either a congenital or acquired Illness or Injury leading to the individual being incapable of independent living.

"Permanent physical or mental impairment" means:

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

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

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

Medical Child Support Order

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

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

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

WHEN COVERAGE BEGINS & ENDS

When Will Coverage Begin?

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

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

Before coverage can start, you must:

- Submit an application within 30 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 30 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 30 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 30 days of the date you become eligible for coverage. Your Dependent is a late applicant if you elect not to cover a Dependent and then later want coverage for that Dependent.

Medical and Prescription Drug Benefits

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

Special Enrollment Rights

For medical and drug benefits, if you or your eligible Dependent experience a special enrollment event as described below, you or your eligible Dependent may be entitled to enroll in the Plan outside of a designated enrollment period and will not be considered a late applicant.

If you are already enrolled for coverage at the time of a special enrollment event, within 30 days of the special enrollment event, you may request enrollment in a different medical and drug benefit option, if any, offered by the Employer and for which you are currently eligible.

Aspecial enrollment event occurs if:

- You did not apply for coverage for yourself or your eligible Dependent within 30 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 COBRAcoverage; or
  - Loss of eligibility for the other plan's coverage due to legal separation, divorce, cessation of dependent status, death of a spouse, termination of employment or reduction in the number of hours of employment; or
  - Loss of eligibility for the other plan's coverage because you or your eligible Dependent no longer resides in the service area; or
  - Loss of eligibility for the other plan's coverage because you or your eligible Dependent incurs a claim that meets or exceeds the lifetime maximum for that plan; or
  - Termination of benefits for a class of individuals and you or your eligible Dependent is included in that class; or
  - Termination of the employer's contribution for the other plan's coverage.

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

- You did not apply for coverage for yourself or your eligible Dependent within 30 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 30 days of the date you were eligible to do so and you or your eligible Dependent later becomes eligible for employment assistance under a state Medicaid or CHIP plan that helps pay for the cost of this Plan's coverage. In this situation, you may request coverage for yourself and/or any affected eligible Dependent not already enrolled in this Plan. Coverage must be requested within 60 days of the date the Member is determined to be eligible for such assistance.
- You did not apply to cover your spouse or a Dependent child within 30 days of the date you became eligible to do so and later are required by a qualified court order to provide coverage under this Plan for that person.
- You did not apply to cover yourself or an eligible Dependent within 30 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 30 days of the date:

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

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

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

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

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

"Health benefits" mean medical and prescription drug benefits.

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

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

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

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

Special Benefits for Pre-Existing Conditions

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

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

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

Will My Coverage Change?

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

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

When Will My Coverage End?

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

- The date the Employer terminates the benefits described in this booklet.
- The 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.
- The due date of the first contribution toward Dependent coverage that you or the Employer fails to make.

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

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

Temporary Layoff or Leave of Absence

If your Service ends due to temporary layoff or leave of absence, your coverage will be continued until the date your Employer cancels your coverage. However, your coverage will not be continued for more than 60 days past the date your Service ends.

Injury or Illness

If your Service ends due to an Injury or Illness, your coverage will be continued while you remain continuously Totally Disabled as a result of the Injury or Illness. However, your coverage will not continue past the date your Employer cancels your coverage.

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.

WHEN COVERAGE BEGINS & ENDS - Continued

Can Coverage Be Reinstated?

If your coverage ended because of termination of your Service, you may be eligible for reinstatement of coverage if you return to Service within 3 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?

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

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

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

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

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

Special Services

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

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

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

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

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

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

Medical Management Program

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

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

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

Network providers are responsible for contacting the 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. The Member must make sure that treatment is approved by the Medical Management Program. Without pretreatment authorization, an ineligible expense penalty (see MEDICAL SUMMARY) will be applied to the claim.

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

- Air ambulance, when used for non-Emergency Medical Conditions.
- Durable medical equipment charges over $500.
- Genetic testing.
- Home health care (including IV therapy).
- Hospital admissions, including partial hospitalization programs for mental health treatment.
- Outpatient 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 evaluations.

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

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

- Urgent Care Requests

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

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

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

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

- Non-urgent Care Requests

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

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

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

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

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

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

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

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

The adverse determination notice will also specify:

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

Appeal of Medical Management Decision

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

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

- **Level I Appeal**

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

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

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

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

- **Level II Appeal**

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

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

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

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

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

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

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

- that an explanation of the scientific or clinical judgment for a decision based on medical necessity, experimental treatment or a similar limitation is available to the Member upon request and at no charge.

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

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

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)

OPEN ACCESS PLUS MEDICAL BENEFITS SUMMARY 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. All providers, including facilities, must be licensed in accordance with the laws of the appropriate legally authorized agency, and acting within the scope of such license. Expenses are covered only if incurred while the Member is covered for these medical benefits.

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. For covered expenses other than Emergency Room Care and ambulance services, 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 percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by CIGNA

The percentile used to determine the Maximum Reimbursable Charge can be obtained by contacting Member Services.

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.

Emergency Room Visit

Emergency Room

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

Inpatient Hospital Care immediately following an Emergency Room Visit

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

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. After care is provided for an Emergency Medical Condition, Medical Management must be contacted within 48 hours.

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 Services Outside the Network Area 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 non-network Hospital charges will not be covered 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 non-network Doctor charges will not be covered.
- 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 non-network Doctor charges will not be covered.

Note: The Member's Authorized 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.

Hospital Care

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

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

Skilled Nursing Facility

The Plan does not cover care provided by a non-network skilled nursing facility. The Plan covers semi-private care, including room and board, in a licensed network 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.

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

Office Visits and Office Services

The Plan covers Doctor office visits and services provided during the visit. The following are considered separate from the office visit:

- Surgery performed in the office.
- X-rays and lab tests performed in the office.
- Advanced radiology performed in the office, such as MRI, MRA, PET, CT-Scan and nuclear medicine.
- 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 does not cover Preventive Care obtained from or prescribed by a non-network provider. The Plan covers the following preventive care services:

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

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

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

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

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

Family Planning

The Plan covers:

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

Infertility Testing

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

Treatment of Mental Health Conditions and Chemical Dependency

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

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

Chiropractic Services

The Plan does not cover non-network chiropractic services. The Plan covers network chiropractic service expenses for services related to spinal adjustment.

Home Health Services

The Plan covers home health services provided by network providers 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 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 nonskilled 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 nonskilled care and/or custodial services needs.

Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals 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 SUMMARY. Outpatient occupational, speech and hearing therapy provided in the home is subject to the Home Health Services benefit limitations described in the MEDICAL BENEFITS SUMMARY.

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 does not cover non-network hospice care. The Plan covers network hospice care if prescribed by a Doctor and the Member's life expectancy is six months or less.

Durable Medical Equipment

The Plan does not cover durable medical equipment obtained from or prescribed by a non-network provider. The Plan covers durable medical equipment obtained from or prescribed by a network provider, 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 does not cover physical therapy rendered by a non-network provider. The Plan covers prescribed physical therapy rehabilitation that is performed by an appropriate networkhealthcare 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.

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

Outpatient Occupational, Speech and Hearing Therapy

The Plan does not cover occupational, speech and hearing therapy rendered by a non-network provider. The Plan covers prescribed occupational, speech and hearing therapy rehabilitation that is performed by an appropriate network healthcare 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.

Cardiac Rehabilitation

The Plan covers Phase II cardiac rehabilitation provided on an outpatient basis following diagnosis if 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 transplant services that are approved by Medical Management. Medical Management will direct the patient to the appropriate designated facility for the patients specific type of transplant. Transplant services must be received at a designated network facility to be covered. Contact Member Services at the phone number or website address shown on the Member's ID card for more information.

Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and procurement required to perform any of the following human to human transplants: cornea, heart, lung, heart/lung, kidney, pancreas, kidney/pancreas, small bowel, liver, small bowel/liver, allogeneic bone marrow/stem cell or autologous bone marrow/stem cell.

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, 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 services coverage does not include outpatient prescription drug charges related to transplants, which may be payable under the prescription drug benefit. If covered under the prescription drug benefit, these will be subject to the provisions of the prescription drug benefit.

Transplant travel benefit - Charges for reasonable travel expenses incurred in connection with certain preapproved transplants, other than cornea transplants, may be covered under the Plan subject to conditions and limitations. 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:

- 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 does not cover clinical trials conducted by a provider that is not a network provider. The Plan covers approved charges made for routine patient services associated with cancer clinical trials approved and sponsored by the federal government. All of the following criteria must be met:

- the cancer clinical trial is listed on the NIH web site www.clinicaltrials.gov as being sponsored by the federal government.
- the trial investigates a treatment for terminal cancer and: the person has failed standard therapies for the disease; the person cannot tolerate standard therapies for the disease; or no effective non-experimental treatment exists for the disease.
- the person meets all inclusion criteria for the clinical trial and is not treated "off-protocol".
- the trial is approved by the Institutional Review Board of the institution administering the treatment.

Routine patient services do not include, and reimbursement will not be provided for:

- the investigational service or supply itself.
- services or supplies excluded from coverage under the Plan.
- services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs).
- services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

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.

Miscellaneous Medical Services and Supplies

- Nursing services.
- Air or ground ambulance when used to transport a Member:
  - from place of Illness or Injury to the nearest Hospital where appropriate treatment can be provided; and
  - from one Hospital to another, when approved by Medical Management.
- General anesthesia and associated facility charges for dental procedures when determined to be Medically Necessary.

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

- 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

The PERFORMANCE prescription drug benefit covers prescription drugs. To be eligible for coverage as a prescription drug covered expense, prescription drugs , including contraceptives, must be approved by the Food and Drug Administration (FDA), prescribed in writing by a Doctor as Medically Necessary for the treatment of Illness or for birth control, received as an outpatient while the Member is covered under the Plan, and purchased from a licensed pharmacist.

New FDA approved drugs are evaluated by a pharmacy and therapeutics committee. Some drugs may have dispensing limits that are primarily based on FDA recommendations. Additionally, some drugs may be subject to prior authorization for Medical Necessity and the Member must make sure to contact their Doctor or Member Services to initiate the authorization process.

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.

The Plan utilizes a tiered list approach to benefits, and the status of a drug within the list structure is subject to change:

- Generic drugs (Tier 1) - drugs on the generic drug list.
- Preferred brand name drugs (Tier 2) - drugs on the preferred brand name drug list.
- Non-preferred brand name drugs (Tier 3) - brand name drugs other than preferred brand name drugs.

If a brand name drug is dispensed when a generic equivalent is available, then the Member must pay 100% of the difference between the brand name price and the generic price, plus the appropriate brand name drug Member cost share. This does not apply if the prescribing Doctor has written "Dispense as Written (DAW)" on the prescription.

Contact Member Services at the phone number or website shown on the Member ID card to obtain a list of network pharmacies and to access lists of covered drugs. Information about whether a particular drug is covered and current drug pricing and generic alternatives is available from a website that is accessible through the website shown on the ID card.

Retail Network Pharmacy - Includes a nationwide network of participating retail pharmacies. When a Member shows his/her ID card at a network pharmacy, the pharmacy will collect the appropriate Member cost share and the Member won't have to file a claim.

Non-Network Pharmacy - A non-network pharmacy is one that is not a network pharmacy. See PRESCRIPTION DRUG BENEFITS SUMMARY for more information.

90-Day Retail Network Pharmacy - Offers the convenience of obtaining a larger supply of a covered maintenance prescription drug when a prescription is filled at a designated retail network pharmacy. This option is available only after the Member has filled a 30-day prescription for the same medication. To locate a designated pharmacy, contact Member Services at the phone number or website on the Member ID card.

Mail Order Pharmacy (Home Delivery) - Offers the convenience of obtaining home delivery of insulin and covered maintenance prescription drugs through designated mail order pharmacies. Contact Member Services at the phone number or website on the Member ID card for more information.

BENEFIT LIMITATIONS

Pre-Existing Conditions Limitation for Medical Benefits

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

Apre-existing condition is an Illness or any related condition for which a Member received services, supplies or medication during the 90 days before the enrollment date of the Member under this medical Plan.

Apre-existing condition is not:

- Apregnancy existing on the enrollment date.
- Genetic information.

Benefits are payable for services, supplies and medication received for a pre-existing condition if they are received 365 days after the enrollment date for the Member.

For a late applicant as described in "What If I Don't Apply On Time?", benefits will be payable for services, supplies and medication for a pre-existing condition only if they are received on or after the date which is 365 days after the person's enrollment date.

"Enrollment date" means:

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

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

Portability of Coverage

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

If the person was covered:

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

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

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

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.
- any amount that is more than the Maximum Reimbursable Charge.
- 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.

BENEFIT LIMITATIONS - Continued

- treatment of an Illness or Injury which is due to war, declared or undeclared, riot or insurrection.
- services, drugs and supplies, other than contraceptives prescribed for the purpose of birth control, that are not Medically Necessary.
- 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.

Medical Benefit Limitations and Exclusions

No amount will be payable for:

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

BENEFIT LIMITATIONS - Continued

- 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 as specifically 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.
- for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Doctor or under medical supervision.
- 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 medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" benefits.
- private Hospital rooms and/or private duty nursing except as provided in the "Home Health Services" benefit.

BENEFIT LIMITATIONS - Continued

- 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.
- eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).
- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- treatment by acupuncture.
- 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.
- enteral feedings, supplies and specially formulated medical foods that are prescribed and non prescribed, except as specifically provided in the "Enteral Nutrition" benefit.
- medical treatment when payment is denied by a primary plan because treatment was received from a provider who was not a participating or network provider under the primary plan. See WHAT IF A MEMBER HAS OTHER HEALTH COVERAGE? for a description of "primary plan".
- massage therapy.
- all noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this Plan.

<u>Prescription Drug Benefit Limitations and Exclusions</u>

No amount will be payable for:

- therapeutic devices and appliances, except as specifically provided under the Plan.
- non-prescription or over-the-counter (OTC) drugs and supplies, unless specifically listed in the Plan as a covered benefit.
- drugs or medicines that are not approved by the Food and Drug Administration (FDA).
- drugs, devices and supplies for cosmetic purposes.
- administration of drugs.
- More than one purchase of a drug or insulin during the dosage period recommended by the prescribing Doctor.

BENEFIT LIMITATIONS - Continued

- allergy serums.
- drugs for treatment of infertility.
- prescription drugs or supplies for which there is a non-prescription or over-the-counter (OTC) equivalent. An OTC equivalent contains the same chemical(s) as a prescription drug or supply, but has been approved by the Food and Drug Administration (FDA) to be sold OTC.
- weight loss medications.

CLAIMS & LEGAL ACTION

How To File Claims

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

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

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

Health Benefits

Medical Benefits

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

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

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

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

Prescription Drug Benefits

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

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

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

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

Claim Decisions

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

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

- the date by which a decision is expected.

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

If A Claim Is Denied

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

The notice will also specify:

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

Appeal of a Health Benefit Claim Denial

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

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

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

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

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

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

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

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

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

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

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 ERISASection 502(a).

For the purposes of health benefits, "medical judgment" includes but is not limited to Medically Necessity determinations.

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

What If a Member Has Other Health Coverage?

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

This provision applies if you are covered under this Plan as an Employee and also as a Dependent of an Employee.

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

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

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

Which Plan Is Primary?

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

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

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

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

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

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

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

  If one of the plans does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.
- When a claim is made for an Employee's Dependent who is also covered under Medicare and as a retiree under his employer's plan:
  - the plan covering the person as a Dependent will determine its benefits prior to Medicare; and
  - the plan covering the person as a retiree will determine its benefits after Medicare.
- If none of the above rules establishes the order of payment, the plan covering the person for a longer period of time will be primary.

What If This Plan Is Primary?

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

What If This Plan Is Secondary?

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

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

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

The COB provision is applied throughout the calendar year.

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

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

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

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

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

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

Under federal law, Medicare Secondary Payer Rules, including those described below, do not apply to domestic partners (including Domestic Partners as defined in the Plan) and spouses who do not meet the definition of spouse under federal law and who are covered under a group health plan. For these individuals, Medicare is considered primary coverage and the group health plan (such as this Plan) is considered secondary coverage.

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

When the Plan is secondary according to Medicare Secondary Payer (MSP) Rules, the 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 determine its benefits first (is primary) or second (is secondary) as permitted by the Medicare Secondary Payer Rules of the Social Security Act of 1965 as amended:

- If you are an Employee and you are, or your spouse is, eligible for Medicare **due to age**, and the Employer employed at least 20 full-time or part-time employees during at least 20 calendar weeks of the preceding or current calendar year, then this Plan will be considered that person's primary coverage and Medicare will be considered secondary coverage.
- If you are an Employee and you are, or your spouse is, eligible for Medicare **due to age**, and the Employer employed fewer than 20 full-time or part-time employees during at least 20 calendar weeks of the preceding or current calendar year, then Medicare will be considered that person's primary coverage and this Plan will be considered secondary coverage.
- If you are an Employee and you are, or your spouse is, eligible for Medicare **due to disability**, and the Employer employed at least 100 full-time or part-time employees during 50% or more of the Employer's business days during the previous calendar year, then this Plan will be considered that person's primary coverage and Medicare will be considered secondary coverage.
- If you are an Employee and you are, or your spouse is, eligible for Medicare **due to disability**, and the Employer employed fewer than 100 full-time or part-time employees during 50% or more of the Employer's business days during the previous calendar year, then Medicare will be considered that person's primary coverage and this Plan will be considered secondary coverage.
- If you or your Dependent are eligible for Medicare solely due to End Stage Renal Disease (ESRD), treatment must be rendered in a Medicare-approved facility in order to be covered under this Plan, and:
  - for the first 30 months the person's Medicare eligibility, this Plan will be considered that person's primary coverage and Medicare will be considered secondary coverage.
  - for the 31st month and beyond, if the person is still eligible for Medicare soley due to ESRD, then Medicare will be considered that person's primary coverage and this Plan will be considered secondary coverage.
  - if the person becomes eligible for Medicare due to ESRD after Medicare became the person's primary coverage under any other provision of Medicare law or this Plan, then Medicare will be considered the person's primary coverage and this Plan will be considered secondary coverage.
- If you are a former Employee or a former Employee's Dependent spouse or a former Dependent spouse, and coverage is continued for any reason as provided in this Plan, then Medicare will be considered that person's primary coverage and this Plan will be considered secondary coverage.

Provision for Subrogation and Right of Recovery

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

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

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

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

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

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

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

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

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

If the Covered Person:

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

then:

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

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

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

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

- on behalf of any incapacitated person.

Other Information a Member Needs to Know

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.

Complaint Process

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

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

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

Legal Actions

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

Physical Examinations

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

Benefit Payments

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

Benefit Payments to a Representative of a Minor

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

Relationship Between CIGNA and Network Providers

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

GLOSSARY

Creditable Coverage

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

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.

Dentist

Aperson licensed to practice dentistry.

Dependent

See ELIGIBILITY.

Doctor/Physician

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

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

Emergency Medical Condition

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

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

Employee

See ELIGIBILITY.

Employer

- Vitrue, 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.

GLOSSARY - Continued

Hospital

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

Illness

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

Injury

Asudden 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 Illness, Injury, disease or its symptoms, and are:

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

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

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

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

Medicare

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

Member

An Employee and any covered Dependent.

GLOSSARY - Continued

Plan

The medical and drug benefits described in this booklet.

Service

See ELIGIBILITY.

Totally Disabled and Total Disability

Active Employees

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

Dependents

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

Urgent Care Facility

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

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

You and Your

An Employee.

USERRA RIGHTS AND RESPONSIBILITIES

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

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

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

Continued Medical and Prescription Drug Coverage

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

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

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

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

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

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

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

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

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

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

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

Period of Continued Coverage

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

Cost of Continued Coverage

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

USERRA RIGHTS AND RESPONSIBILITIES - Continued

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

COBRA Coverage

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

Reinstatement of Coverage

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

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

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

CONTINUATION OF COVERAGE - FMLA

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

CONTINUATION OF COVERAGE - COBRA

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

In some circumstances, COBRA requires that Members who are "qualified beneficiaries" and who lose group Medical and Prescription Drug plan coverage be given an opportunity to continue that coverage when there is a "qualifying event" that would result in a loss of that Plan coverage. The law permits continuation of the same coverage under which the person was covered on the day before the qualifying event occurred, unless the person moves out of the Plan's coverage area or the Plan is no longer in force. Each qualified beneficiary will have the same rights under the Plan as others who are covered under the Plan, including open enrollment and special enrollment rights.

Only a "qualified beneficiary", as defined by COBRA law, may elect to continue coverage. Depending on the type of qualifying event, qualified beneficiaries can include you (the Employee) and/or your spouse and Dependent children.

Pursuant to federal law, the following individuals are *not* qualified beneficiaries for purposes of COBRA continuation, regardless of whether the individual was covered under the Plan on the day before the qualifying event: domestic partners (including Domestic Partners as defined in the Plan), spouses who do not meet the definition of spouse under federal law, children who have not been legally adopted by the Employee (such as children of a domestic partner, step-children and grandchildren, unless adopted by the Employee). Although these individuals do not have an independent right to elect COBRA continuation coverage, if you (the Employee) elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, coverage for such individuals will terminate when your COBRA continuation coverage terminates. The provision entitled "Extension of COBRA Continuation Coverage" does not apply to these individuals.

CONTINUATION OF COVERAGE - COBRA - Continued

Right to COBRA Continuation Coverage

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

Length of COBRA Continuation Coverage

Generally:

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

Extension of COBRA Continuation Coverage

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

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

Health FSA

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

CONTINUATION OF COVERAGE - COBRA - Continued

Notice Requirements

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

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

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

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

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

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

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

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

Reasonable Notice Procedures

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

Cindy Buell

101 Marietta Street

Suite 1700

Atlanta, GA

30303

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

Election of COBRA Continuation Coverage

CONTINUATION OF COVERAGE - COBRA - Continued

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

Cost of Coverage

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

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

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

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

If you are a resident of Tennessee, you may be entitled to have the State of Tennessee pay the contribution for your on-going health coverage. For more information, contact your local Tennessee Department of Human Services.

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

Termination of COBRA Continuation Coverage

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

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

The qualified beneficiary must notify the Employer or its representative of the beneficiary's entitlement to Medicare coverage under

CONTINUATION OF COVERAGE - COBRA - Continued

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

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

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

The Trade Act of 2002

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

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

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

ERISA GENERAL INFORMATION - HEALTH PLAN BENEFITS

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

The name of the Plan is: Vitrue, Inc.

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

Vitrue, Inc.

101 Marietta Street, Suite 1700, Atlanta, GA 30303

678-819-5286

The Employer Identification Number (EIN) is: 20-4803169

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.

ERISA GENERAL INFORMATION - HEALTH PLAN BENEFITS - Continued

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 December 31.

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

STATEMENT OF ERISA RIGHTS - Continued

Continue Group Health Plan Coverage

- 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 this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.
- There may be a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for up to 12 months (up to 18 months if you are a late enrollee) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain without charge copies of documents relating to the decision and to appeal any denial, all within certain time schedules.

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

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

Assistance With Your Questions

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