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

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

POLICYHOLDER: City of Fullerton

ADDRESS: Fullerton, California

ACCOUNT NUMBER: 3330495

Group Insurance Policy and Policy Number	Effective Date	Anniversary Date
Employee Assistance Program Clinical Services 3330495 CASTC	01/01/2008	1/01

This policy is issued in California and shall be governed by its laws.

This Policy contains the terms under which the Insurance Company agrees to insure certain Employees and pay benefits.

The Insurance Company and the Policyholder have agreed to all of the terms of this policy.

Deborah Young

Deborah Young, Corporate Secretary

David M. Cordani, President

Wilbur E. Parsell

Wilbur E. Parsell, Registrar

CONTENTS

	Section
THE SCHEDULE	
THE INSURANCE SCHEDULE	3
ALL OTHER SCHEDULE SECTIONS	Certificate
DEFINITIONS	Certificate
ELIGIBILITY	Certificate
EFFECTIVE DATE	Certificate
BENEFITS	
Employee Assistance Program Clinical Services	Certificate
GENERAL LIMITATIONS	Certificate
PAYMENT OF BENEFITS	Certificate
TERMINATION OF INSURANCE	Certificate
PREMIUMS	34
CANCELLATION OF POLICY	36
MISCELLANEOUS PROVISIONS	38, 40, and Certificate

THE INSURANCE SCHEDULE

The terms set forth herein and in the Certificate(s) listed below describe the insurance underwritten by the Insurance Company. These Certificates are included in and made a part of the policy(ies). Each Certificate is identified by a Certificate Number (CN).

Any reference in the certificate to "you" or "yours" refers to the Employee.

An Employee in any of the classes shown below may be insured but only for the policy(ies) listed for his Employee Class. The Effective Date shown below is the date on which a policy becomes effective for an Employee Class.

An Employee will become eligible and insured in accordance with the terms of the "Eligibility" and "Effective Date" sections of the Certificate.

GROUP POLICY(IES)		EMPLOYEE CLASS	
Certificate Number	Policy(ies)	Eligible Employees	Effective Date
CN001	Employee Assistance Program Clinical Services 3330495 CASTC	Each Employee as reported to the insurance company by your Employer	01/01/2008

PREMIUMS

PREMIUM PAYMENT. The first premium will be due on the Effective Date. After that, premium will be due monthly unless the Policyholder and the Insurance Company agree on some other method of premium payment. The Policyholder and the Insurance Company may agree to change the method of premium payment from time to time. Premiums are payable at the Home Office of the Insurance Company or to an authorized agent of the Insurance Company.

PREMIUM DUE DATE. After the Effective Date, the Premium Due Date will be the first of the month. The Anniversary Date will be the first of the month when the policy becomes effective. If the Policyholder and the Insurance Company agree that premiums will be paid on a quarterly, semiannual or annual basis, the Premium Due Date will be at the appropriate regular interval, quarterly, semiannually or annually. Premiums must be received at the Home Office or by an authorized agent of the Insurance Company on the Premium Due Date or the policy will be cancelled except as set forth in the Grace Period.

MONTHLY STATEMENT DATE. If premiums are to be paid monthly, the Monthly Statement Date will be the same as the Premium Due Date. If premiums are to be paid on a quarterly, semiannual or annual basis, the Monthly Statement Date will be the day in each month with the same number as the Premium Due Date.

MONTHLY PREMIUM STATEMENT. If premiums are due monthly, a Monthly Premium Statement will be prepared as of the Premium Due Date. This Monthly Premium Statement will show the premium due. If premiums are due quarterly, semiannually or annually, a Monthly Premium Statement will be prepared as of the Monthly Statement Date for the time from the Monthly Statement Date to the next Premium Due Date. This Monthly Statement will reflect any pro rata premium charges and credits due to changes in the number of insured persons and changes in insurance amounts that took place in the preceding month.

SIMPLIFIED ACCOUNTING. To simplify the accounting process, premium adjustments will be made on the Monthly Statement Date that is the same as or next follows the date that (1), (2) or (3) below takes place.

(1) A person becomes insured.

(2) The amount of insurance on a person changes, but not due to a revision of The Schedule.

(3) A person ceases to be insured.

PREMIUMS (Continued)

MONTHLY PREMIUM RATE FOR MEDICAL EXPENSE INSURANCE. The monthly premium rate for Medical Benefits for Mental Illness, Alcohol and Drug Abuse is determined by written agreement between the Policyholder and Connecticut General Life Insurance Company.

MEDICAL EXPENSE INSURANCE PREMIUM. The monthly premium for Medical Benefits for Mental Illness, Alcohol and Drug Abuse will be calculated as follows:

(1) Multiply the number of Employees insured on the Premium Due Date in each rate class shown in the "Monthly Premium Rate for Medical Expense Insurance" section by the premium rate in effect on that date for that class.

(2) Add the results.

PREMIUMS (Continued)

CHANGE IN METHOD OF PREMIUM PAYMENT. If premiums are to be paid other than monthly, the method of calculation is the same. However, the rate for each class is first changed to quarterly, semiannual or annual rates by multiplying them by 2.9852, 5.9557 or 11.8227, respectively. All results are taken to the nearer cent. If the Policyholder and the Insurance Company agree to a change in the method of premium payment or to a change in the Anniversary Date, a pro rata adjustment will be made in the premium due.

CHANGES IN PREMIUM RATES. Any premium rate may be changed by the Insurance Company from time to time with at least 31 days advance written notice. No such change will be made until 12 months after the Effective Date. An increase will not be made more often than once in a 12-month period. If an increase in premium rates takes place on a date that is not a Premium Due Date, a pro rata premium will be due on the date of the increase. The pro rata premium will apply for the increase from the date of the increase to the next Premium Due Date. If a decrease in premium rates takes place on a date that is not a Premium Due Date, a pro rata credit will be granted. The pro rata credit will apply for the decrease from the date of the decrease to the next Premium Due Date.

As of any Anniversary Date after the policy has been in force for 12 months, the Insurance Company may grant a credit in such amount as it may determine, based on experience. The experience under this policy may be combined with the experience under other contracts issued by the Insurance Company or its affiliates and covering the policyholder or its employees.

PREMIUMS (Continued)

CHANGES IN PREMIUM RATES (Continued)

The Insurance Company may change rates immediately if, in its opinion, its liability is altered by any change in state or federal law or by a revision in the insurance under the policy. Any such change in rates will take effect on the effective date of the change in law or change in the insurance.

The Insurance Company may change rates immediately if, in its opinion, its liability is altered by interaction with an HMO.

Experience for Pooled Coverage under this policy may be combined with the experience for coverage which is deemed pooled under other group insurance policies providing similar insurance issued by the Insurance Company.

POOLED COVERAGE. Pooled Coverage includes all benefits payable for a person for treatment of mental illness, alcohol or drug abuse.

CANCELLATION OF POLICY

The Policyholder may cancel the policy as of any Premium Due Date by giving written notice to the Insurance Company before that date.

The Insurance Company may cancel the policy as of any Premium Due Date if: (a) the number of insured Employees is less than 25 or less than 75% of those eligible; and (b) it has given the Policyholder at least 31 days advance written notice of its intent. Dependent Insurance may be cancelled as of any Premium Due Date if the number of Employees insured for their Dependents is less than 75% of those eligible.

If a premium is not received at the Home Office or by an authorized agent of the Insurance Company when due, the policy will automatically be cancelled as of the Premium Due Date, except as set forth below.

GRACE PERIOD. If, before a Premium Due Date, the Policyholder has not given written notice to the Insurance Company that the policy is to be cancelled, a Grace Period of 31 days will be granted for the payment of each premium after the initial premium. The policy will stay in effect during that time. If any premium is not received at the Home Office or by an authorized agent of the Insurance Company by the end of the Grace Period, the policy will automatically be cancelled at the end of the Grace Period; except that, if the Policyholder has given written notice in advance of an earlier date of cancellation, the policy will be cancelled as of the earlier date. The Policyholder will be liable to the Insurance Company for any unpaid premium for the time the policy was in force.

MISCELLANEOUS PROVISIONS

EXECUTION OF POLICY. The policy is executed at the Home Office of the Insurance Company. The Post Office address of the Insurance Company is Hartford, Connecticut.

CONSIDERATION. The policy is issued to the Policyholder in consideration of the application and payment of premiums.

INSURANCE DATA. The Policyholder will give the Insurance Company all of the data that it needs to calculate the premium and all other data that it may reasonably require. Failure of the Policyholder to give this data will not void or continue an Employee's insurance. The Insurance Company has the right to examine the Policyholder's records relative to these benefits at any reasonable time while the policy is in effect. It also has this right until all rights and obligations under the policy are finally determined.

MALE PRONOUN. The male pronoun as used herein will be deemed to include the female.

PROVISIONS

ENTIRE CONTRACT. The entire contract will be made up of the policy, the application of the Policyholder, a copy of which is attached to the policy, and the applications, if any, of the Employees.

POLICY CHANGES. Changes may be made in the policy only by amendment signed by the Policyholder and by the Insurance Company acting through its President, Vice President, Secretary, or Assistant Secretary. No agent may change or waive any terms of the policy.

STATEMENTS NOT WARRANTIES. All statements made by the Policyholder or by an insured Employee will, in the absence of fraud, be deemed representations and not warranties. No statement made by the Policyholder or by the Employee to obtain insurance will be used to avoid or reduce the insurance unless it is made in writing and is signed by the Policyholder or the Employee and a copy is sent to the Policyholder, the Employee or his Beneficiary.

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

PROVISIONS (Continued)

LEGAL ACTIONS. No action at law or in equity will be brought to recover on the policy until at least 60 days after proof of loss has been filed with the Insurance Company. No action will be brought at all unless brought within 3 years after the time within which proof of loss is required by the policy.

TIME LIMITATIONS. If any time limit set forth in the policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity is less than that permitted by the law of the state in which the Employee lives when the policy is issued, then the time limit provided in the policy is extended to agree with the minimum permitted by the law of that state.

PHYSICIAN/PATIENT RELATIONSHIP. The Employee will have the right to choose any physician who is practicing legally. The Insurance Company will in no way disturb the physician/patient relationship. However, benefits for mental illness, alcohol or drug abuse treatment are payable only if the physician is a Participating Provider.

CERTIFICATES. The Insurance Company will issue to the Policyholder for delivery to each insured Employee an individual certificate. The Policyholder will be responsible for distributing the certificates to its Employees. The certificate will show the benefits provided under the policy. It will set forth any changes in benefits due to age and to whom benefits will be paid. Nothing in the certificate will change or void the terms of the policy.

City of Fullerton

California Residents
EFFECTIVE DATE: January 1, 2008

CN001
3330495

This document printed in April, 2008 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

Certification **5**

Eligibility – Effective Date **7**

Requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA'93) 7

Employee Assistance Program Clinical Services **8**

The Schedule 8

Certification Requirements 8

Covered Expenses 8

Expenses Not Covered 9

Exclusions **9**

Payment of Benefits **10**

Termination of Insurance **10**

Employees 10

Dependents 10

Continuation of Insurance 10

Continuation Required By Federal Law 11

Requirements of Family and Medical Leave Act of 1993 12

Provisions **13**

Summary Plan Description **13**

Definitions **15**

To contact the Department of Insurance, write or call:

Consumer Affairs Division
California Department of Insurance
Ronald Reagan Building
300 South Spring Street
Los Angeles, CA 90013

Toll free number: 1-800-927-4537 (In state only, except for area codes 213, 310 and 818).

Out of State: 1-213-897-8921 (including area codes 213, 310 and 818),

The Department of Insurance should be contacted only after discussions with the insurer have failed to produce a satisfactory resolution to the problem.

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

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

POLICYHOLDER: City of Fullerton

GROUP POLICY(S) — COVERAGE
3330495 - CASTC – EMPLOYEES ASSISTANCE PROGRAM CLINICAL SERVICES

CERTIFICATEHOLDER:

EFFECTIVE DATE: January 1, 2008

THIS CERTIFICATE APPLIES ONLY TO EMPLOYEES WHO ARE RESIDENTS OF CALIFORNIA

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

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

Deborah Young

Deborah Young, Corporate Secretary

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

The Schedule

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

Eligibility – Effective Date

Eligibility for Employee Insurance

- You are eligible for the EAP if you are a Full-Time Benefited Regular employees and you work 40 hours a week or you are a Part-Time Benefited Regular employees and you work a minimum of 20 hours a week and must have logged 3,120 hours
- You will become eligible for insurance on your first day of active employment.

Eligibility for Dependent Insurance

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

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

Classes of Eligible Employees

Each Employee who resides in California

GM6000 EL 2 V-32
ELI6 M

This plan is offered to you as an Employee.

Effective Date of Your Insurance

You will become insured on the date you become eligible.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

Your Dependents will be insured only if you are insured.

GM6000 EF 3 V-1
ELI36

Requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA'93)

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

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

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

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

You must notify your Employer and elect coverage for that child within 31 days of the court order being issued.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or state agency, and satisfies all of the following:

(1) the order specifies your name and last known address, and the child's name and last known address;

(2) the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;

(3) the order states the period to which it applies; and

(4) the order specifies each plan that it applies to.

The Qualified Medical Child Support Order may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy.

GM6000 ELI98V20

B. Eligibility for Coverage for Adopted Children

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

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

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

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

GM6000 ELI98V21

Employee Assistance Program Clinical Services

The Schedule

These benefits provide coverage for confidential* and convenient access for assessment, referral and/or for short term problem resolution sessions for Clinical Services in connection with Mental Health or Substance Abuse for care received In-Network.

To qualify for In-Network coverage, you must contact the Review Organization and receive care through a Participating Provider. In case of an emergency, immediate crisis intervention is available on a 24 hour basis. If your care is not authorized as In-Network, it is not a Covered Expense.

Maximum Benefits

For You and Your Dependents	**This Plan Will Pay:**
In-Network Maximum for:	
Outpatient Care	5 visits per occurrence, per calendar year

For Clinical Services, the Review Organization shall offer an appointment within forty-eight (48) hours with a Participating Provider. In a Clinical Services emergency, trained clinicians shall be available at the Review Organization to telephonically address the situation and to make a referral to a local counselor or crisis intervention center for assessment, referral and/or short term problem resolution.

After the 5 EAP sessions have been utilized, you may be eligible to continue your treatment plan through the mental health provisions of the medical benefit program of the Plan in which you and your Dependents are currently enrolled.

*Confidentiality is maintained except for a few situations in which information may be disclosed. For example, various situations, such as where the life and/or safety of an individual is seriously threatened or if the disclosure is required by law are exceptions to confidentiality rules.

GM600 MHSA1

Certification Requirements

For You and Your Dependents

Referrals for Employee Assistance Program Clinical Services in connection with Mental Health and Substance Abuse while Not Confined in a Hospital

You or your Dependent must request referrals for any treatment for Employee Assistance Program Clinical Services while Not Confined in a Hospital. A referral should be should be requested by you or your Dependent prior to the treatment.

Expenses incurred for benefits under this plan will not include expenses incurred while you or your Dependent are Confined in a Hospital.

The referral process is performed by the Review Organization with which CG has contracted.

The Review Organization is an organization with a staff of mental health and substance abuse professionals, and other trained staff members who perform the assessment and referral process.

GM6000 OVC1

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a person for the charges listed below, if they are incurred after he becomes insured for these benefits:

- charges made by a Physician, a Psychologist for or a master's level clinician for short-term problem resolution sessions in connection with Mental Health or Substance Abuse.

GM6000 CM5

COM402V1

Employee Assistance Program Clinical Services

If you or any one of your Dependents, while insured for these benefits, incurs Covered Expenses for short-term problem resolution sessions in connection with Mental Health or Substance Abuse, CG will pay an amount determined as follows, subject to all other terms of this certificate and Maximum as shown in The Schedule. The percentage payable will be as follows:

100% of the Covered Expenses incurred for In-Network treatment for short-term problem resolution sessions in connection with Mental Health or Substance Abuse while the person is not Confined in a Hospital.

No benefits are payable for expenses incurred for short-term problem resolution sessions in connection with Mental Health or Substance Abuse unless those resolution sessions are received from, or arranged by, Participating Providers and are authorized by the Review Organization.

Employee Assistance Program Clinical Services Maximums

The total number of sessions for In-Network benefits payable for each occurrence due to Issues in connection with Mental Health or Substance Abuse will not exceed the In-Network Maximums as shown in The Schedule for those causes.

The Maximums identified in The Schedule as "Outpatient Care" applies to expenses incurred while not Confined in a Hospital.

GM6000 MHS1 COM404V1

Expenses Not Covered

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

- for conditions which are: (a) within the scope of usual medical practice; and (b) normally handled by non-mental health and substance abuse clinicians; or
- for charges in excess of the amount which the provider has agreed to accept for the service;

GM6000 CM9

COM403

Exclusions

The following are specifically excluded from Employee Assistance Program Clinical Services in connection with Mental Health and Substance Abuse:

- services provided by a Non-CBH Network provider.
- services provided by a CBH Network provider who is a member of your family or your Dependent's family.
- inpatient hospital treatment.
- counseling services beyond a total of 5 sessions per episode, per calendar year for each of you and your Dependents.
- charges for unnecessary care or treatment or in connection with experimental procedures or treatment methods.
- charges for custodial services, education or training.
- counseling required by law or paid for by any workers' compensation or similar law or by a public program other than Medicaid.
- services received before your participation in the EAP begins.

The following are also specifically excluded from Employee Assistance Program Clinical Services in connection with Mental Health and Substance Abuse:

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless medically necessary and otherwise covered under this policy or agreement.
- Treatment of medical disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorder or developmental articulation disorders.
- Counseling for activities of an educational nature.
- Counseling for borderline intellectual functioning.
- Counseling related to consciousness raising.
- Vocational or religious counseling.
- I.Q. testing.
- Residential treatment.
- Custodial Care, including but not limited to geriatric day care.
- Psychological testing on children requested by or for a school system.
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

GM6000 INDEM12

Clinical Services in connection with Mental Health and Substance Abuse are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Clinical Services will not be considered to be Covered Expenses.

Examples of Mental Health and Substance Abuse issues for which assessment, referral or short-term counseling sessions are available include:

- marital problems;
- alcohol and drug problems;
- depression;
- stress;

- parent and child conflict;
- single parenting;
- aging parents;
- job "burn out"
- financial/legal concerns;
- death and dying; and'
- retirement concerns.

GM6000 INDEM9

Payment of Benefits

To Whom Payable

All Medical Benefits are paid directly to the Provider.

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

Time of Payment

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

Recovery of Overpayment

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

GM6000 POB12 PMT135V9

Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the date the policy is canceled.

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

GM6000 TRM23V3

Dependents

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

- the date your Dependent ceases to qualify as a Dependent.
- the date you cease to be eligible to participate in the Employee Assistance Program Clinical Services.
- the date Employee Assistance Program Clinical Services are canceled or amended so that your Dependent is no longer eligible to participate.

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

GM6000 TRM62

Continuation of Insurance

Continuation Following Coverage Required by Federal Law

You or your Dependent spouse may elect to continue health coverage after that required by Federal Law would end due to expiration of the maximum continuation period, if: (a) your employment ended at age 60 or older, and (b) you had worked for the Employer for at least the prior 5 years. Such coverage will continue until the earliest of:

- for a Dependent spouse, five years from the date the Employee's employment ended;
- the date the Employee or Dependent spouse reaches age 65;
- the last day for which premium is paid;
- the date the group policy or replacement policy is canceled; or
- the date the Employee or Dependent spouse becomes covered under another group health benefit plan or elects Medicare.

Conversion will be offered to eligible Employees and Dependent spouses after their continuation under this law ends.

Coverage Under Prior Plan

If you or your Dependent spouse were continuing coverage under a prior carrier's plan and such person becomes covered under this plan within 60 days after the prior plan's termination, coverage which was not extended will be continued under this plan for the remainder of the continuation period.

Election of Continuation Coverage

Your Employer will notify you or your Dependent spouse of your right to further continue benefits when you receive notice of Federal Continuation rights. You or your Dependent spouse

must provide written notice to the Employer no later than 30 days prior to the date the Federal Continuation period will expire.

Continuation During Strike Under Collective Bargaining Agreement

If your Active Service ends due to strike, your insurance will be continued until the earliest of: (a) six months past the date your Active Service ends; (b) the last day for which you have paid the required premium; (c) the date the strike ends; or (d) the date you become a full-time Employee of another Employer.

GM6000 TRM193 V1

Continuation Required By Federal Law

For You and Your Dependents

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

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

A. Employees and Dependents Continuation Provision

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

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

GM6000 TER5

TRM139V7

B. Dependent Continuation Provision

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

(1) your death;

(2) divorce or legal separation; or

(3) with respect to a Dependent child, failure to continue to qualify as a Dependent,

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

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

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

C. Subsequent Events Affecting Dependent Coverage

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

Dependent may continue coverage for up to 36 months from the date of loss of employment or reduction in work hours.

GM6000 TER5 TRM140V24

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

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

Disabled Individuals Continuation Provisions

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

The disabled person may also continue the coverage for other family members continuously covered for the initial 18-month continuation period as either the Employee covering a Dependent, or as the Employee's Dependents; if they otherwise remain eligible.

To be eligible you or your Dependent must:

(a) be declared disabled as of a day before or during the first 60 days of continuation, under Title II or XVI by the Social Security Administration; and

(b) notify the Plan Administrator of the Social Security Administration's determination within 60 days following the determination and within the initial 18-month continuation period, and provide the plan administrator with a copy of the determination.

Termination of coverage for all covered persons during the 29-month period will occur if the disabled person is found by the Social Security Administration to be no longer disabled. Termination for this reason will occur on the first day of the month beginning more than 30 days after the date of the final determination.

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

GM6000 TER5 TRM140V25

Interaction With Other Continuation Benefits

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

Newly Acquired Dependents

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

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

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

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

GM6000 TER5

TRM142V4

Requirements of Family and Medical Leave Act of 1993

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

A. Continuation of Health Insurance During Leave

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

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

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

B. Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave

Act of 1993, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

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

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

GM6000 TRM191V1

Provisions

NOTICE OF CLAIM, CLAIM FORMS and PROOF OF LOSS provisions do not apply to services or supplies recommended by and received from Participating Providers, if that service or supply is authorized by the Provider Organization.

Proof of Loss

Written proof of loss must be given to CG within 90 days after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

Legal Action

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

GM6000 PRO14V5

Summary Plan Description

Please see your Plan Administrator for the following information:

- The name of the Plan;
- The name, address, ZIP code and business telephone number of the sponsor of the Plan;
- Employer Identification Number (EIN);
- Plan Number;
- The name, address and ZIP code of the person designated as agent for the service of legal process;
- How the cost of the Plan is paid;
- The Plan's fiscal ending date.

The office designated to consider the appeal of denied claims is the CG Claim Office responsible for this Plan.

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

Discretionary Authority

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

ERISA ERI7V2

Plan Modification, Amendment and Termination

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

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

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

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

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

Funding

The method for funding the insured parts of the Plan is for the employer to pay premiums for the insurance benefits from the general assets of the employer's business, after any required contribution for the insurance benefits is obtained from the employees by payroll deduction.

ERISA-7

ERISA- 8V-1

ERI1V3

Claim Review Procedure

You may get claim forms and guidance for filing claims from the Plan Administrator or from the CG claim office. If a claim is denied, you will be given the reason for denial in writing. You, or a person in your behalf, may ask the CG claim office for a review of the denied claim in writing within 60 days of receipt of the denial notice. This written request for review should state the reasons why you feel your claim should not have been denied. It should include any additional documents (medical or dental records, etc.) which you feel support your claim. You may also ask additional questions or make comments and you may review pertinent documents. In normal cases, you will receive the final decision within 60 days of the date your request for review is received. In special cases requiring a delay, you will receive notice of the final decision no later than 120 days after your request for review is received.

The Plan is handled by the Plan Administrator with benefits as set forth in the group insurance policies issued by CG.

Statement of Rights

The following statement of ERISA rights is required by Federal law and rulings:

As a person covered under this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. This law called ERISA, provides that all people covered by the Plan are entitled to:

- examine, without charge, all Plan documents, including insurance policies, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- obtain copies of all Plan documents and other Plan information by writing to the Plan Administrator and asking for them. The Administrator may make a reasonable charge for the copies.
- receive a summary of the Plan's annual financial report if the Plan covers 100 or more people. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

GM6000 ERI2V1

In addition to creating rights for persons covered by the Plan, ERISA imposes duties upon the people who are responsible for the operation of the benefit portion of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and in the interest of the other people covered by the Plan and beneficiaries.

The law provides that no one may fire you or otherwise discriminate against you in any way to prevent you from getting a benefit or exercising your rights under ERISA. The law provides that if your claim for a benefit is denied in whole or in part, you will receive a written notice, explaining why your claim was denied. You have the right to have your claim reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request copies of documents 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 documents and pay up to $110 a day until you receive them, unless they 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. If it should happen that the people who operate the Plan misuse the Plan's money or if you are discriminated against for asserting your rights, you may ask the U.S. Department of Labor for help, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If your suit is successful, the court may order the person you have sued to pay costs and fees. If you lose, the court may

order you to pay these costs and fees, for example, if it finds your claim frivolous.

If you have any questions about your rights under ERISA, you should get in touch with the nearest Area Office of the U.S. Labor-Management Services Administration of the Department of Labor.

If you have any questions about your Plan, you should see your Plan Administrator.

GM6000 ERI3V1

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

Benefits provided under this certificate are fully guaranteed by CG.

This certificate is issued by:

Connecticut General Life Insurance Company

900 Cottage Grove Road

Hartford, CT 06152

If you have questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

GM6000 ERI8

Definitions

Charges

The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with CG for a different amount.

DFS940

Dependent

Dependents are:

- your lawful spouse or your domestic partner who has filed a Declaration of Domestic Partnership with the California Secretary of state pursuant to Section 298 of the Family Code or an equivalent document issued by a local agency of California, another state, or a local agency of another state under which the partnership was created; and
- any unmarried child of yours who is
  - less than 19 years old;
  - 19 years but less than 23 years old, enrolled in school as a full-time student and primarily supported by you;
  - 19 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CG within 31 days after the date the child ceases to qualify above. During the next two years CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

A child includes a legally adopted child from the start of any waiting period prior to the finalization of the child's adoption or your domestic partner's dependent child. It also includes a stepchild living with the Employee, or not living with the Employee if:

- a court orders the Employee to provide medical support to the child; and
- the Employee applies to enroll the child within 90 days of the date of issuance of the court order.

Benefits for a Dependent child or student will continue until the last day of the calendar year in which the limiting age is reached.

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee.

DFS983

Employee

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

DFS1427 M

Employer

The term Employer means the Policyholder and all Affiliated Employers.

DFS212

Expense Incurred

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

DFS60

Hospital

The term Hospital means:

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

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

DFS76

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Abuse Services in a Partial Hospitalization program;
- receiving treatment for Substance Abuse in a Substance Abuse Intensive Therapy Program;
- receiving treatment in a Mental Health Residential Treatment Center.

DFS1649

In-Network (For EAP Clinical Services)

- The term In-Network refers to care which is received from a Participating Provider and is authorized by the Review Organization.
- You are responsible for obtaining the authorization for the referral from the Review Organization prior to receiving care.
- Emergency care which is authorized as such by the Review Organization is also considered In-Network.

DFS904

Participating Provider

The term Participating Provider means:

- a health care professional who has contracted directly or indirectly with CG.

The providers qualifying as Participating Providers may change from time to time.

DFS902

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

DFS164

Review Organization

The term Review Organization refers to CBH (CIGNA Behavioral Health) which contracts with a network of Participating Providers.

DFS680

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who

is considered qualified as a clinical psychologist by a recognized psychological association. It will also include: (1) any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is: (a) operating within the scope of his license; and (b) performing a service for which benefits are provided under this plan when performed by a Psychologist; and (2) any psychotherapist while he is providing care authorized by the Provider Organization if he is: (a) state licensed or nationally certified by his professional discipline; and (b) performing a service for which benefits are provided under this plan when performed by a Psychologist.

DFS585

Reasonable and Customary Charge

A charge will be considered Reasonable and Customary if:

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

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

DFS903