

Medical Plan



The Company's Medical benefits protect you and your family from the high cost of medical treatment and hospitalization. Depending on where you live, you may enroll for coverage under a Point-of-Service Plan or the Indemnity Plan. The Indemnity Plan is only available if you do not live in the areas covered by the Point-of-Service Plans.

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Highlights



Your Medical Benefits...

...Offer Coverage Under Point-of-Service Plans for Most Employees

If you have access to a point-of-service network, you can enroll in one of the Point-of-Service Plans, administered by CIGNA. Networks are available in the Washington, D.C. and Oak Ridge areas.

...Provide Coverage Under the Indemnity Plan for Employees who do not Have Access to a Point-of-Service Network

If you live in an area where a Point-of-Service Plan is not available, you can enroll in the Indemnity Plan.

...Let You Waive Coverage

You may also choose to waive coverage. If you initially waive coverage, you may enroll during the next open enrollment period or when you experience a qualifying life event, as described within the "About Your Benefits" section.

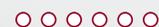
...Provide Protection for Your Family

You may enroll your spouse and eligible children for coverage under the same plan in which you are enrolled. For example, if you are enrolled in a Point-of-Service Plan, you may enroll your dependents in that plan.



What happens to your benefits when...

For more information about what happens to your medical coverage when you have a qualifying life event, see the "About Your Benefits" section.



This summary plan description provides details about the CIGNA Point-of-Service Plans Option 1 and Option 2, and the CIGNA Indemnity Plan.

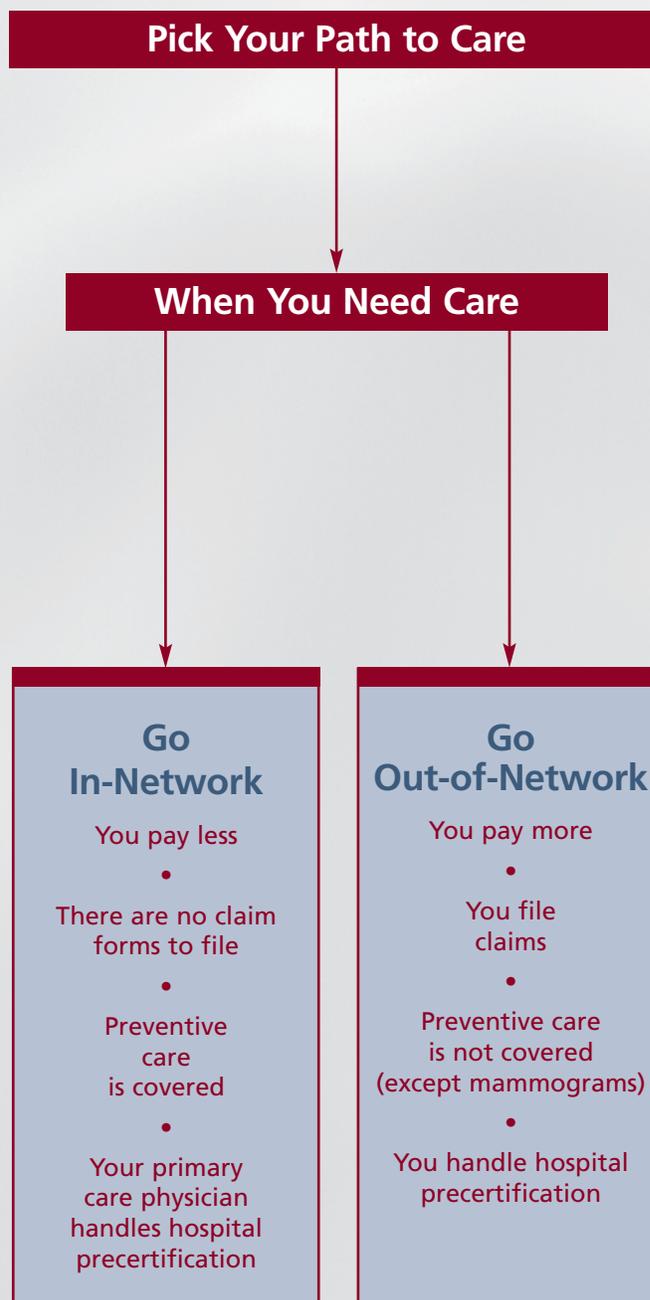
How the Point-of-Service Plans Work

The Point-of-Service Plans center around a network of physicians, hospitals and other health care providers who have agreed to provide care to patients at prenegotiated rates.

With a Point-of-Service Plan, you have a choice each time you need health care - at the "point-of-service:"

- you can choose to have your care coordinated by a primary care physician who is a member of the network and receive in-network benefits
- or*
- you can seek care on your own and receive out-of-network benefits.

The choice is always yours. And, you can decide whether to go in-network or out-of-network each time you need medical care. The Point-of-Service Plans center around a network of physicians, hospitals and other health care providers who have agreed to provide care to patients at prenegotiated rates.





How the Point-of-Service Plans Work (cont'd.)

In-Network Benefits

If you use the network:

- Care is coordinated through a primary care physician - including hospital precertification.
- The plan pays 100% of the cost of most physician's services - including preventive care - after you pay a copayment.
- The plan pays 100% of the cost of inpatient surgery and hospital expenses and may include a copayment.
- The plan pays 100% of the cost of outpatient surgery and may include a copayment.
- In the event of an emergency, the plan pays 100% of the cost of treatment at an emergency room and may include a copayment.
- There is no annual deductible.
- There are no reasonable and customary limits.
- Claim forms are not required.

Primary Care Physicians: The Heart of the Network

Primary care physicians are the key to using the network. These physicians are family practitioners, general practitioners, internists, and pediatricians who contract with the network manager to provide their services at prenegotiated rates. You must pick a primary care physician for each covered family member.

Primary care physicians are responsible for coordinating all in-network health care and, when necessary, for making referrals to network specialists. Primary care physicians also handle all in-network hospital precertifications.

Remember, you must go through a primary care physician to receive in-network benefits. If you go to a network specialist or hospital on your own without a referral from your primary care physician, you will not receive in-network benefits. Your expenses will be covered at the out-of-network benefit level.

There are four situations where you do not need a referral from a primary care physician to receive care:

- A woman may "self-refer" to a network OB/GYN.
- For mental health/alcohol and drug abuse care, you must contact your mental health provider shown on your ID card. Although your primary care physician may make this call for you if you wish, you do not need a referral from your primary care physician to receive mental health/alcohol and drug abuse care.
- Emergency care does not require a primary care physician referral. However, you will need to call your primary care physician within 48 hours after the emergency to ensure in-network benefits and have your primary care physician coordinate any follow-up care.
- You do not need a referral from a primary care physician to see an optometrist for a routine eye exam. See the "Vision Care" section, for more information.

You can change primary care physicians by calling CIGNA Member Services. The CIGNA Member Services telephone number is listed on your Point-of-Service Plan ID card.

How the Point-of-Service Plans Work (cont'd.)

About Preventive Care

Preventive care, like simple health screenings and immunizations, can help prevent or detect serious illnesses early - when they are less expensive to treat and you are more likely to fully recover. Primary care physicians provide a full range of preventive care based on recognized medical guidelines for a person's age, gender, and personal and family health history. This care includes:

- immunizations
- annual well-woman exam
- well-child care
- cholesterol screenings
- prostate exams
- mammograms
- routine physical exams.

Seeing a Specialist

When your primary care physician refers you to a specialist, you receive in-network benefits. If you go to a specialist without your primary care physician's referral - even if the specialist participates in the network - the care is considered an out-of-network expense.

Usually, your primary care physician authorizes a specific number of visits to a specialist for a specific course of treatment. Make sure you and your specialist know how many visits have been approved. If the specialist refers you to another specialist, the referral must be made through your primary care physician.

If You Have an Emergency

If you have an emergency, go to the nearest emergency facility for treatment - even if it is not a network facility. After you pay the copayment required by the plan, the plan pays 100% of the cost of emergency room treatment. The copayment is waived if you are admitted to the hospital from the emergency room.

Someone must contact your primary care physician or CIGNA Member Services within 48 hours of your emergency treatment to ensure that in-network benefits are paid and to arrange for follow-up care.

If you go to the emergency room for a non-emergency, your expenses will be covered at the out-of-network level.

If the situation is urgent, but not an emergency, you should contact your primary care physician first and follow his or her directions.

Definitions for "Emergency" and "Urgent" can be found in the Glossary.

The Network Credentialing Process

All network doctors - primary care physicians and specialists - must meet certain educational and professional requirements before they are admitted into the network. CIGNA has a regular credentialing process to ensure that the doctors in the network meet certain standards, such as:

- medical degree and current unrestricted state license
- admitting privileges at a network hospital
- board certification or board eligibility
- malpractice criteria
- good reputation among peers
- 24-hour emergency availability
- sufficient office hours to meet patient demand
- on-site review of office facilities.

CIGNA reviews its physicians regularly. If any physician does not meet the requirements, that physician will be dropped from the network.

Network hospitals are also credentialed. Hospitals are selected based on their facilities, services, medical outcomes, staff quality measures, and reputation in the community.

CIGNA has the right to change network doctors and network hospitals at any time and without advance notice.



How the Point-of-Service Plans Work (cont'd.)

Special Circumstances

The Point-of-Service Plans have certain provisions that apply to special circumstances. If you have any questions about these situations or others not described here, please contact CIGNA Member Services or the Benefit Plans Office.

CIGNA Option 1 and 2

- **If you need care while traveling outside your network area** - You are covered for emergency care or urgent care on an in-network basis, as long as you call your primary care physician or CIGNA Member Services within 48 hours of receiving the emergency or urgent treatment. (If you are traveling outside the U.S. you may wait until you return home to contact your primary care physician.) You must file a claim for reimbursement as soon as possible when you return. For other types of care, call your primary care physician to determine your best options.
- **If you are on an off-site assignment for more than 90 days** - Contact the Benefit Plans Office for information.

CIGNA Option 1

- **If your child attends school away from home** - Your child should pick a primary care physician in your home network and use that physician for routine care while he or she is home. While away at school, your child should use the campus health care facilities for any illness or injury. If your child needs ongoing care while at school, you should contact CIGNA Member Services. If a local CIGNA network is available, your child may be able to "guest" in that network which means he or she may choose a primary care physician in that network to receive in-network benefits. Remember, if your child "guests" while at school, he or she will be covered only for emergency or urgent care while at home.

In an emergency, your child should follow the standard emergency procedures.

- **If your child lives permanently elsewhere** - You may enroll your child in the Option 1 Point-of-Service Plan, provided you are also enrolled and your child is an eligible dependent. If you are in a CIGNA network and there is a CIGNA network where your child lives, he or she may choose a primary care physician from that network to receive in-network benefits. If there is no CIGNA network available, benefits will be paid at the out-of-network rate.

Out-of-Network Benefits

When you go out-of-network, you can use any physician or facility you like. After you meet an annual deductible, the plan pays 70% or 80% of the reasonable and customary charges for most kinds of medically necessary services, until the annual out-of-pocket maximum has been reached, depending on which health insurance option you have selected.

The out-of-pocket maximum protects you from excessive medical costs by establishing a ceiling on the amount you pay for covered medical expenses during a year. Once you reach the out-of-pocket maximum, the plan pays 100% of the reasonable and customary charges for the rest of that year.

You must file claims to be reimbursed for out-of-network expenses. Claim forms are available from CIGNA Member Services or the Benefit Plans Office.

If your physician recommends any non-emergency hospitalization or surgery, you are responsible for calling CIGNA Member Services for hospital precertification at least seven days, or as soon as reasonably possible, before you are admitted to the hospital. If you do not call, your benefit will be reduced by \$500 if you have selected the CIGNA Option 1 Plan, or by 50% if you have selected the CIGNA Option 2 Plan.

Reasonable and Customary

All out-of-network benefit payments are subject to reasonable and customary limits. Any charges above the reasonable and customary charge are not covered by the plan and you will not be reimbursed for that amount. Also, these amounts will not count toward the deductible or out-of-pocket maximum.

"Reasonable and Customary Charge" is defined in the Glossary.

The Deductible

The individual deductible for the CIGNA Option 1 Plan is 1% of pay, effective January 1, 2002 (\$200 minimum). The maximum family deductible is 3% of pay, effective January 1, 2002 (\$400 minimum). The individual deductible for the CIGNA Option 2 Plan is \$200. The maximum family deductible is \$400.

In-network copayments do not apply toward the deductible.

"Pay" is defined in the Glossary.



How the Point-of-Service Plans Work (cont'd.)

The Family Deductible

Although the deductible applies separately to each covered family member, the plan contains a provision - called the family deductible - that limits the amount you pay in deductibles each year.

The most you pay to meet deductibles for your entire family in a year is three individual deductibles (1% + 1% + 1% = 3%) for the CIGNA Option 1 Plan and \$400 for the CIGNA Option 2 Plan. You can also meet the family deductible with any combination of individual expenses. However, once one family member meets his or her individual deductible, any further expenses incurred by that person may not be applied to the family deductible. Once the family deductible is met, no other family member needs to meet the deductible for that year.

Common Accident Deductible

Only one deductible applies to all covered medical expenses resulting from an accident where two or more family members are injured.

The Out-of-Pocket Maximum

The out-of-pocket maximum limits the amount you pay for medical expenses in one year. The individual out-of-pocket maximum is 6% of pay (\$2,000 minimum). The family out-of-pocket maximum is 9% of pay (\$4,000 minimum) for the CIGNA Option 1 Plan. The individual out-of-pocket maximum for Option 2 is \$1,000 for in-network services and \$3,000 for out-of-network services. The family out-of-pocket maximum is \$2,000 for in-network services and \$6,000 for out-of-network services.

Once you reach the out-of-pocket maximum, the plan pays 100% of covered expenses. Certain expenses do not count toward the out-of-pocket maximum:

- expenses for mental health/alcohol and drug abuse treatment
- penalties for not following hospital precertification requirements
- in-network copayments
- deductibles
- charges above reasonable and customary
- care that is received but not covered by the plan.

Hospital Precertification

Hospital precertification helps ensure that all hospital admissions are medically necessary.

If you stay in-network, you do not have to worry about hospital precertification. Your primary care physician will handle it for you. But, if you go out-of-network for care, you are responsible for calling CIGNA Member Services at least seven days, or as soon as possible, before you are admitted to the hospital. If you do not call, your benefit will be reduced by \$500 under the CIGNA Option 1 Plan or by 50% under the CIGNA Option 2 Plan.

When you call CIGNA Member Services for hospital precertification, you need to provide the following information:

- your name, address and telephone number
- your physician's name and telephone number
- the date of your admission
- the reason for your admission.

For mental health/alcohol and drug abuse admissions, whether in-network or out-of-network, you must call the mental health provider listed on your ID card. You do not call CIGNA Member Services.

Mental Health/Alcohol and Drug Abuse Treatment

Under the Point-of-Service Plans, you must have mental health/alcohol and drug abuse treatment reviewed and authorized by the mental health provider listed on your ID card.

If you prefer, your primary care physician, local employee assistance program, or your site's Health Services Department can make the call for you. A primary care physician referral is not necessary.



How the Point-of-Service Plans Work (cont'd.)

CIGNA Member Services

CIGNA Member Services is a customer service line staffed by network representatives trained to answer your questions and provide information about your Point-of-Service Plan participation and benefits.

CIGNA Member Services can help you:

- find out more about network primary care physicians and specialists
- get more information about plan features and procedures
- change primary care physicians
- order replacement ID cards
- register comments about network providers and services
- request out-of-network claim forms.

If you go out-of-network, you must also call CIGNA Member Services for hospital precertification.

Contacting CIGNA Member Services

For CIGNA Option 1 Plan, 1-800-832-3211.

For CIGNA Option 2 Plan, 1-800-515-7378.

Summary of Benefits

CIGNA Point-of-Service Option 1

Refer to the "Covered Expenses" section, provided on the following pages, for details.

	In-Network	Out-of-Network
Annual Deductible Amount for injury, illness, or maternity	None	1% of pay/individual (minimum \$200) 3% of pay/family (minimum \$400)
Out-of-Pocket Annual Limit	n/a	6% of pay/individual (minimum \$2,000) 9% of pay/family (minimum \$4,000)
Pre-Existing Conditions	n/a	n/a
Maximum Lifetime Benefit	\$1,000,000 (in- and out-of-network combined maximum)	\$1,000,000 (in- and out-of-network combined maximum)
Annual Reinstatement	\$5,000 (in- and out-of-network combined)	\$5,000 (in- and out-of-network combined)



Summary of Benefits (cont'd.)

CIGNA Point-of-Service Option 1 (cont'd.)

Hospital Care

Services Covered	In-Network	Out-of-Network*
Inpatient Services: semi-private room, operating room, X-ray, and laboratory services	Covered 100% after \$250 copayment	Covered 70% of R&C after deductible
Outpatient Services: <ul style="list-style-type: none"> Outpatient surgery X-ray and laboratory services 	Covered 100% after \$100 copayment	Covered 70% of R&C after deductible
	No charge if ordered by primary care physician or plan specialist	Covered 70% of R&C after deductible
Transplant Coverage	Covered 100% after \$250 inpatient copayment - approved facilities	Covered 70% of R&C after deductible
Emergency Room Services	Covered 100% after \$100 copayment (waived if admitted) if true emergency or referred by PCP, otherwise out-of-network benefits	\$100 copayment (waived if admitted) if true emergency, covered 70% of R&C after deductible if not true emergency
Urgent Care Facility	Covered 100% after \$20 copayment if referred by PCP \$40 without a referral	Covered 70% of R&C after deductible
Inpatient Mental Health - 20 days per calendar year in-network and out-of-network combined	Covered 100% after \$100 copayment per admission	Covered 70% of R&C after deductible
Inpatient Alcohol and Drug Abuse - Limited to 2 admissions and 100 days per lifetime maximum in-network and out-of-network combined	Covered 100% after \$100 copayment per admission	Covered 70% of R&C after deductible
Maternity - Inpatient	Covered 100% after \$250 inpatient copayment for mother and child	Covered 70% of R&C after deductible
Skilled Nursing Facility (short-term) - 60 days per calendar year for in-network and out-of-network combined	Covered 100% for up to 60 days \$250 copay if not following hospital confinement	Covered 70% of R&C after deductible for up to 60 days
Ambulance Services	Covered 100% if medically necessary	Covered 100% of R&C after deductible if medically necessary
Hospice Care	Covered 100% after \$250 copayment (waived following a hospital confinement)	Covered 70% of R&C after deductible
Outpatient (short-term) rehabilitation - 60 visits in-network and out-of-network combined. Includes physical, speech, and occupational therapy	Covered 100%	Covered 70% of R&C after deductible

*R&C — reasonable and customary charges in your geographic area for similar services.



Summary of Benefits (cont'd.)

CIGNA Point-of-Service Option 1 (cont'd.)

Physician Care

Services Covered	In-Network	Out-of-Network*
Primary Care or Specialist Office Visit	Covered 100% after \$20 copayment	Covered 70% of R&C after deductible
Vision Exam Services <i>Provided by VSP</i>	No charge for yearly exam; no charge for standard frames every 24 months; no charge for standard lenses every 12 months; or reimbursement up to \$75 for one pair of contact lenses (replaces all other benefits)	Plan covers up to \$25 toward yearly exam; up to \$40 toward pair of frames every 24 months; lenses according to fee schedule or one pair of contact lenses every 12 months up to \$75 (replaces all other benefits)
Physician and Surgeon Services in Hospital	Covered 100%	Covered 70% of R&C after deductible
Maternity Office Visits	Covered 100% after one-time \$20 office visit copayment	Covered 70% of R&C after deductible
Maternity Delivery (Physician charges)	Covered 100%	Covered 70% of R&C after deductible
Preventive Health Services:		
• Well-Baby Care	Covered 100% after \$20 copayment (including immunizations)	Not covered
• Periodic Health Assessments	Covered 100% after \$20 copayment	Not covered
• Routine Gynecological Exams	Covered 100% after \$20 copayment	Not covered
• Routine Mammogram	No charge	Covered 70% of R&C after deductible
• Hearing Aid Benefits	\$750 every 36 months	Not covered
Laboratory and X-ray	Covered 100%	Covered 70% of R&C after deductible
Home Health Care (skilled visits only)	Covered 100%	Covered 70% of R&C after deductible for up to 60 visits per calendar year reduced by any in-network visits
Chiropractic Care - 25 visit limit per year in- and out-of-network combined, when medically necessary and appropriate	Covered 100% after \$20 copayment	Covered 70% of R&C after deductible for up to 25 visits per year, reduced by any in-network visits

*R&C — reasonable and customary charges in your geographic area for similar services.

Summary of Benefits (cont'd.)

CIGNA Point-of-Service Option 1 (cont'd.)

Physician Care (cont'd.)

Services Covered	In-Network	Out-of-Network*
Alcohol/Drug Detoxification: • Outpatient	Covered 100% after \$15 copayment per visit for individual therapy; \$10 copayment per visit for group therapy	Covered 70% of R&C after deductible (authorization required for more than 8 visits) up to 35 visit limit per year
Mental Health Service: • Outpatient	Covered 100% after \$10 copayment per visit for individual or group therapy	Covered 70% of R&C after deductible (authorization required for more than 8 visits) up to 35 visit limit per year
Physician Services in Emergency Room	Covered 100%	Covered 70% of R&C after deductible
Durable Medical Equipment	Covered 100%	Covered 70% of R&C after deductible
Infertility Treatment	Limited coverage	Limited coverage
External Prosthetic Devices - Requires approval by Health Plan	Covered 100% after \$100 copayment	Covered 70% of R&C after deductible

Prescription Drugs

For prescription drug benefit information, please refer to the Prescription Drug section.

*R&C — reasonable and customary charges in your geographic area for similar services.



Summary of Benefits (cont'd.)

CIGNA Point-of-Service Option 2 (formerly Healthsource)

Refer to the "Covered Expenses" section, provided on the following pages, for details.

	In-Network	Out-of-Network*
Annual Deductible Amount for injury, illness or maternity	None	\$200 per individual \$400 per family
Out-of-Pocket Annual Limit	\$1,000 per individual \$2,000 per family	\$3,000 per individual \$6,000 per family
Pre-Existing Conditions	n/a	n/a
Maximum Lifetime Benefit	Unlimited	\$2,000,000 lifetime/ \$1,000,000 annual maximum
Annual Reinstatement	n/a	n/a

Hospital Care

Services Covered	In-Network	Out-of-Network*
Inpatient Services: semi-private room, operating room, X-ray and laboratory services	Covered 100%	Covered 80% of R&C after deductible
Outpatient Services: <ul style="list-style-type: none"> Outpatient surgery X-ray and laboratory services 	Covered 100%	Covered 80% of R&C after deductible
	Covered 100% after office visit copayment	
Transplant Coverage	Covered 100% at approved facilities	Not covered
Emergency Room Services	Covered in full if life-threatening or PCP referred; \$100 if not (waived if admitted)	Covered in full if life-threatening or PCP referred; \$100 if not (waived if admitted)
Urgent Care Facility	Covered 100% after \$25 copayment	Covered 100% after \$25 copayment
Inpatient Mental Health/Alcohol and Drug Abuse	Covered 100%	Covered 80% of R&C after deductible
Maternity - Inpatient	Covered 100%	Covered 80% of R&C after deductible
Skilled Nursing Facility	Covered 100%, maximum of 100 days per benefit period, 200 days per lifetime	Covered 80% of R&C after deductible, combined in- and out-of-network 30 days per benefit period, 200 days per lifetime
Ambulance Services	Covered 100% if medically necessary, otherwise not covered	Covered 100% if medically necessary, otherwise not covered
Hospice Care	Covered 100%	Covered 80% of R&C after deductible

*R&C — reasonable and customary charges in your geographic area for similar services.



Summary of Benefits (cont'd.)

CIGNA Point-of-Service Plan Option 2 (formerly Healthsource) (cont'd.)

Physician Care

Services Covered	In-Network	Out-of-Network*
Primary Care or Specialist Office Visit	Covered 100% after \$10 copayment	Covered 100% after \$15 copayment
Vision Exam - Annual:	Covered 100% after \$10 copayment	Not covered
• Eyeware Allowance	\$150 allowance every 12 months for children through age 17; every 24 months for age 18 and over	Not covered
Physician and Surgeon Services in Hospital	Covered 100%	Covered 80% of R&C after deductible
Maternity Office Visits	Covered 100% after \$10 copayment each office visit	Covered 100% after \$15 copayment each office visit
Maternity Delivery (Physician charges)	Covered 100%	Covered 80% of R&C after deductible
Preventive Health Services:		
• Well-Baby Care	\$10 copayment (including immunizations)	Not covered
• Periodic Health Assessments	\$10 copayment	Not covered
• Routine Gynecological Exams	\$10 copayment	Not covered
• Routine Mammogram	Covered 100%	Not covered
• Hearing Aid Benefits	Not covered	Not covered
Laboratory and X-ray	Covered 100%	Covered 80% of R&C after deductible
Home Health Care (skilled visits only)	Covered 100%	Covered 80% of R&C after deductible, precertification required
Chiropractic Care	Not covered	Covered 80% of R&C after deductible
Outpatient Occupational, Speech, and Physical Therapy	Covered 100% after \$10 copayment per visit; no maximum visit limit	Covered 100% of R&C after \$15 copayment per visit. Maximum of 50 visits per member per benefit year
Alcohol/Drug Detoxification:		
• Outpatient	Covered 100% after \$10 copayment per visit; no maximum limit	Covered 80% of R&C after \$15 copayment per visit. 20 visits or \$750 maximum per member per benefit year
Mental Health Service:		
• Outpatient	Covered 100% after \$10 copayment per visit; no maximum limit	Covered 80% of R&C after \$15 copayment per visit. 20 visits or \$750 maximum per member per benefit year

*R&C — reasonable and customary charges in your geographic area for similar services.



Summary of Benefits (cont'd.)

CIGNA Point-of-Service Plan Option 2 (formerly Healthsource) (cont'd.)

Physician Care (cont'd.)

Services Covered	In-Network	Out-of-Network*
Physician Services in Emergency Room	Covered 100%	Covered 80% of R&C after deductible
Durable Medical Equipment	Covered 100%, maximum of \$2,000 per benefit period	Not covered
Infertility Treatment	Not covered	Not covered
External Prosthetic Devices - Requires approval by Health Plan	Covered 100%, maximum of \$2,000 per benefit period	Not covered

Prescription Drugs

Services Covered	In-Network	Out-of-Network*
Retail Pharmacy - up to 30-day supply	Generic: \$5 copayment	80% after deductible at retail pharmacy
	Brand: \$15 copayment	
	Select: \$35 copayment	
Home Delivery - up to 90-day supply Tel-Drug: 1-800-TEL-DRUG	Generic: \$5 copayment for each 30-day supply	Not covered
	Brand: \$15 copayment for each 30-day supply	
	Select: \$35 copayment for each 30-day supply	

*R&C — reasonable and customary charges in your geographic area for similar services.



How the Indemnity Plan Works

If you do not have access to a point-of-service network, you may enroll for medical coverage under the Indemnity Plan, administered by CIGNA.

Under the Indemnity Plan, you may receive care from any provider you choose. After you meet your annual deductible, the plan pays 80% of reasonable and customary charges for medically necessary services and supplies until you reach the annual out-of-pocket maximum.*

The out-of-pocket maximum protects you from excessive medical costs by establishing a ceiling on the amount you pay for covered medical expenses during a year. Once you reach the out-of-pocket maximum, the plan pays 100% of reasonable and customary charges for eligible medical expenses for the rest of that year.

You must file claims to be reimbursed for your eligible expenses. Claim forms are available from the Benefit Plans Office.

You must also call Intracorp to precertify any non-emergency hospitalization. If you do not call, your benefit will be subject to a penalty.

* The Indemnity Plan does not cover routine physical exams except for mammograms.

Reasonable and Customary

All Indemnity Plan benefit payments are subject to reasonable and customary limits. Any charges above reasonable and customary are not covered by the plan, and you will not be reimbursed for them. Also, these amounts will not count toward the deductible or out-of-pocket maximum.

See the Glossary for a definition of "Reasonable and Customary Charge."

The Deductible

The individual deductible is 0.5% of pay (\$200 minimum). The maximum family deductible is 1.5% of pay (\$400 minimum).

"Pay" is defined in the Glossary.

The Family Deductible

Although the deductible applies separately to each covered family member, the plan contains a provision - called the family deductible - that limits the amount you pay in deductibles each year.

The most you pay to meet deductibles for your entire family in a year is three individual deductibles (0.5% + 0.5% + 0.5% = 1.5%). You can also meet the family deductible with any combination of individual expenses. However, once one family member meets his or her individual deductible, any further expenses incurred by that person may not be applied to the family deductible. Once the family deductible is met, no other family member needs to meet the deductible for that year.

Common Accident Deductible

Only one deductible applies to all covered medical expenses resulting from an accident where two or more family members are injured.

The Out-of-Pocket Maximum

The out-of-pocket maximum limits the amount you pay for medical expenses in one year. The individual out-of-pocket maximum is 5% of pay (\$2,000 minimum). The family out-of-pocket maximum is 8% of pay (\$4,000 minimum).

Once you reach the out-of-pocket maximum, the plan pays 100% of covered expenses. Certain expenses do not count toward the out-of-pocket maximum:

- expenses for mental health/alcohol and drug abuse treatment
- penalties for not following hospital precertification requirements
- charges above reasonable and customary
- care that is received but not covered by the plan.

Contacting Intracorp

For questions on eligibility, plan benefits, or claims, call 1-800-628-3996.

This telephone numbers is also listed on your ID card.



How the Indemnity Plan Works (cont'd.)

Hospital Precertification

To help ensure that all hospital admissions are medically necessary, the Indemnity Plan uses Intracorp - a service that reviews and evaluates recommended treatment plans. You or your physician are required to call Intracorp if your physician recommends hospitalization.

You should call Intracorp at least seven days before a regular non-emergency admission, or as soon as reasonably possible. You must call Intracorp by the fourth month of pregnancy to precertify a maternity admission. It is important to have your admission and length of stay confirmed before you enter the hospital.

If you do not have your admission precertified, the first \$300 of hospital charges for each separate admission will not be covered under this plan.

When you call Intracorp, you or your physician will discuss your proposed admission and length of stay with a registered nurse specially trained for this job. If the nurse approves your admission and hospital stay, your admission certification will be mailed to you within 24 hours.

If there are questions, the nurse will refer your case to an Intracorp physician who will follow-up with your physician. If your physician and the Intracorp physician cannot agree on your treatment, a second Intracorp physician will consider your case. In the rare event that an agreement cannot be reached, your physician may appeal the decision to the Intracorp physicians and have the disputed hospitalization resolved by local physicians qualified to consult on your case.

After your admission is certified and you are hospitalized, Intracorp will monitor your hospital stay by telephone calls to your physician or the hospital.

Your physician must contact Intracorp to extend your hospital stay. Intracorp will approve or deny the extension. If it is denied, an Intracorp professional will contact you and your physician directly.

Emergency Hospitalization

If you have a medical emergency and are admitted to the hospital, someone must contact Intracorp within two days of your admission or on the first business day following your admission, if later.

Reduction of Benefits

You will be penalized if you do not call Intracorp or if you do not follow Intracorp's recommendations.

- If you do not precertify your admission before you enter the hospital or within two days of an emergency admission, the plan will not pay the first \$300 of hospital benefits, after the deductible.
- If you stay in the hospital longer than the period approved by Intracorp, the plan will not pay your room and board expenses for the unapproved portion of your stay.
- The plan will not pay any benefits for an unapproved hospital stay.

Second Surgical Opinion

Second surgical opinions are not mandatory, but are covered by the plan with certain limitations. If your physician recommends surgery, the plan pays 100% of the reasonable and customary charge for a second surgical opinion, with no deductible. If additional opinions are necessary, they will be covered at 80% of reasonable and customary charges.

Preadmission and Post-Confinement Testing

The plan pays 100% of the cost of preadmission and post-release testing performed on an outpatient basis within 14 days before a scheduled admission or within 14 days after you leave the hospital, provided the testing is related to your surgery.

If the preadmission tests are performed and your admission is later cancelled, or if the tests are duplicated while you are in the hospital, the plan will pay 80% of reasonable and customary charges for the tests, after you meet the deductible.

Mental Health/Alcohol and Drug Abuse Treatment

After you meet the deductible, the Indemnity Plan pays 80% of reasonable and customary charges for mental health/alcohol and drug abuse treatment, up to the limits described in the chart on the following pages. Inpatient care must be precertified by contacting Intracorp.

Contacting Intracorp

For hospital precertification review, call:
1-800-633-9900.



Summary of Benefits

CIGNA Indemnity Plan

Refer to the "Covered Expenses" section, provided on the following pages, for details.

Annual Deductible Amount for injury, illness or maternity	.5% of pay/individual (minimum \$200) 1.50% of pay/family (minimum \$400)
Out-of-Pocket Annual Limit (includes deductible)	5% of pay/individual (minimum \$2,000) 8% of pay/family (minimum \$4,000)
Pre-Existing Conditions	n/a
Maximum Lifetime Benefit	\$1,000,000
Annual Reinstatement	\$5,000

Hospital Care

Services Covered

Inpatient Services: semi-private room, operating room, X-ray, and laboratory services	Covered 80% of R&C after deductible
Outpatient Services: <ul style="list-style-type: none"> • Outpatient surgery • X-ray and laboratory services 	Covered 80% of R&C after deductible
Transplant Coverage	Covered 80% of R&C after deductible
Emergency Room	Covered 80% of R&C after deductible
Inpatient Mental Health	Covered 80% of R&C after deductible, limit 20 inpatient days per calendar year
Inpatient Substance Abuse - Limited to 2 inpatient treatments per lifetime	Covered 80% of R&C after deductible, limit 60 inpatient days per lifetime
Maternity - Inpatient	Covered 80% of R&C after deductible
Skilled Nursing Facility (short-term) 60 days per calendar year	Covered 100% of R&C, no deductible if admitted in lieu of hospital confinement for up to 60 days.
Ambulance Services	Covered 80% of R&C after deductible if medically necessary
Hospice Care	Covered 100% of R&C, inpatient limited to 60 days per lifetime
Outpatient short-term rehabilitation 60 visits. Includes physical, speech, and occupational therapy	Covered 80% of R&C after deductible

R&C — reasonable and customary charges in your geographic area for similar services.



Summary of Benefits (cont'd.)

CIGNA Indemnity Plan (cont'd.)

Physician Care

Services Covered

Physician Office Visit	Covered 80% of R&C after deductible
Emergency Care at Doctor's Office	Covered 100% of R&C
Urgent Care Facility	Covered 100% of R&C if care is received within 48 hours of the accident or onset of illness
Physician and Surgeon Services in Hospital	Covered 80% of R&C after deductible
Maternity Office Visits	Covered 80% of R&C after deductible
Maternity Delivery (physician charges)	Covered 80% of R&C after deductible
Preventive Health Services:	
• Well-Baby Care	Not covered
• Periodic Health Assessments	Not covered
• Routine Gynecological Exams	Not covered
• Routine Mammogram	Covered 80% of R&C after deductible
• Hearing Aid Benefits	Not covered
Laboratory and X-ray	Covered 80% of R&C after deductible
Home Health Care (skilled visits only)	Covered 100% of R&C, no deductible if admitted in lieu of hospital confinement for up to 60 visits per calendar year
Chiropractic Care	Covered 80% of R&C after deductible 25 visit limit per year
Alcohol/Drug Detoxification:	
• Outpatient	Covered 80% of R&C after deductible 30 visit limit per year
Mental Health Service:	
• Outpatient	Covered 80% of R&C after deductible 30 visit limit per year
Physician Services in Emergency Room	Covered 80% of R&C after deductible
Durable Medical Equipment	Covered 80% of R&C after deductible
Infertility Treatment	Limited coverage
External Prosthetic Devices - Requires approval by Health Plan	Covered 80% of R&C after deductible

R&C — reasonable and customary charges in your geographic area for similar services.

Summary of Benefits (cont'd.)

CIGNA Indemnity Plan (cont'd.)

Prescription Drugs

For Prescription Drug benefit information, please refer to the Prescription Drug section.

Vision Care

Services Covered	In-Network	Out-of-Network*
Vision Exam Services provided by VSP	No charge for yearly exam; no charge for standard frames every 24 months; no charge for standard lenses every 12 months; or reimbursement up to \$75 for one pair of contact lenses (replaces all other benefits)	Plan covers up to \$25 toward yearly exam; up to \$40 toward pair of frames every 24 months; lenses according to fee schedule or one pair of contact lenses every 12 months up to \$75 (replaces all other benefits)

*R&C — reasonable and customary charges in your geographic area for similar services.

Notes

- All hospitalizations and outpatient surgeries must be precertified. Failure to do so will result in payments being reduced by \$300.
- Hospital stays not deemed medically necessary will be denied.



Information for all Medical Plans

Lifetime Maximum Benefits

The CIGNA Option 1 Plan and the Indemnity Plan pay up to \$1 million in lifetime benefits in- and out-of-network for each covered individual. The CIGNA Option 2 Plan pays unlimited in-network and \$2 million lifetime maximum out-of-network, \$1 million annual out-of-network. Benefits administered and paid by CIGNA count toward this maximum.

Restoration of Benefits

Any benefits you receive will reduce your lifetime maximum. However, each January 1, the CIGNA Option 1 Plan and the Indemnity Plan will automatically increase your maximum by the amount of benefits paid, up to \$5,000. For example, assume you received \$6,000 in benefits last year, reducing your lifetime limit to \$994,000. On January 1, \$5,000 was restored to your maximum, increasing it to \$999,000.

Covered Expenses

The Point-of-Service Plans and the Indemnity Plan cover most of the same services, but at different reimbursement levels. The amount of eligible expenses depend on which plan you are in and - if you are in the Point-of-Service Plans - whether you go in-network or out-of-network for care. However, except for routine mammograms, preventive care is only covered in-network under the Point-of-Service Plans. Both plans pay benefits for care that is medically necessary. Care is considered medically necessary if CIGNA determines that it is required for the treatment of an illness or injury according to generally accepted medical practices.

Expenses Not Covered

Although the Point-of-Service Plans and the Indemnity Plan cover most types of medical, hospital and surgical expenses, there are some expenses that are not covered. They include, but are not limited to:

- hospital care, surgery or other medical treatment found to be medically unnecessary (except in a hospice care program), including all or part of a hospital stay found to be unnecessary by Intracorp or CIGNA Member Services
- services and supplies for the treatment of a work-related injury or illness covered by workers' compensation or other similar laws (except in a hospice care program)
- services and supplies provided by a federal government agency
- services and supplies reimbursed through no-fault automobile insurance
- services and supplies provided through any public program (other than Medicare and Medicaid for a dependent)
- services and supplies for which you are not legally required to pay
- services and supplies provided by a hospital owned by the U.S. government if the charges are directly related to a sickness or injury connected to military service.
- treatment for which you would not have been charged if you did not have coverage, or for which payment is provided by another plan under coordination of benefits
- treatment for which payment is prohibited by law
- nursing care provided by a member of your family or someone who normally lives in your house
- custodial care, education or training (except in a hospice care program)
- eyeglasses or examinations for their prescription (these expenses are covered under the vision care plan)
- dental treatment except for injuries to sound natural teeth received within 12 months of the accident while you or your family member is covered
- appliances for temporomandibular joint disorder (TMJ) and/or orthodontic treatment

Information for all Medical Plans (cont'd.)

- experimental procedures or treatment methods not approved by the American Medical Association or the appropriate medical specialty society
- vitamins
- radial keratotomy or lasik surgery
- sterilization reversal
- hospice care services for curative or life-prolonging procedures or to help you or your family in daily living
- second surgical opinions for cosmetic or dental procedures, for procedures normally performed in a physician's office, or for an opinion obtained more than six months after the surgery is first recommended
- cosmetic surgery and related hospital expenses, except when required for accidental injuries sustained while covered by the plan, a birth defect, or breast reconstruction following a radical mastectomy
- amniocentesis, ultrasound or any other procedures requested solely for the sex determination of a fetus, unless medically necessary to determine the existence of a sex-linked genetic disorder
- over-the-counter disposable or consumable supplies
- orthotics
- speech therapy that is not restorative in nature
- transsexual surgery and related services
- routine foot care
- hospital care, surgery, or other medical treatment received before you were covered by the plan
- expenses above the reasonable and customary limit
- wigs
- air purification systems
- hot tubs
- blood pressure monitors
- intentionally self-inflicted injury while sane or insane (CIGNA Option 2 only)
- charges incurred for injuries sustained as a result of misuse or abuse of a controlled substance (CIGNA Option 2 only).

Filing Claims

If you stay in-network under the Point-of-Service Plans, your network provider is responsible for filing your claims.

To file a claim for out-of-network treatment under the Point-of-Service Plans or for any treatment under the Indemnity Plan, you must complete a claim form and send it to CIGNA within two years of the date the expense is incurred. Be sure to:

- include your Social Security number
- use a separate form for each covered dependent
- indicate whether you want payment made to you or your health care provider.

You can either attach itemized bills or have your physician complete the physician's section of the form. Either way, the following information must be provided:

- patient's full name, date of birth and relationship to you
- physician's full name, address and tax identification number
- diagnosis code
- date and charge for each service.

Claim forms can be obtained from CIGNA Member Services or the Benefit Plans Office.



Coordination of Benefits

The Point-of-Service Plans and the Indemnity Plan have a provision that is designed to prevent duplication of benefits when you or your eligible dependents are covered by more than one medical plan. Under this provision, when coverage is provided both by the Company and another employer group plan, the total of benefits paid by both plans will not exceed the amount that would have been paid by our plan if no other coverage existed. To ensure you are not paying for coverage that may not provide benefits, there are a couple of things you should consider.

Who Pays First

You should understand which plan will pay benefits first, or is "primary." The Company plan is primary if you are the patient. If your spouse has other medical coverage, his or her plan will pay first if he or she is the patient.

If your child is the patient, and he or she is covered by the Company plan and your spouse's plan, the decision about which plan pays first is determined by the "birthday rule," a standard method used by the insurance industry. This means the Company plan pays first if your birthday (month/day) comes before your spouse's in the calendar year (for example, if your birthday is March 1 and your spouse's birthday is August 1 your plan will pay first). If you and your spouse have the same birthday, the plan covering you or your spouse longest pays first. If your spouse's plan does not use the birthday rule, the rules of his or her plan determine which plan pays first.

In the case of divorce, the plan of the parent with custody of the child pays first. If the parent with custody remarries, that parent's plan still pays benefits first. However, if a court decree gives financial responsibility to the parent without custody, that parent's plan will pay first.

If none of these situations apply, the plan covering the person longest pays first. If the other plan does not have any coordination of benefits guidelines, that plan will pay benefits first.

Who Pays Second

You should also consider how the plans pay benefits when they are secondary. When the Company plan is secondary, it will pay a benefit (after the deductible and any coinsurance) equal to the difference between what it would ordinarily pay and what the primary plan pays. For example, if the Company plan would normally pay \$200 for an expense and your spouse's plan already paid \$210, the Company plan would not pay a benefit. On the other hand, if your spouse's plan paid \$190, the Company plan would pay the \$10 difference.

Medicare Eligibles

Benefits will also be coordinated with benefits you or a covered dependent receives or is eligible to receive under Part A and Part B of Medicare. This means that your plan benefit will be reduced to account for Medicare benefits you are eligible to receive - whether you are enrolled or not.

Other Important Information

Company Right to Reimbursement (Subrogation)

If you or a covered dependent receives benefits for a covered expense and then collects payment for the same expense from a third party by settlement, judgment or otherwise, you or your dependent must reimburse the Company for the amount of benefits paid by the plan or the amount received from the third party, whichever is less. This is called "subrogation."

As a condition of participation in the medical plan, you and your covered dependents agree to cooperate with the plan fully to permit the plan to recover the amounts it has paid or will pay on you or your covered dependents' behalf for an injury caused by a third party, but not more than these amounts. You or your covered dependent may keep the portion of any recovery from or settlement with the third party or its insurer for your out-of-pocket medical expenses not covered by the plan such as copayments and deductibles, and your reasonable attorney's fees to obtain the recovery. The plan is entitled to recover these amounts regardless of whether the recovery is designated as compensation for medical expenses. It is your responsibility to notify the Plan Administrator when you or your covered dependent may have an injury which may entitle the plan to assert subrogation rights.

Newborns' and Mothers' Health Protection Act of 1996

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

Medical Insurance After Age 65 - During Active Service

If you continue working after age 65, you have the right to make one of the following elections:

- **Continue primary coverage under the Company medical plan**

In this case, the plan will pay benefits first. If your claim is for an item or service that is also covered by Medicare, you may receive all or part of the unpaid balance of the claim, up to Medicare limitation.

- **Elect primary coverage under Medicare**

In this case, Medicare will pay your medical claims.

If you elect primary coverage under Medicare, you must, under the law, cancel your coverage under the Company plan.



Other Important Information (cont'd.)

Dependent Coverage In the Event of Your Death

If you should die while in active service, your spouse and eligible dependents may elect to continue medical coverage for three months at the active rate for the coverage level selected.

If you had at least 10 years of full-time Company service and were retirement eligible under the pension plan when you died, your spouse and eligible dependents may elect to continue medical coverage until your spouse reaches age 65 or remarries – whichever comes first. Currently, the Company will pay 75% of the cost for this plan continuation for your spouse and eligible dependent children. If your spouse remarries within three years of your death and before age 65, he or she may continue coverage until the third anniversary of your death – provided he or she pays the full cost of this coverage and is not covered by another group plan. However, if the other group plan contains pre-existing condition exclusions affecting the covered individual, coverage under the Company plan may continue until the pre-existing condition waiting period ends or until the individual becomes eligible for Medicare. Your eligible dependent children may continue coverage (after your spouse reaches age 65 or remarries) until the third anniversary of your death provided they pay the full cost for this coverage and are not covered by another group plan. If the other plan contains pre-existing condition exclusions, coverage may not automatically terminate as discussed above.

If you had less than 10 years of full-time Company service and were retirement eligible under the pension plan when you died, your spouse and eligible dependents may elect to continue medical coverage until your spouse reaches age 65 or remarries – whichever comes first. Your spouse and any eligible dependent children will pay 100% of the cost. If your spouse remarries within three years of your death and before age 65, he or she may continue coverage until the third anniversary of your death – provided he or she pays the full cost of this coverage and is not covered by another group plan. However, if the other group plan contains pre-existing condition exclusions affecting the covered individual, coverage under the Company plan may continue until the pre-existing condition waiting period ends or until the individual becomes eligible for Medicare. Your eligible dependent children may continue coverage (after your spouse reaches age 65 or remarries) until the third anniversary of your death provided they pay

the full cost for this coverage and are not covered by another group plan. If the other plan contains pre-existing condition exclusions, coverage may not automatically terminate as discussed above.

If you were not eligible to retire under the pension plan when you died, after the initial three months continuation, your eligible dependents may elect to continue coverage for an additional 33 months – provided your eligible dependents pay the full cost, plus a 2% administrative charge for this coverage. However, if your spouse becomes covered under another group plan, his or her coverage under this plan will terminate immediately, as will coverage for any dependent who becomes covered by any other group health plan or Medicare. However, if the other group plan contains pre-existing condition exclusions affecting the covered individuals, coverage under the Company plan may continue.

When plan coverage terminates, your dependents will be able to convert their medical insurance to an individual policy.

Continuation of Medical Coverage

You and your covered dependent may continue your medical coverage in certain cases when coverage would otherwise end. Refer to COBRA within the "Administrative Information" section.

Proof of Prior Coverage

After your coverage terminates, a certificate of health insurance coverage will automatically be provided and mailed to your last known address within a reasonable period of time. If applicable, another certificate will be provided after the COBRA continuation coverage ends. In addition, you may request another certificate within 24 months after coverage terminates.

Extended Coverage

If you or your covered dependent is totally disabled at the time your coverage ends, plan benefits will continue to be payable for medical expenses related to that disability which are incurred during the 12 months after your employment terminates (or until recovery, if sooner). This extended coverage is provided at no cost to you.

Other Important Information (cont'd.)

Coverage for Reconstructive Surgery Following Mastectomy

When a covered individual receives benefits for a mastectomy and decides to have breast reconstruction, based on consultation between the attending physician and the patient, the health plan must cover:

- reconstruction of the breast on which the mastectomy was performed
- surgery and reconstruction of the other breast to produce symmetrical appearance
- prostheses and physical complications in all stages of mastectomy, including lymphedema.

This coverage must be the same as for any other benefit under the plan.

Conversion Privileges

You may convert your coverage to an individual policy within 30 days after plan coverage terminates or during the final 180 days of continued contributory COBRA coverage (see the "Administrative Information" section), without taking a medical examination.

To convert your coverage, you must submit the appropriate form to the insurance company. Your cost for this coverage will be based on the insurance company's regular premium rates for the type of coverage you elect. Your coverage may differ from the coverage provided under this plan.

Conversion of plan coverage is also available to your dependents if you die or if your dependents no longer meet the plan's eligibility requirements. Your spouse may also convert coverage in the case of divorce or annulment.

Call the Benefit Plans Office to obtain forms and instructions for converting coverage to an individual policy.



