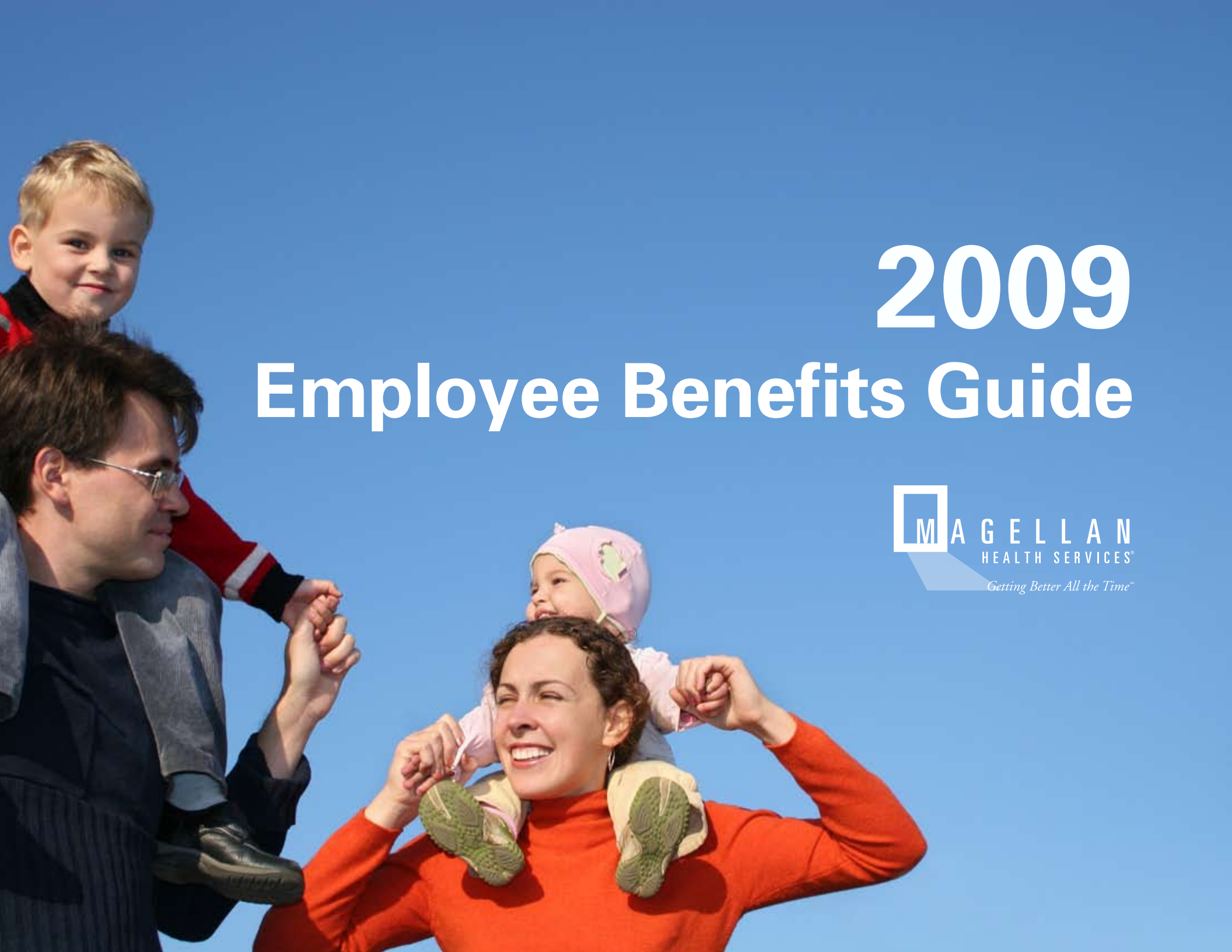

2009
Employee Benefits Guide

MAGELLAN
HEALTH SERVICES®
Getting Better All the Time℠

Welcome to a Healthier You!

Welcome to the Magellan Health Services 2009 Benefits Guide! Living a healthy life and maintaining a balance between work and family...that's what Magellan's benefits are all about. We offer a comprehensive, competitive health and wellness program to assist you and your families in getting and staying healthy.

Magellan's benefits provide YOU the power to best care for yourself and your loved ones. We invite you to use this guide to better acquaint yourself with Magellan's benefits offerings and make the best decisions for you and your family's health and wellness. Inside you will find information on:

- Health Plans; including medical, pharmacy, dental and vision
- Wellness and Enhanced Care Management Plans
- Disability Plans
- Flexible Spending Accounts
- Retirement Plan (401k)
- Voluntary Benefits, including MetLife ancillary products and CIGNA voluntary life insurances
- Paid Time Off, Company Paid Holidays
- Tuition Reimbursement and Adoption Assistance Plans

Look for interactive links that join benefit plans where cross-over occurs and interactive links that take you outside this guide to our many vendors' websites. We've also redesigned the benefits guide with employee-friendly symbols to identify new plan features, new programs, wellness initiatives and areas where you have the opportunity to choose what's right for you!

It's important to us that you fully understand the many benefits Magellan has to offer you. Please take the time to carefully read this guide, seek answers to any questions you have and make your benefits decisions according to plan requirements detailed within. Should you need assistance throughout this process, please contact any one of the resources below.

Welcome to a healthier you through Magellan Health Services!

MAGELLAN HEALTH SERVICES®
Getting Better All the Time℠

You Choose What's Right for YOU!

Magellan's benefit plans let you decide which plans and levels of coverage are best for you and your family. Don't forget, the choices you make during your enrollment are yours through the entire plan year unless you have a qualified change in status. So, choose carefully!

Live Well, Be Well

Magellan promotes wellness through:

- Magellan *LifeResources*' own Weight Management Program
- Healthy Rewards Program through CIGNA when you elect CIGNA medical coverage. Check out Page 13.
- CareFirst Blue Cross Blue Shield Options Program when you elect BCBS medical coverage. Check out page 13.
- Free & Clear Smoking Cessation Program. See MyMagellan/Benefits page for further details.

Magellan HR Service Center
888-411-6343 Option 2
MyMagellan@MagellanHealth.com

Hewitt (formerly known as RealLife HR)
888-860-6145
www.MyMagellanBenefits.com

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Symbols Key

BENEFIT CHANGE

When you see this symbol it denotes a benefit that has been changed or enhanced.

WELLNESS BENEFIT

When you see this symbol it denotes a Wellness benefit.

YOUR CHOICE

When you see this symbol it denotes an opportunity for choice.

IMPORTANT!

When you see this symbol it denotes an important feature, rule or action required for a benefit.

NEW!

When you see this symbol it denotes a new benefit offered to eligible Magellan employees.

Page Jumps: When you see text in this color, it denotes an automatic page jump feature that will link you directly to a plan's page or a page that is related in content.

Resource Directory

Do you have a question about your coverage? Don't know where to send your claim forms? Or do you just need help with better understanding your voluntary benefits? Help is right here! Listed below are the customer service numbers and website addresses (hyperlinks) to Magellan's many benefits vendors.

Adoption Assistance	*MyMagellan@MagellanHealth.com*	*MagNet > MyMagellan > Benefits*
Benefits Concepts (FSA)	1-800-969-2009	*www.AvantServe.com*
Benefits Concepts (COBRA)	1-800-969-2009	*www.AvantServe.com*
BlueCross/BlueShield (All Medical Plans)	1-800-628-8548 (Please refer to your I.D. card for your local customer service number)	*www.BlueCares.com*
CIGNA (Dental, Medical, Pharmacy)	1-800-244-6224	*www.CIGNA.com*
CIGNA GUL Plan	1-800-828-3485	*www.CIGNA.com*
Hewitt (formerly known as RealLifeHR)	1-888-860-6145	*www.MyMagellanBenefits.com* ✹
HR Service Center	1-888-411-6343 opt. 2	*MyMagellan@MagellanHealth.com*
Magellan *LifeResources*	1-866-266-2376	*www.MagellanHealth.com*
Matrix/Reliance Standard (STD/LTD)	1-866-533-3438	*www.MatrixEServices.com*
Medco Health	1-800-711-0917	*www.MedcoHealth.com*
MetLife Voluntary Benefits	1-800-438-6388	*www.MetLife.com/MyBenefits*
Prudential	1-877-PRU-2100	*www.Prudential.com/Online/Retirement*
Tuition Reimbursement/CEUs	*MyMagellan@MagellanHealth.com*	*MagNet > MyMagellan > Benefits*
Vision Service Plan	1-800-877-7195	*www.VSP.com*

Eligibility Requirements

Full-time employees are employees who are regularly scheduled to work a minimum of 30 hours per week and are eligible for all benefits described in the Benefits Guide.

Part-time employees are employees who are regularly scheduled to work from 20 to 29 hours per week and are eligible for Medical, Dental, Vision, Basic Life Insurance, Voluntary Accidental Death and Dismemberment, Group Universal Life, 401(k), PTO (pro-rated), EAP, Transportation Expense Reimbursement Accounts, Flexible Spending Health and Dependent Care Accounts, MetLife Voluntary Products and Educational Assistance (prorated).

Part-time employees are not eligible for Short Term Disability, Long Term Disability, or Adoption Assistance.

Intermittent employees are employees who are regularly scheduled to work less than 20 hours per week and are eligible only for the EAP.

Float employees are employees who only work when scheduled to work at various locations and various times. Float employees may work full time, part time or intermittent, dependent on business needs. Float employees are eligible only for the 401(k) and EAP.

Eligible Dependents for Medical, Dental & Vision Insurance

Your eligible dependents include:

- A spouse to whom you are legally married.
- Same-sex domestic partner who meets all eligibility and carrier requirements, completes and signs a domestic partner affidavit and submits required documentation. Dependents of same sex domestic partners are not eligible. (Refer to page 6 for details)
- A dependent child under age 19 who is unmarried and is legally dependent upon you for financial support. Dependent children are covered until the end of the year in which they turn 19.
- A dependent child under age 25 who is unmarried, legally dependent upon you for support, and a full time student attending an accredited college taking at least 12 credit hours per semester. Full time students are covered until the end of the month in which they turn 25 or graduate.
- If a dependent child is mentally or physically challenged, coverage may be extended beyond these age limits.
- Employees must enroll in a medical plan in order to receive mental health and prescription drug benefits.

⚠ *Please Note*

This booklet provides a summary of the benefits available. This booklet is not a Summary Plan Description. Magellan Health Services reserves the right to modify, amend, suspend, or terminate any plan at any time, and for any reason without prior notification. The plans described in this booklet are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this booklet as accurate as possible. However, should there be a discrepancy between this booklet and the provisions of the insurance contracts, the plan documents will govern. In addition, you should not rely on any oral descriptions of these plans, since the written descriptions in the insurance contracts or plan documents will govern.

Domestic Partner Eligibility

Same-sex Domestic Partners will be eligible for medical, dental and vision benefits under Magellan's Benefits Plan. In order to be eligible, an employee and his/her domestic partner must complete an affidavit of Domestic Partnership. Children or other dependents of Domestic Partners will not be eligible and dependent Domestic Partners will not be eligible for COBRA or Flexible Spending Accounts.

A domestic partner is defined as a person of the same sex who:

- Shares your permanent residence
- Has resided with you for a certain time period (please see the Domestic Partner enrollment kit for more information)
- Is financially interdependent with you and has proof of such interdependence by providing documentation of two of the following: common ownership property, common leasehold interest in property, common ownership of a motor vehicle, a joint bank account or joint credit account, designation as a beneficiary for life insurance or other such proof as is considered sufficient to establish financial interdependency
- Is not a blood relative any closer than would prevent legal marriage
- Has signed jointly with you a notarized affidavit
- Has registered with the state as a domestic partner if your state requires such registration
- Is not currently legally married to another person.

The employee will be taxed on the fair market value of the benefits received by his/her domestic partner. Refer to the Domestic Partner Enrollment Kit for further information.

Domestic partner enrollment kit is available online at *www.MyMagellanBenefits.com* in the Documents Library or on *MagNet > MyMagellan > Benefits*.

Benefit Election Changes

Pre-tax benefits elections for medical, dental, vision and flexible spending accounts will remain in effect and cannot be changed or revoked until an affirmative election is made during an open enrollment period or unless the change is as a result of and consistent with a Qualified Status Change as defined by the IRS. Post-tax benefits elections such as Voluntary Group Universal Life, Voluntary Accidental Death & Dismemberment, and MetLife may be elected or dropped at anytime. However, Long Term Disability may not be dropped or added until Open Enrollment. You must log onto *www.MyMagellanBenefits.com* to complete your status change request or call Hewitt at 1-888-860-6145 **within 30 days of the status change** in order to make a change in your benefit elections.

In order to be permitted to make a change of election relating to your coverage or due to a Status Change, the Status Change must result in you or your spouse or dependent gaining or losing eligibility for coverage under this Plan or a plan sponsored by another employer for whom you, your spouse, or dependent are employed. The election change must correspond with that gain or loss of eligibility. For purposes of medical, dental, vision, and flexible spending accounts, you will be deemed to have a Status Change when the following occur, which affect eligibility for plan benefits:

- your marital status changes through marriage, the death of your spouse, divorce, or annulment;
- your number of dependents changes through birth, adoption, placement for adoption or death of a dependent;
- you, your spouse, or dependent terminate or begin employment;
- you, your spouse, or dependent experience an increase or reduction in hours of employment (including a switch between part-time and full-time employment,
- a strike or lockout, or the beginning or ending of an unpaid leave of absence);
- your dependent satisfies or ceases to satisfy the requirements for coverage under the Plan due to attainment of age, student status, or similar circumstance; or
- you, your spouse or dependent experience a change in residence or work site.

You may also be permitted to change your election for health coverage under the following circumstances:

- a court order requires that your child receive accident or health coverage under this plan or a former spouse's plan;
- you, your spouse, domestic partner, or dependent becomes entitled to Medicare or Medicaid;
- you have a Special Enrollment Right; or
- there is a significant change in the health coverage or cost to you or your spouse attributable to you or your spouse's employment.
- if you, your spouse or your dependent becomes eligible for and elects COBRA, you may make a corresponding election to pay for continuation coverage;
- if you take leave under the Family and Medical Leave Act of 1993 (FMLA) you may make other elections concerning group health coverage that are permitted by FMLA.

For purposes of all other benefits under the Plan you will be deemed to have a Status Change if the change is a result of and is consistent with a change in status, as determined by the Plan Administrator, in its discretion, under applicable law and the Plan provisions.

⚠ *Reporting Eligibility Changes*

Any ineligible dependents should be removed from your coverage as soon as they become ineligible. You must log onto *www.MyMagellanBenefits.com* to begin the status change process within 30 days of any event (e.g. marriage, birth of a child, divorce) affecting your eligibility or the eligibility of your dependents.

Magellan shall have the right of determining eligibility of a spouse, domestic partner and dependents consistent with the provisions of the Plan. Magellan also reserves the right to perform routine dependent eligibility audits and subsequent removal of any ineligible dependents from coverage(s).

As a reminder we have included a few examples of ineligible dependents:

- Anyone who is not your legal spouse or opposite-sex domestic partner, as defined by the Plan (ex-spouse, fiancé, common-law spouse, etc.)
- Married children
- Dependents no longer covered by a court order
- Children of live-in partners (including domestic partners, as defined by the Plan)
- Stepchildren following divorce from a natural parent
- Parents

Summary of Eligibility

Benefits	*Benefit Eligibility Date*
Employee Assistance Program	Date of hire
Magellan *LifeResources*	Date of hire
Education Assistance (Including Tuition Reimbursement)	Date of Hire with appropriate application
Other Paid Time Off	Date of hire
MetLife Voluntary Benefits	Date of hire
Retirement Savings Plan 401(k)	Date of hire
Medical/Prescription Drug (Including Mental Health)	1st of the month following 30 days of employment*
Dental	1st of the month following 30 days of employment*
Vision	1st of the month following 30 days of employment*
Life Insurance/AD&D	1st of the month following 30 days of employment*
Voluntary AD&D	1st of the month following 30 days of employment*
Voluntary Group Universal Life	1st of the month following 30 days of employment*
Flexible Spending Accounts	1st of the month following 30 days of employment*
Paid Time Off	After 90 days of employment
Short Term Disability	1st of the month following 6 months of employment
Long Term Disability	1st of the month following 6 months of employment
Adoption Assistance	After one year of employment

* 1st of the Month Clause: When an employee's 30th day of continuous employment falls on the first day of the month, benefits are effective on that day.

Section 125—Tax Benefit

Magellan Health Services' benefits plans utilize Section 125 of the Internal Revenue Code. This enables you to pay premiums for medical, dental, vision and flexible spending account coverage on a pre-tax basis. When you use pre-tax dollars, you will reduce your taxable income and have fewer taxes taken out of your paycheck. Under Section 125, you can actually have more spendable income than if the same deductions were taken on an after-tax basis. However, the IRS requires premiums for Domestic Partner coverage be paid on a post-tax basis.

Eligibility, Enrollment and General Benefits Questions should be directed to: Hewitt at 1-888-860-6145 or online at *www.MyMagellanBenefits.com*.

Waiver of Medical Coverage and Default Provisions

Notice Regarding Special Enrollment Rights

If you are declining enrollment in the medical plan for yourself or your dependents (including your spouse) because of other medical insurance coverage, you may in the future be able to enroll yourself or your dependents in the medical plan, provided that you request enrollment **within 30 days** after your other coverage ends.

☑ In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your dependents, provided that you request enrollment **within 30 days** after the marriage, birth, adoption, or placement for adoption.

Default Plan Provision (New Hires Only)

If you do not make your 2009 benefits election during your new hire enrollment period, you will only receive the following company-paid benefits plans as indicated:

- Magellan Health Services Basic Life and AD&D Insurance
- Magellan Health Services Short-Term Disability
- Magellan Health Services Basic Long-Term Disability
- Magellan LifeResources (Excluding Magellan's Managed Mental Health Benefit)

You will **not** receive the following benefits:

- Magellan Health Services Medical/Mental Health/ Prescription Drug
- Magellan Health Services Dental Insurance
- Magellan Health Services Vision Insurance
- Magellan Health Services Flexible Spending Accounts
- Magellan Health Services Voluntary Accidental Death & Dismemberment Insurance
- Magellan Health Services Voluntary Group Universal Life
- MetLife Voluntary Benefits

You will not be able to change these selections unless you have a Qualified Status Change or until the next annual Open Enrollment period.

* Please remember that eligibility for Mental Health and Prescription Drug benefits are dependent on your election of medical benefits with Magellan Health Services.

Basic Life Insurance and Basic Accidental Death & Dismemberment

Basic Life Insurance/Reliance Standard

(Employer Paid)

Life insurance, provided by Reliance Standard, provides financial protection for your family in the event of your death. Magellan Health Services provides **full-time employees** with Basic Life Insurance equal to one times your base annual earnings rounded to the next higher $1,000 up to a maximum of $200,000. A flat $10,000 life insurance benefit is provided to **part-time employees** working 20 – 29 hours per week.

You may elect to limit your coverage to $50,000 so as not to increase your taxes. Because basic life insurance is fully paid by Magellan Health Services, there is imputed taxable income for basic life insurance in excess of $50,000. The imputed income tax can be calculated using the following IRS Table I rates:

Age	*Rate per $1,000 per month*
under 25	$ .05
25 – 29	$ .06
30 – 34	$ .08
35 – 39	$ .09
40 – 44	$ .10
45 – 49	$ .15
50 – 54	$ .23
55 – 59	$ .43
60 – 64	$ .66
64 – 69	$1.27
70+	$2.06

Example:

Employee Age Bracket = 50 – 54
Salary = $80,000
Taxable Income = $80,000 minus $50,000 = $30,000
Imputed Taxable Income = .23 x 30 = $6.90 per month

>> Magellan pays 100% of the cost of this benefit.

Basic AD&D Insurance/Reliance Standard

(Employer Paid)

Accidental Death & Dismemberment Insurance, provided by Reliance Standard, provides financial protection to you and your family should you become injured in an accident or in the event of your accidental death. In addition to your Basic Life Insurance, Magellan Health Services provides **full-time employees** with AD&D coverage equal to one times your annual base earnings rounded to the next higher $1,000 up to a maximum of $200,000. A reduced benefit is provided for lesser injuries as a result of an accident. A flat $10,000 AD&D benefit is provided to **part-time employees** working 20 – 29 hours per week.

>> Magellan pays 100% of the cost of this benefit.

Certificates of Coverage are available in the Documents Library at *www.MyMagellanBenefits.com*.

Short Term Disability & New Parent Coaching Program

Short-Term Disability (STD)/ Matrix/Reliance Standard *(Employer Paid)*

Short-Term Disability is a core benefit that provides income replacement benefits if you become disabled and unable to work. Benefits begin after you have been disabled and under a physician's care for 5 days as certified by your physician. The benefits are paid at 60% of your weekly earnings for up to 26 weeks. Short-Term Disability benefits are taxed as income. Benefits will be coordinated with any state mandated disability benefits as well as FMLA*. New employees are eligible to participate on the first day of the month following six months employment.

Matrix/Reliance Standard provides 3rd party review for all Short Term Disability claims.

>> Magellan pays 100% of the cost of this benefit.

To Apply for Short Term Disability you must:

1. Notify your Manager as soon as possible
2. Complete the Magellan request for Leave of Absence form and send to Supervisor
3. If you have worked with Magellan for a least one-year, you may be eligible for a leave of absence of up to 12 weeks, under the Family and Medical Leave Act (FMLA). See *MagNet > MyMagellan > Benefits* for further information.
4. Instruct physician or health care provider to provide information to Matrix/Reliance Standard. Please see the Documents Library at *www.MyMagellanBenefits.com* or *MagNet > MyMagellan > Benefits* for further information.

New Parent Coaching Program— Caring for Baby; Returning to Work

The New Parent Return-to-Work Support Program provides resources and support to make your transition back to work as smooth as possible. This program is designed to assist any new parent—mother, father, birth or adoptive—make the transition back to work easier.

What the Parent Return to Work Support Program Offers You:

- A complete needs assessment to identify your return-to-work concerns or desires.
- Supportive consultation from specially trained coaches on your work-life balance concerns such as work load, relationships, parenting and child care.
- Resource and referral support for choosing quality child care.
- Return-to-work planning for a successful return to work and facilitated communication assistance with you and your supervisor to establish a mutually beneficial return to work plan for a successful return to the workplace.
- Resources such as books, articles and other information to help you integrate work and family life.
- Coaching support and problem-solving to successfully blend parenting and career aspirations.

Through the New Parent Return-to-Work Support and Retention Program, new parents are successfully integrating work and family life resulting in happy, healthy and productive employees and families.

Getting Started

To access the program, simply send an email to *ParentRTWSupportProg@magellanhealth.com* and a new parent coach will contact you to begin your coaching. Please include your contact information including your name, company, telephone number and the best time to reach you.

Resources Are Available

Additional information, self-help tools and other resources are available online at *www.MagellanHealth.com/Member*.

**Continuation of Coverage:*

While on a leave of absence covered by short-term disability and/or FMLA (or any other leave covered under Magellan Health Services' leave of absence policy), your elected benefit coverage(s) will continue. While on paid leave, your premiums will continue to be paid through payroll deduction. If at any time your leave is unpaid, Magellan Health Services will bill you directly for your contribution toward the premiums. The bill will be mailed to your last known home address.

You have a 30-day grace period in which to make premium payments. If timely payment is not made, your group health insurance may be canceled; Magellan Health Services will notify you in writing at least 15 days before the date that your health coverage will lapse. If we do pay your premiums for other benefits, when you return from leave you will be expected to reimburse us for the payments made on your behalf.

Long Term Disability

Long-Term Disability (LTD) Plans/ Matrix/Reliance Standard

Basic Only: (Employer Paid)

Long-Term Disability (LTD) benefits begin after you've been disabled for 180 days. The LTD benefit is reduced by certain other sources of disability income (for example, Social Security) to replace a portion of your earnings. Benefits are paid for two years if you are unable to perform the job duties of your occupation when the disability occurs. This plan replaces 50% of your monthly earnings to a maximum benefit payable of $3,000 per month. Benefits are paid to age 65 so long as you are determined to be totally disabled from any occupation and under a physician's care, and in some cases may be paid beyond age 65. Basic Long-Term Disability benefits are taxed as income.

>> Magellan pays 100% of the cost of this benefit.

If you select the Basic Only LTD plan, the entire cost of coverage will be paid by Magellan Health Services. However, benefits received will be subject to income taxes. If you select Option 1 or Option 2, the entire cost of LTD coverage will be paid by you on an "after tax" basis and benefits are not subject to tax when received.

**Your Plan does not pay a benefit for pre-existing conditions.* Pre-existing condition is defined as follows: A disability which begins in the first 12 months after the effective date or increase of coverage unless you have been treatment free for the condition for 3 consecutive months.

Long-Term Disability (LTD) Buy-Up Plans/ Matrix/Reliance Standard

Option 1: (Employee Paid)

You may choose an LTD plan which replaces 60% of monthly earnings, reduced by other sources of income. The maximum benefit payable under Option 1 is $7,500 per month. If you do not choose this coverage the first time it is available to you, the insurance carrier may require proof of good health if you decide to elect it later.

>> Employee pays 100% of the cost of these benefit. Benefit payments are not subject to income tax

Option 2: (Employee Paid)

You may choose an LTD plan which replaces 66 2/3% of monthly earnings, reduced by other sources of income. The maximum benefit payable under Option 2 is $10,000 per month. If you do not choose this coverage the first time it is available to you, the insurance carrier may require proof of good health if you decide to elect it later.

>> Employee pays 100% of the cost of these benefit. Benefit payments are not subject to income tax.

Medical Wellness Plans

At Magellan, we are committed to enriching your livelihood through better wellness. When you select a Magellan-offered medical plan, we further extend this commitment. Seeing is believing, just take a look!

CIGNA Healthy Rewards:

*If **good health** is its own reward, consider this a well-deserved **bonus**.*

CIGNA Healthy Rewards provides access to a range of health and wellness programs and services often not covered by many traditional benefits plans. Brand names such as Weight Watchers®, Mayo Clinic books, Jenny Craig®, Curves®, SpaFinder™ and more. You also have access to links, discounts and other programs such as Fitness Club Memberships, Yoga Journal, Acupuncture, Massage Therapy, Drugstore.com, Healthyroads for Living, and Sonicare® to name a few.

CIGNA **Healthy Rewards®** broadens your health care choices and saves you money—by providing discounts whenever you use Healthy Rewards participating providers. To find them, simply call 1.800.870.3470. Or, visit *myCIGNA.com*.

There's no time limit or maximum to **Healthy Rewards** if you're a member. So use them whenever you need them.

If your CIGNA HealthCare plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. Healthy Rewards are separate from your plan benefits. The program doesn't apply to your plan copayments or coinsurance. The choice to use the discounts is entirely yours—no doctor's referral is required. No claim forms, either. Set the appointments yourself, and enjoy savings by showing your ID card when you pay for services.

A better, healthier lifestyle is only a click away at *myCIGNA.com*.

CareFirst BCBS Options—

Discounts on a variety of Alternative Therapies and Wellness Services

Options is a discount program provided to members of CareFirst. Because this is a discount program and not a covered benefit, there are no claim forms, referrals or paperwork. To receive these discounts, simply show your CareFirst ID card. In order to be responsive to your needs, Options continually adds new services. Visit *www.CareFirst.com* for the latest Options programs.

Discounts Include:
Weight Loss Assistance Programs (Weight Watchers and Jenny Craig)
Fitness Club Memberships (GlobalFit's and National Fitness Network)
Hearing Care Services (Beltone Hearing Care Centers and TruHearing)
Laser Vision Correction and Contact Lenses (TruVision)
ElderCare Information & Referral Program—ElderCarelink
Alternative Health and Wellness Services—Healthways WholeHealth Networks, Inc.

- Acupuncture
- Guided Imagery
- Massage Therapy
- Mind-Body Instruction
- Personal Training/Pilates
- Yoga
- Chiropractic Care
- Magazine Discount Program
- Meditation Instruction
- Nutrition Counseling
- Qi Gong/Tai Chi

Magellan offers several medical plans:

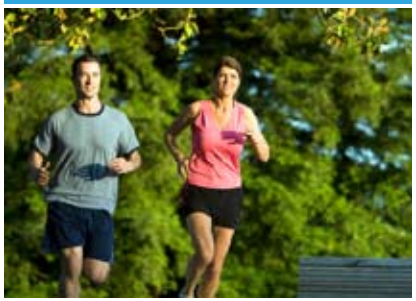
- CIGNA Choice Fund with CIGNA Rx (pages 15 – 18)
- CIGNA OAPIN with CIGNA Rx (pages 19 – 23)
- CIGNA OAP with CIGNA Rx (pages 24 – 29)
- CareFirst EPPO with Medco Rx (pages 30 – 32)

Mental Health and Substance Abuse Services:

Please Note: You do not receive Mental Health and Substance Abuse care through your medical plan. If you elect medical through Magellan Health Services your Mental Health and Substance Abuse care is through Magellan *LifeResources*.

For claims or benefits questions regarding Mental Health and Substance Abuse, please contact Magellan *LifeResources* at 1-866-266-2376.

Medical Plan Choices—CIGNA Medical Plans



It's Your Health

When you choose CIGNA HealthCare, you can take advantage of our health and wellness programs:

- Preventive care services for your children through age 2 and any additional preventive care benefits described in the Benefits Highlights. CIGNA Well Aware for Better Health® can help you manage certain chronic conditions.
- The CIGNA HealthCare Healthy Babies program provides you with information to help you have a healthy pregnancy and a healthy baby.

Features that Add Value

- The convenience of referral-free access to physicians, and the option to select a personal Primary Care Physician (PCP) as your source for routine care and guidance when you need specialized care. As your needs change, so may your choice of doctors. That's why you can change your PCP for any reason.
- The CIGNA HealthCare 24-Hour Health Information Line℠ connects you to registered nurses and a library of hundreds of recorded programs on important health topics 24 hours a day, seven days a week, from anywhere in the U.S. CIGNA Healthy Rewards includes special offers on health and wellness programs and services often not covered by many traditional benefits plans. Just call 1.800.870.3470 or visit our web site at *www.CIGNA.com*.
- Prescription drug coverage is a part of your plan. More than 50,000 pharmacies participate nationwide, so you can have your prescription filled wherever you go. Mail-order service means quick, convenient delivery of your medications right to your home.

Quality Service Is Part of Quality Care

- Service is at the heart of everything we do. Our goal is to give you: fast, accurate answers; responsive, courteous and professional assistance; and ease and convenience in finding the information you need to manage your health.
- *www.CIGNA.com*—Visit our interactive Web site to learn more about your plan and get health information, 24 hours a day. Once you enroll, register for *www.CIGNA.com*, our convenient, secure web site that combines WebMD® tools with personalized benefits information to help you make the most of your plan.
- We Speak Many Languages℠. We offer Language Line Services so that you can talk with us in 150 different languages. Just call Customer Service and ask for an interpreter to assist you.
- Our interactive voice response system helps you find what you need faster over the phone. Use the speech recognition feature for information on your benefits, level of coverage, claims status, and more.

You Can Depend on CIGNA HealthCare

- Quality comes first. We select "preferred providers" carefully. And we make sure you have a wide range of doctors to choose from.
- Emergency and urgent care are covered wherever you go, worldwide, 24 hours a day. Urgent care centers can take care of your urgent care needs, and your cost is lower.

Medical Plan Choices continued—CIGNA Choice Fund

CIGNA Choice Fund is a new kind of health care program. It's called a consumer-driven program because consumers like you—the people who actually use health care services—control when and where they receive their health care.
These are the components of the CIGNA Choice Fund:

Health Reimbursement Fund (HRF):

The HRF is like a savings account for your health care:

- Each year, Magellan allocates a specific dollar amount to your HRF. Starting on your first day of coverage, you use the dollars in your HRF to pay for 100% of the cost of covered medical expenses—including office visits, prescription drugs and lab tests—without having to first spend anything out of your own pocket for copays or deductibles.

Magellan Contributions

Each year, Magellan allocates a specific dollar amount to your HRF. Based on your eligibility date, the HRF allocation schedule is listed below:

Month Eligible	*Amount Allocated*
January – March	100% of the annual allocation
April – June	75% of the annual allocation
July – September	50% of the annual allocation
October – December	25% of the annual allocation

Starting on your first day of coverage, you use the dollars in your HRF to pay for 100% of the cost of covered medical expenses—including office visits, prescription drugs and lab tests—without having to first spend anything out of your own pocket for copays or deductibles.

- Any unused funds in your HRF at the end of the year roll over to the next year to save and use for your future health care needs. Nearly 60% of CIGNA customers have funds remaining in their HRF at the end of the year.
- You can visit any licensed doctor you want without having to get a referral. Plus you'll have access to CIGNA's network of providers.

Preventive Care Benefit: ♥

The program also provides 100% coverage for certain preventive care services. This is in addition to your HRF and will not cost you anything out of your pocket.

Traditional Health Coverage:

The program includes a Traditional Health Coverage component to protect you and your family if expenses exceed your annual HRF allocation. It is similar to the coverage you would receive under a typical health plan.

Mental Health and Substance Abuse Services:

Please Note: You do not receive Mental Health and Substance Abuse care through your medical plan. If you elect medical through Magellan Health Services your Mental Health and Substance Abuse care is through Magellan *LifeResources*.

For claims or benefits questions regarding Mental Health and Substance Abuse, please contact Magellan *LifeResources* at 1-866-266-2376.

Medical Plan Choices continued—CIGNA Choice Fund

Use first—to pay for covered services:	
Health Reimbursement Account (HRA) Annual allocation from Magellan Health Services. Covers 100% of the cost of covered services, no deductibles or copayments to pay first. Unused dollars roll over year-to-year.	**Your Healthcare Reimbursement Fund** $1,000 for employee only coverage $1,500 for employee + one $2,000 for family coverage
Plus—stay healthy with:	
Preventive Care No deductions from the HRF or out-of-pocket costs for you.	**Preventive Care** 100% coverage for nationally recommended services.
Use Second—if needed:	
Traditional Health Coverage Protects you if you need additional coverage. Begins after spending your annual HRF allocation and a limited amount of out-of-pocket expenses on covered services. After reaching the coinsurance maximum, the plan pays 100% of reasonable & customary charges for covered services for the remainder of the plan year.	**Traditional Health Coverage** Coverage begins after incurring a specific amount out-of-pocket on covered services—your Bridge amount: **Bridge** $1,00 for employee only coverage $1,500 for employee + one $2,000 for family coverage Then the plan pays: 90% for providers offering discounts 70% for providers not offering discounts
Annual Out-of-Pocket Maximum	*In Network* $1,000 Fund + $2,000 Member Paid Coinsurance = $3,000 $1,500 Fund + $3,000 Member Paid Coinsurance = $4,500 $2,000 Fund + $4,000 Member Paid Coinsurance = $6,000 *Out of Network* $1,000 Fund + $2,000 Member Paid Coinsurance = $3,000 $1,500 Fund + $3,000 Member Paid Coinsurance = $4,500 $2,000 Fund + $4,000 Member Paid Coinsurance = $6,000
Behavioral Health (A separate benefit; See Magellan Life Resources Benefit Summary)	Behavioral Health is a separate benefit and is not part of your CIGNA Choice Fund. As a result, the payment of these services works differently than the CIGNA Choice Fund. All Behavioral Health benefits are provided by Magellan Behavioral Health. Please contact Magellan Life Resources at 1-866-266-2376 for any behavioral health or chemical dependency questions or issues.
Vision Benefits (A separate benefit; See VSP Summary)	Vision is a separate benefit and not part of your CIGNA Choice Fund. As a result, the payment for these services works differently than the CIGNA Choice Fund. All vision benefits are provided by VSP. Please contact VSP at 1-800-877-7195 for any vision benefit questions or issues.
Lifetime Maximum	Unlimited per person

Medical Plan Choices continued—CIGNA Choice Fund

Summary of Covered Services

Service Type	*When Using Your HRA, the Plan Pays:*	*When Using Your Traditional Health Coverage, after your Bridge is satisfied, the Plan Pays:*	
	Any Licensed Provider	In Network	Out of Network Provider
Preventive Care (not deducted from HRA)	100%	100%	100% of reasonable and customary charges
Physician Office Visit	100%	90%	70% of reasonable and customary charges
Inpatient Hospital Services	100%	90%	70% of charges
Outpatient Surgery Hospital Services			
Diagnostic X-rays/Lab Tests	100%	90%	90% of reasonable and customary charges
Emergency Hospital Services	100%	90%	90% of charges
Prescription Drugs	100%	(Retail and Mail Order)	In Network Only
Chiropractic Care	100%	90% limited to $1,000 per person per plan year	70% of reasonable and customary charges limited to $1,000 per person per plan year

Charges incurred above reasonable and customary rates do not count towards the annual deductible (HRF + Bridge) for the Traditional Health Coverage. These charges may also increase your out-of-pocket costs.

Limits on services noted above are only for the Traditional Health Coverage component of the plan and are combined for both providers offering Lumenos discounts and for providers not offering discounts. These are not separate limits.

Medical Plan Choices continued—CIGNA Choice Fund

(100% coverage for eligible preventive benefits—not deducted from Preventative Care Benefit HRF) ♥

The CIGNA plan covers preventive services based on guidelines from the U.S. Preventive Services Task Force, the American Cancer Society, the Advisory Committee on Immunization Practices (ACIP), and the American Academy of Pediatrics. The Preventive Care Benefit includes screening tests, immunizations and counseling services designed to detect and treat medical conditions to prevent avoidable premature injury, illness and death. All discounted rates and Reasonable & Customary (R & C) charges will be paid by the plan at 100%, with no out-of-pocket responsibility for preventive services. Charges over R & C will be deducted from the HRA, if applicable, or be self-paid by the customer. None of these charges will apply toward the Out-of-Pocket Maximum. Services that fall outside of the Preventive Care Benefit and other services performed during a preventive office visit will be considered for coverage under your HRA and/or Traditional Health Coverage portion of your plan.

Well-Child Care (through age 18)

Well-baby and Well-child visits

- Periodic visits, depending on your age

Immunizations as appropriate by age, such as:
- Diphtheria, tetanus and acellular pertussis (DTAP)
- Haemophilus influenzae b (Hib)
- Hepatitis A & B
- HPV in girls and women ages 9 – 26
- Influenza
- Measles-mumps-rubella (MMR)
- Meningococcal (MCV4)
- Pneumococcal conjugate (PCV) (pneumonia)
- Poliovirus (IPV)
- Rotavirus
- Varicella (chickenpox)

Screenings (as appropriate by age)
- Blood pressure
- Cholesterol
- Hearing and vision
- Height and weight
- Hemoglobin or hematocrit
- Pap smear and pelvic exam, as appropriate by age

Adult Care (after age 18)

Well-man and Well-woman visits

- Periodic visits, depending on your age

Immunizations
- Hepatitis A and B (HBV), for those at risk
- HPV in girls and women ages 9 – 26
- Influenza: ages 19 to 49, as your doctor advises; ages 50+, annually
- Pneumonia: once for those ages 65+ (or younger for those with risk factors)
- Rubella (German Measles) for women of childbearing age if not immune
- Tetanus-diphtheria (Td) every 10 years (or TdaP, as indicated)
- Varicella (chicken pox: if no evidence of prior immunization or chickenpox
- Zoster: ages 60+

Screenings
- Chlamydia for sexually active females under age 25
- Mammogram once a year for women age 40+
- Osteoporosis screening for women ages 65+, 60 for women at high risk.
- Pap test once a year for women ages 19 – 64
- Prostate screening (PSA) once per year
- Colorectal cancer screenings ages 50+:
  Sigmoidoscopy once every 5 years
  Fecal occult blood test annually
  Colonoscopy once every 10 years
  Barium enema once every 5 years

For additional information on what is covered by your plan, review your Summary of Benefits.

CIGNA OAPIN—Open Access Plus In Network

Under the CIGNA OAPIN all services must be provided by one of the participating providers on CIGNA's list in order to be covered. Once the out-of-pocket maximum is reached, the plan pays 100% of coinsurance charges for the remainder of the plan year.

Summary of Benefits	*In-Network*
Calendar Year Deductible Individual Family Maximum	 None None
Calendar Year Out-of-Pocket Maximum Individual Family Maximum	 ★ $3,000 ★ $6,000
Coinsurance	CIGNA HealthCare pays 90% of eligible charges. You pay 10% of charges.
Precertification—Inpatient—PHS (required for all inpatient admissions)	Coordinated by your physician
Lifetime Maximum	Unlimited
Pre-existing Condition Limitation	No
Physician Services Primary Care Physician (PCP) Office Visit Specialty Care Physician Office Visit Consultant and Referral Physician Services*	 $25 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed. $35 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.
***Note: A copayment applies for OB/GYN visits. If your doctor is listed as a PCP in the provider directory, you will pay a PCP copayment. If your doctor is listed as a specialist, you will pay the specialist copayment.**	
Allergy Treatment/Injections—PCP or Specialist Physician	$25 copayment per office visit ($35 for specialist) or actual charge, whichever is less
Allergy Serum (dispensed by physician in office)	No charge
Second Opinion Consultations (provided on voluntary basis)	$25 copayment per office visit
Surgery Performed in the Physician's Office—PCP or Specialist Physician	$25/$35 copayment per office visit

Prescription Coverage for CIGNA OAPIN, OAP & CareFirst BCBS EPPO:

^ **Mandatory Generic:** Members who choose to purchase a brand name or non-preferred brand name drug when a generic equivalent is available, the member will pay the applicable copay plus the difference in cost between the generic and brand name or non-preferred brand name drug.

^^ **Mandatory Mail Order Drug:** For maintenance drugs, members must fill through CIGNA's Tel-Drug or Medco's Mail Order Program. Members are permitted to fill through the retail pharmacy three times. On the forth and subsequent fills through the retail pharmacy, the member will be forced to pay 100% of the retail cost.

^^ **Step Therapy:** Recommends a clinically valid lower cost drug alternative before dispensing a more expensive drug.

Important Note: See CIGNA OAPIN, OAP and CareFirst BCBS EPPO summary pages for further detail. Formularies for all prescription drug coverage plans are available on *www.MyMagellanBenefits.com* or *Magnet>MyMagellan>Benefits*.

Medical Plan Choices continued—CIGNA OAPIN

CIGNA OAPIN—Open Access Plus In-Network

Summary of Benefits	*In-Network*
Preventive Care ♥	
Routine Preventive Care for Children through age 2 (including routine immunizations)	$25 copayment per office visit; No charge after office visit. copay if only x-ray and/or lab services are performed and billed.
Immunizations	No charge, no plan deductible
Routine Preventive Care for Children and Adults from age 3 (including routine immunizations) Unlimited maximum per calendar year	$25 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.
Immunizations	No charge, no plan deductible
Mammograms, PSA, Pap Test ***Note:*** *Preventive care related services and diagnostic related services are paid at the same level of benefits as other x-ray and lab service, based on place of service.*	10% of charges if billed by independent diagnostic facility or outpatient hospital; $25 copayment per visit for associated wellness exam
Prescription Drugs^ Includes insulin, insulin needles & syringes, diabetic test strips/lancets, prenatal vitamins and certain prescription vitamins oral contraceptives and contraceptive devices, Lifestyle drugs, and certain specified injectables.	
CIGNA Pharmacy Retail Drug Program— Generic*** drugs on the Prescription Drug List for a 30-day supply	$15 copayment per prescription/refill
Brand Name*** drugs designated as preferred on the Prescription Drug List with no Generic equivalent for a 30-day supply	$30 copayment per prescription/refill
Brand Name*** drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List for a 30-day supply	$50 copayment per prescription/refill
CIGNA Tel-Drug Mail Order Drug Program Generic*** drugs on the Prescription Drug List for a 90-day supply Brand Name*** drugs designated as preferred on the Prescription Drug List with no Generic equivalent for a 90-day supply	$60 copayment per prescription/refill
Brand Name*** drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List for a 90-day supply	$100 copayment per prescription/refill
All new mail order requests require a prescription from your physician authorizing a 90-day supply It is easy to reorder your prescription refills online by visiting www.CIGNA.com. Please make sure you have a 7 – 10 day supply of medication on hand. ****Designated as per generally-accepted industry sources and adopted by CG*	
Inpatient Hospital Doctor's Visits/Consultations	10% of charges
Inpatient Hospital Professional Services	10% of charges

Medical Plan Choices continued—CIGNA OAPIN

CIGNA OAPIN—Open Access Plus In-Network

Summary of Benefits	*In-Network*
Outpatient Facility Services includes:	★$250 copayment per facility visit, plus 10% of charges
Operating Room, Recovery Room, Procedure Room and Treatment Room and Observation Room including: Diagnostic/Therapeutic Lab and X-rays Anesthesia and Inhalation Therapy	
Physician & Outpatient Professional Services	10% of charges
Note: Non-surgical treatment procedures are not subject to the facility copay.	
Laboratory and Radiology Services (includes preadmission testing)	
Physician's Office	$25 copayment per office visit
Outpatient Hospital Facility	10% of charges
Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit)	10% of charges
Independent X-Ray and/or Lab Facility	10% of charges
Independent X-Ray and/or Lab Facility (in conjunction with an Emergency Room visit)	10% of charges
Advanced Radiological Imaging (MRIs, MRAs, CAT Scans, PET Scans, etc.)	
Inpatient Facility	Same as inpatient hospital facility benefit
Outpatient Facility	10% of charges
Emergency Room (billed by facility as part of the Emergency Room visit)	10% of charges
Physician's Office	No charge
Short-Term Rehabilitative Therapy and Chiropractic Services—(includes physical, speech, occupational, chiropractic, pulmonary rehab & cognitive therapy) 60 days maximum per calendar year for all therapies combined	$25 copayment per office visit ($35 if specialist); No charge after office visit copay if only lab services are performed and billed.
Note: therapy sessions provided as part of Home Health Care accumulate to the Short-Term Rehab Therapy maximum.	
Outpatient Cardiac Rehabilitation—up to 36 days maximum per calendar year	$25 copayment per office visit ($35 if specialist)
Acupuncture Acupuncture services will be covered if rendered by a licensed provider and the services are for the following: • Chronic pain associated with the following conditions: arthritis, menstrual pain and irregularity, back pain, migraine, lumbago, pinched nerve, sciatica, post laminectomy, slipped disc, rheumatism, bell's palsy, spastic colon, bursitis, stroke, dysmenorrhea, tennis elbow, headaches, tendonitis, herpes zoster, and trigeminal neuralgia. • In lieu of traditional anesthesia • Nausea related to chemotherapy or pregnancy $1,000 maximum per calendar year	$25 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.

Medical Plan Choices continued—CIGNA OAPIN

CIGNA OAPIN—Open Access Plus In-Network

Summary of Benefits	*In-Network*
Emergency and Urgent Care Services Physician's Office—PCP or Specialist Physician	$25 copayment per office visit ($35 if specialist); No charge after office visit copay if only x-ray and/or lab services are performed and billed.
Hospital Emergency Room	★ $100 copayment per visit (copay waived if admitted) plus 10% of charges 10% of charges
Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician)	
Urgent Care Facility or Outpatient Facility	$25 copayment per visit (copay waived if admitted) plus 10% of charges
Ambulance	No charge
Maternity Care Services	$25 copayment for initial office visit ($35 if specialist); No charge after office visit copay if only x-ray and/or lab services are performed and billed.
Initial Office Visit to Confirm Pregnancy Note: A copayment applies for OB/GYN visits. If your doctor is listed as a PCP in the provider directory, you will pay a PCP copayment. If your doctor is listed as a specialist, you will pay the specialist copayment	
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (total maternity fee)	10% of charges
Office Visits not included in the total maternity fee performed by OB or Specialist Physician	$25 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services performed and billed.
Delivery—Facility (Inpatient Hospital/Birthing Center Charges)	★ $350 copayment per admission, plus 10% of charges
Inpatient Services at Other Health Care Facilities Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities. 120 days maximum per calendar year combined for all facilities listed	10% of charges
Home Health Services—Includes outpatient private duty nursing when approved as medically necessary. 120 days maximum per calendar year; 16 hour maximum per day.	10% of charges
Family Planning Services Office Visits (lab & radiology tests, counseling)	$25 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services performed and billed.
Vasectomy/Tubal Ligation (excludes reversals) Inpatient Facility Outpatient Facility Physician's Services—Inpatient or Outpatient Physician's Office	★ $350 copayment per admission, plus 10% of charges ★ $250 copayment per facility visit, plus 10% of charges 10% of charges $25 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services performed and billed.
Infertility Services ***Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.***	Not covered

Medical Plan Choices continued—CIGNA OAPIN

CIGNA OAPIN—Open Access Plus In-Network

Summary of Benefits	*In-Network*
TMJ—Surgical and Non-Surgical	Not covered
Bariatric Surgery— Treatment of clinically severe obesity, as defined by the body mass (BMI) is covered only at approved centers. Members must participate in and complete the Condition Care Management Obesity Program offered by Magellan Life Resources. The following are specifically excluded with this buy-up: • Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity. • Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.	Covered only after successful completion of the Condition Care Management Obesity Program offered by Magellan Life Resources.
Physician's Office	$25 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services performed and billed.
Inpatient Facility	★ $350 copayment per admission, plus 10% of charges
Outpatient Facility	★ $250 copayment per facility visit, plus 10% of charges
Physician's Services—Inpatient or Outpatient	10% of charges
Mental Health and Substance Abuse Treatment Services	Provided by Magellan Life Resources
Durable Medical Equipment ($3,500 maximum per calendar year)	10% of charges
External Prosthetic Appliances ($3,500 maximum per calendar year)	10% of charges

These Are Only the Highlights

As you can see, the plan is designed to combine in-depth coverage with cost-effective prices. This summary contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations including legislated benefits are contained in the Summary Plan Description or Insurance Certificate. This plan is insured and/or administered by Connecticut General Life Insurance Company, a CIGNA Company.

"CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.

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CIGNA OAP—Open Access Plus

As a participant in a Open Access Plus Plan you have the freedom to choose from a large network of preferred providers within the CIGNA network, or you may go to the provider of your choice. When you access providers within the network, your out-of-pocket costs are lower. Going outside the network will result in higher deductibles and coinsurance.

For claims or benefits questions, please contact CIGNA member services at: 1-800-CIGNA-24 or at *www.CIGNA.com*.

Benefit Information	*In-Network*	*Out-of-Network*
Calendar Year Deductible		
Individual	$250	$300
Family	$500	$600
Out-Of-Pocket Maximum	Excluding Plan Deductible	Excluding Plan Deductible
Individual	★$3,000	★$4,000
Family	★$6,000	★$8,000
Coinsurance	CIGNA HealthCare pays 80% of eligible charges. You pay 20% of charges after plan deductible.	CIGNA HealthCare pays 60% of eligible charges. You pay 40% of charges after plan deductible.
Precertification—Inpatient—PHS (required for all inpatient admissions)	Coordinated by your physician	Participant must obtain approval for inpatient admission; subject to penalty/reduction or denial for noncompliance
Lifetime Maximum	Unlimited	Unlimited
Pre-existing Condition Limitation	No	No

Medical Plan Choices continued—CIGNA OAP

CIGNA OAP—Open Access Plus		
Benefit Information	*In-Network*	*Out-of-Network*
Physician Services Primary Care Physician (PCP) Office Visit	$25 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.	40% of charges**
Specialty Physician Office Visit	$35 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.	40% of charges**
Consultant and Referral Physician Services ***Note: A copayment applies for OB/GYN visits. If your doctor is listed as a PCP in the provider directory, you will pay a PCP copayment. If your doctor is listed as a specialist, you will pay the specialist copayment.***		
Allergy Treatment/Injections— PCP or Specialty Physician	$25 copayment per office visit or actual charge, whichever is less	40% of charges**
Allergy Serum (dispensed by physician in office)	No charge	40% of charges**
Second Opinion Consultations (provided on voluntary basis)	$25 copayment per office visit	40% of charges**
Surgery Performed in the Physician's Office—PCP or Specialty Physician	$25 copayment per office visit	40% of charges**
Preventive Care ♥ Routine Preventive Care for Children through age 2 (including routine immunizations)	$25 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.	40% of charges**
Immunizations	No charge, no plan deductible	40% of charges**
Routine Preventive Care for Children and Adults from age 3 (including routine immunizations) Unlimited maximum per calendar year	$25 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.	40% of charges**
Immunizations	No charge, no plan deductible	40% of charges**
Mammograms, PSA, Pap Test ***Note: Preventive care related services and same level of benefits as other x-ray and lab services, based on place of service.***	20% of charges* if billed by independent diagnostic facility or diagnostic related services are paid at the outpatient hospital; $25 copayment per visit for associated wellness exam	
Prescription Drugs^ Includes insulin, insulin needles & syringes, diabetic test strips/lancets, prenatal vitamins and certain prescription vitamins oral contraceptives and contraceptive devices, Lifestyle drugs, and certain specified injectables.		
CIGNA Pharmacy Retail Drug Program— Generic*** drugs on the Prescription Drug List for a 30-day supply	$15 copayment per prescription/refill	Covered in-network only

Medical Plan Choices continued—CIGNA OAP

CIGNA OAP—Open Access Plus

Benefit Information	*In-Network*	*Out-of-Network*
Brand Name*** drugs designated as preferred on the Prescription Drug List with no Generic equivalent for a 30-day supply	$30 copayment per prescription/refill	Covered in-network only
Brand Name*** drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List for a 30-day supply	$50 copayment per prescription/refill	Covered in-network only
CIGNA Tel-Drug Mail Order Drug Program Generic*** drugs on the Prescription Drug List for a 90-day supply	$30 copayment per prescription/refill	Covered in-network only
Brand Name*** drugs designated as preferred on the Prescription Drug List with no Generic equivalent for a 90-day supply	$60 copayment per prescription/refill	Covered in-network only
Brand Name*** drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List for a 90-day supply	$100 copayment per prescription/refill	Covered in-network only
All new mail order requests require a prescription from your physician authorizing a 90-day supply It is easy to reorder your prescription refills online by visiting www.CIGNA.com. Please make sure you have a 7 – 10 day supply of medication on hand. ****Designated as per generally-accepted industry sources and adopted by CG*		
Inpatient Hospital Services including: Semi-Private Room and Board Diagnostic/Therapeutic Lab and X-ray Drugs and Medication Operating and Recovery Room Radiation Therapy and Chemotherapy Anesthesia and Inhalation Therapy	20% of charges*	$250 deductible per admission, plus 40% of charges* Precertification required
Inpatient Hospital Doctor's Visits/Consultations	20% of charges*	40% of charges**
Inpatient Hospital Professional Services	20% of charges*	40% of charges**
Outpatient Facility Services includes: Operating Room, Recovery Room, Procedure Room and Treatment Room and Observation Room including: Diagnostic/Therapeutic Lab and X-rays Anesthesia and Inhalation Therapy	20% of charges*	$250 deductible per facility visit, plus 40% of charges**
Physician & Outpatient Professional Services ***Note: Non-surgical treatment procedures are not subject to the facility copay.***	20% of charges*	40% of charges**

Medical Plan Choices continued—CIGNA OAP

CIGNA OAP—Open Access Plus

Benefit Information	*In-Network*	*Out-of-Network*
Laboratory and Radiology Services (includes preadmission testing)		
Physician's Office	$25 copayment per office visit	40% of charges**
Outpatient Hospital Facility	20% of charges*	40% of charges**
Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit)	20% of charges no plan deductible	20% of charges no plan deductible; if not a true emergency, then 40% of charges**
Independent X-Ray and/or Lab Facility	20% of charges*	40% of charges**
Independent X-Ray and/or Lab Facility (in conjunction with an Emergency Room visit)	20% of charges no plan deductible	20% of charges no plan deductible
Advanced Radiological Imaging (MRIs, MRAs, CAT Scans, PET Scans, etc.)		
Inpatient Facility	Same as inpatient hospital facility benefit	Same as inpatient hospital facility benefit
Outpatient Facility	20% of charges*	40% of charges**
Emergency Room (billed by facility as part of the Emergency Room visit)	20% of charges no plan deductible	20% of charges no plan deductible; except if not a true emergency, 40% of charges**
Physician's Office	No charge	40% of charges**
Short-Term Rehabilitative Therapy and Chiropractic Services—(includes physical, speech, occupational, chiropractic, pulmonary rehab & cognitive therapy) 60 days maximum per calendar year# for all therapies combined ***Note: therapy sessions provided as part of Home Health Care accumulate to the Short-Term Rehab Therapy maximum.***	$25 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.	40% of charges**
Outpatient Cardiac Rehabilitation—up to 36 days maximum per calendar year#	$25 copayment per office visit	40% of charges**
Acupuncture Acupuncture services will be covered if rendered by a licensed provider and the services are for the following: • Chronic pain associated with the following conditions: arthritis, menstrual pain and irregularity, back pain, migraine, lumbago, pinched nerve, sciatica, post laminectomy, slipped disc, rheumatism, bell's palsy, spastic colon, bursitis, stroke, dysmenorrhea, tennis elbow, headaches, tendonitis, herpes zoster, and trigeminal neuralgia. • In lieu of traditional anesthesia • Nausea related to chemotherapy or pregnancy $1,000 maximum per calendar year#	$25 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed.	40% of charges**

Medical Plan Choices continued—CIGNA OAP

CIGNA OAP—Open Access Plus

Benefit Information	*In-Network*	*Out-of-Network*
Emergency and Urgent Care Services Physician's Office—PCP or Specialty Physician Hospital Emergency Room Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician) Urgent Care Facility or Outpatient Facility Ambulance	$25 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed. ★ $100 copayment per visit (copay waived if admitted) plus 20% of charges, no plan deductible 20% of charges no plan deductible $25 copayment per visit (copay waived if admitted) plus 20% of charges, no plan deductible No charge, no plan deductible	Care will be provided at in-network levels if it meets the "prudent layperson" definition of an emergency. Otherwise 40% of charges**
Maternity Care Services Initial Office Visit to Confirm Pregnancy ***Note: A copayment applies for OB/GYN visits. If your doctor is listed as a PCP in the provider directory, you will pay a PCP copayment. If your doctor is listed as a specialist, you will pay the specialist copayment.*** All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (total maternity fee) Office Visits not included in the total maternity fee performed by OB or Specialty Physician Delivery—Facility (Inpatient Hospital/ Birthing Center Charges)	$25 copayment for initial office visit; No charge after office visit copay if only x-ray and/or lab services are performed and billed. 20% of charges* $25 copayment per office visit ($35 if specialist); No charge after office visit copay if only x-ray and/or lab services performed and billed. 20% of charges*	40% of charges** 40% of charges** 40% of charges** $250 deductible per admission, plus 40% of charges*, precertification required
Inpatient Services at Other Health Care Facilities Skilled Nursing, Rehabilitation Hospital and Sub-Acute Facilities *120 days maximum per calendar year# combined for all facilities listed*	20% of charges*	40% of charges**
Home Health Services—Includes outpatient private duty nursing when approved as medically necessary *120 days maximum per calendar year#; 16 hour maximum per day#*	20% of charges*	40% of charges**
Office Visits *(lab & radiology tests, counseling)* Vasectomy/Tubal Ligation *(excludes reversals)* Inpatient Facility Outpatient Facility Physician's Services—Inpatient or Outpatient Physician's Office	$25 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services performed and billed. 20% of charges* 20% of charges* 20% of charges* 20% of charges* $25 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services performed and billed.	40% of charges** $250 deductible per admission, plus 40% of charges*, precertification required $250 deductible per facility visit, plus 40% of charges** 40% of charges** 40% of charges**

Medical Plan Choices continued—CIGNA OAP

CIGNA OAP—Open Access Plus		
Benefit Information	*In-Network*	*Out-of-Network*
Infertility Services ***Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.***	Not covered	Not covered
TMJ—Surgical and Non-Surgical	Not covered	Not covered
Bariatric Surgery— Treatment of clinically severe obesity, as defined by the body mass index (BMI) is covered only at approved centers. Members must participate in and complete the Condition Care Management Obesity Program offered by Magellan Life Resources. The following are specifically excluded with this buy-up: • Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity. • Weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision.	Covered only after successful completion of the Condition Care Management Obesity Program offered by Magellan Life Resources.	Covered only after successful completion of the Condition Care Management Obesity Program offered by Magellan Life Resources.
Physician's Office	$25 copayment per office visit; No charge after office visit copay if only x-ray and/or lab services performed and billed.	40% of charges**
Mental Health and Substance Abuse Treatment Services	Provided by Magellan Life Resources	
Durable Medical Equipment $3,500 maximum per calendar year#	20% of charges*	40% of charges**
External Prosthetic Appliances $3,500 maximum per calendar year#	20% of charges*	40% of charges**

Footnotes:

* Services are subject to calendar year deductible.
** Services are subject to calendar year deductible and reasonable and customary charge/maximum reimbursable charge limitations.

CareFirst BCBS Exclusive Preferred Provider Organization (EPPO)—

90% In-Network / 0% Out-of-Network

The BCBS Exclusive Preferred Provider Organization (EPPO) is strictly an in-network benefit option available to employees in all states. As a participant of the EPPO you have the freedom to choose from a large network of preferred providers and any participating acute-care hospitals each time care is needed. **There are no "gatekeepers" with the EPPO plan.** In addition to the benefits, cost savings and flexible plan design there are no deductibles and your provider will submit claims on your behalf. You are only responsible for your copayment and co-insurance at the time of service. **Any care provided by a non-preferred provider will not be covered.**

For claims or benefits questions, please contact BCBS member services at: 1-800-628-8548 or at *www.BlueCares.com* or refer to your identification card for your local customer service number.

Summary of Benefits	*In-Network*
Calendar Year Deductible	
Individual	None
Family Maximum	None
Out-of-Pocket Maximum	
Individual	★ $3,000
Family Maximum	★ $6,000
Lifetime Maximum	Unlimited
Physician Office Visits	$25 copayment per visit, $35 specialist, then 100%
Inpatient Hospital	★ $350 copayment, then 90%
Outpatient Hospital	★ $250 copayment, then 90%
Surgery	
Inpatient	★ $350 copayment, then 90%
Outpatient	★ $250 copayment, then 90%
Diagnostic, X-ray and Lab	90%
Preventive Outpatient Diagnostic, Not limited to: ♥	
Mammograms	$25 copayment per visit, then 90%
Prostate Cancer Screening	$25 copayment per visit, then 90%
Osteoporosis Prevention	$25 copayment per visit, then 90%
Emergency Room (copayment waived if admitted)	★ $100 copayment, then 90%
Maternity Care	
Includes Pre and Post Natal	90%
Preventive Care ♥	
Adult Physical	$25 copayment per visit, then 100%
Routine GYN	$25 copayment per visit, then 100%
Well Child	$25 copayment per visit, then 100%

Medical Plan Choices continued—CareFirst BCBS EPPO

Medco Prescription Drug Coverage for BCBS EPPO

If you are enrolled in the BCBS CareFirst EPPO, your Pharmacy Benefits Manager is Medco.

Medco Health's customer service number is 1-800-711-0917 and the web address is *www.MedcoHealth.com*.

Network Retail Pharmacy—30 Day Supply

$15 COPAY—Generic drugs contain the same active ingredient as their brand-name equivalent in the same dose. Generics can only differ from the brand-name product by their inactive ingredients, i.e. binders, fillers or dyes. Please ask the physician to allow generic substitution whenever possible.

$30 COPAY—Preferred Brand Name drugs are drugs that the P&T committee have found to be as effective as non-preferred brand name drugs while more cost effective. Medco Health can provide you with the list of drugs that are considered Preferred or refer to the preferred drug list in the formularies on at *www.MyMagellanBenefits.com*. The formularies are also on *MagNet > MyMagellan > Benefits* and on the web sites for Medco Health (*www.MedcoHealth.com*)

$50 COPAY—Non-Preferred Brand Name drugs are those drugs which the P&T committees has determined to have a more cost-effective alternative or may not be clinically necessary.

100% COPAY—Non-Covered Pharmaceuticals are any prescription items that you and your physician feel are appropriate and/or necessary even if not covered by the Plan. While paying 100% of the cost, you will benefit from the discounts that our pharmacy managers have negotiated for your Magellan pharmacy benefit. Discounts range from 15% to 30%.

Mandatory Mail Order—90 Day Supply

If you are currently taking a maintenance prescription, you must use the Medco Health or CIGNA and receive, at your home, up to a 90-day supply of covered medications for: $30 Generic, $60 Preferred Brand, $100 Non-Preferred Brand, 100% Copay (of discounted price) for Non-Covered Pharmaceuticals. If you are a first time user please remember to obtain a new prescription from your physician authorizing a 90-day supply for all Mail Service orders.

It is easy to reorder your prescription refills online by visiting *www.MedcoHealth.com*. Please make sure you have 7 – 10 days of medication on hand.

CareFirst BlueCross BlueShield EPPO Benefits Travel with You

You can take comfort in knowing that no matter where you are, your BlueCross BlueShield (BCBS) Preferred Provider benefits will travel with you because of the Blue Card Program.

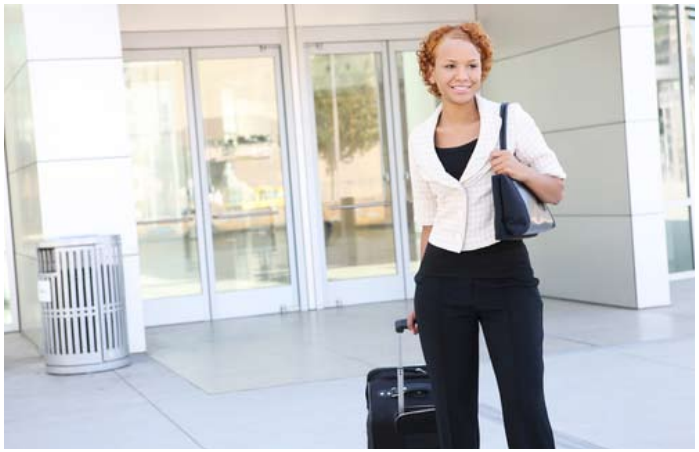
With the Blue Card EPPO Program, you will have plenty of participating providers from which to choose should you experience a medical problem while away from home. By calling the Blue Card EPPO Doctor and Hospital Information Line at 1-800-810-BLUE (2583), BlueCross BlueShield makes it fast and easy for you to find the nearest provider. You will be responsible for obtaining pre-certification/prior authorization from BlueCross BlueShield in order to ensure that you receive the maximum allowed benefits.

When you visit a EPPO doctor or hospital, you will not have any claim forms to complete. You will be identified by your BlueCross BlueShield membership ID card with the "PPO in a suitcase" logo. Participating providers will recognize this symbol and identify you as a BlueCross BlueShield EPPO member. As long as you receive pre-certification/prior authorization from BlueCross BlueShield and present your EPPO membership card, you will not be balance billed for any amount above the approved payment allowance (i.e. the doctors have agreed to accept payment in full). Your responsibility will only be for your copayments, co-insurance or deductibles (if applicable).

Here's how the program works:

If you are outside of your BlueCross BlueShield service area and need medical attention.

1. You call 1-800-810-BLUE (2583) for information on the closest EPPO provider.
2. You obtain pre-certification/prior authorization from BlueCross BlueShield.
   (As always, in case of emergency, you should seek immediate care from the closest health care provider.)
3. The provider verifies your Blue Card EPPO membership eligibility and coverage and submits your claim to his/her local BlueCross BlueShield plan for processing.
4. BlueCross BlueShield processes the claim and approves payment.
5. The BlueCross BlueShield plan, in the state where care was rendered, sends a check to the provider and BlueCross BlueShield sends an Explanation of Benefits report to you



Your Blue Cross Blue Shield EPPO Identification Card

In addition to the "PPO in the suitcase" logo on the front of your card, your card also has another unique feature; **a three letter prefix to your identification number.** No matter where you are in the country, when you present your BCBS EPPO card, these three letters identify you as a covered member of the Magellan Health Services Plan. Whenever you are asked for your identification number, remember to include these three letters. This not only identifies you as a covered member of Magellan Health Services, but will also expedite the processing of your claims.

For claims or benefits questions, please contact BCBS member services at 1-800-628-8548 or at *www.BlueCares.com*.

Magellan's Enhanced Care Management Programs

These Programs Include:

Utilization Management

This program includes hospital pre-certification, concurrent review and discharge planning to ensure that the patient receives quality care in the most appropriate setting.

Case Management

Sometimes, patients need extended care and follow-up that goes beyond the standard inpatient and outpatient utilization management program. This program offers individualized case management beginning when the patient is hospitalized and continuing on after discharge. The Care Manager becomes part of the team that includes the patient, provider and family. Together, they work to improve the patient's health by delivering quality health care services in a cost-effective manner.

Disease Management

This voluntary program reaches out to members at risk for certain chronic conditions, including:

- Diabetes
- Asthma
- Chronic heart failure
- Coronary artery disease
- Low back pain

The Disease Management program coordinates education, counseling, patient self-care, and physician support to help our patients manage their conditions. By identifying and managing the condition early, you can avoid complications and improve your quality of life. Once patients are identified and they elect to participate in the program, patients receive educational materials, counseling on topics pertinent to their condition and, in some cases, individualized case management, with an emphasis on lifestyle changes. Periodic follow-up calls are made to the patient (frequency dependent upon severity of condition) to support the ongoing educational process and compliance with the physician's plan of care.

☑ *Maternity Management*

This voluntary program provides women with services, information and resources to help improve pregnancy outcomes. Members are asked to notify Future Health (for CareFirst BlueCross Blue Shield medical plans) or CIGNA during their first trimester of pregnancy. Once enrolled in the program, the Mom-to-be will be contacted by a maternity care manager, who will complete a prenatal risk assessment and offer information and educational materials, as well as advice and guidance throughout her pregnancy. By applying early interventions, the Maternity Management program is able to identify high-risk pregnancies, help expectant mothers deliver a happy, healthy baby as well as reduce the costs associated with maternity and obstetrical care.

These programs are administered by:

Medical Plan	*Who to Call*	*Telephone Number*
CareFirst BlueCross Blue Shield	Future Health	1-877-232-0990
CIGNA Choice Health Plan	CIGNA	1-800-CIGNA24

♥ If you or a family member are enrolled in one of our medical plans and suffer from a chronic illness or sudden accident and requires hospitalization or on going medical treatment, our Enhanced Care Management Programs can help you better manage your care in a cost-effective manner, saving you out of pocket costs.

Dental Plan Choices—CIGNA PPO

CIGNA Preferred Provider Organization (PPO) Dental Plan

A PPO dental plan is flexible so you can use the provider of your choice. Your dentist does not need to be "participating" with CIGNA in order for you or any covered members in your family to receive benefits. However, you will receive a greater benefit by seeing an in-network CIGNA PPO Dentist. For out-of-network benefits, the plan reimburses based on "reasonable and customary" charges for dental services that you receive. The reasonable and customary charge is determined by CIGNA based on the average fee charged by most providers in your area. If your out-of-network provider charges more than the reasonable and customary charges, you are responsible for any difference, in addition to any copayment or deductible that may apply.

Summary of Benefits	*In-Network*	*Out-of-Network**
Calendar Year Maximum (*Applies to Classes I, II, III*)	★ $2,000 per person	$1,250 per person
Calendar Year Deductible *(Applies to Classes II, III, only)*		
Individual	$50 per person	$50 per person
Family	$150 max per family	$150 max per family
Class I: Preventive & Diagnostic Care	100% no deductible	100% of R&C no deductible
Oral Exams *(2 per calendar year)*		
Cleanings *(2 per calendar year)*		
Bitewing X-ray *(2 per calendar year)*		
Space Maintainers		
Full Mouth X-rays *(1 complete set every three calendar years)*		
Fluoride Application *(1 per calendar year for persons under 19 years old)*		

CIGNA offers two plans from which to choose: The Dental PPO Plan and the Dental DHMO Plan. Please review each plan and select the one that is right for you.

"A great reason to smile!" ♥

The best way to maintain your oral health is through a sound program of regular dental care. Benefits are available for preventive care as well as diagnostic services, so that minor problems don't become major. Receiving the appropriate dental care is especially important for maintaining healthy teeth and gums.

Dental Plan Choices—CIGNA PPO continued

Summary of Benefits	*In-Network*	*Out-of-Network**
Class II: Basic Restorative Care Fillings Osseous Surgery Root Canal Therapy/Periapical X-rays Periodontal Scaling & Root Planing Denture Adjustment & Repair Simple Extractions for Oral Surgery Oral Surgery *(partial bony impaction)* Anesthesia	80% after deductible	60% of R&C after deductible
Class III: Major Restorative Care Crowns Bridges Dentures	50% after deductible	30% of R&C after deductible
Class IV: Orthodontia Lifetime Maximum Child	50% no deductible $1,000 per person	30% of R&C , no deductible $750 per person
Missing Tooth Provision	The amount payable at 50% of amount otherwise payable, until person is insured for 24 months.	
Pretreatment Review	Recommended when dental work, including orthodontia, in excess of $500 is proposed.	

Please Note: The Texas summary of benefits may vary slightly. Please refer to the CIGNA Dental Benefit Summary on *MagNet > MyMagellan > Benefits* or *www.MyMagellanBenefits.com*.

Please Note: If you need to see a dental Specialist and there is no Specialist available in-network in your area, then you will be required to pay the out-of-network rate.

*All out-of-network benefits are subject to Reasonable and Customary (R&C) charges.

Dental Plan Choices—CIGNA DHMO

CIGNA's DHMO Plan operates very much like an HMO. When you enroll in the plan, you must choose a Primary Care Dentist (PCD) from the directory of participating dentists. Typically, the plan pays for all or a portion of the charges for your dental care. The plan payment will vary depending upon the type of service being rendered. Payment for care rendered outside the DMO and not approved by the plan is your responsibility. Like an HMO, preventive care is also encouraged. When you enroll, you must select a Primary Care Dentist for each family member. Please refer to the chart below for a brief overview of member copayments for selected services with a participating provider. Before you choose the DHMO, make sure there are dentists in your area network accepting new patients.

If you are choosing the CIGNA DMO, you must select a Primary Care Dentist. You and your family can change your Primary Care Dentist as often as once a month. Just call the Member Services number on your ID card by the 15th of any month, and the change will be effective the first day of the following month. Referrals are required from your Primary Care dentist to a specialist including but not limited to Endodontists, Periodontists and Oral Surgeons.

How to Select a Primary Care Dentist:

1. Visit DocFind at *www.CIGNA.com* to locate participating dentists.
2. Contact the dental office to verify that they are accepting new patients.
3. If you are enrolling in the DHMO for the first time, identify your Primary Care Dentists and ID number through the on-line 2008 benefits enrollment process. If you do not do this it could take as long as 3 or 4 months to get an appointment.
4. If you are currently enrolled in the DHMO and you want to change your primary care dentist please contact CIGNA.

Some Examples of Care:

Typical Adult Annual Cost	*With CIGNA Dental Care* ★
Two periodic exams	$ 0
Four bitewing x-rays	$ 0
Periodontal scaling and root planing, one to three teeth, per quadrant	$ 35
Two routine cleanings	$ 0
One resin/composite 1-surface filling (anterior)	$ 0
Anterior root canal	$ 175
Porcelain/Ceramic crown	$ 465
Subtotal	$ 675
Typical Child Annual Cost	*With CIGNA Dental Care* ★
Two periodic exams	$ 0
Two bitewing x-rays	$ 0
Two routine cleanings	$ 0
Two fluoride treatments	$ 0
Single extraction	$ 10
Orthodontic evaluation, treatment plan, and records	$ 215
Banding for Comprehensive Orthodontic Treatment*	$ 425
12 months Comprehensive Orthodontic Treatment, child*	$ 850
Subtotal	$1,500
Grand Total	**$2,175**

Orthodontia Benefits for PPO and DMO

- If you or your dependents are currently undergoing orthodontic treatments prior to your employment with Magellan or if your treatment has not been covered by a Magellan-sponsored dental plan, then your treatment will not be eligible for continued coverage.

For claims or benefits questions, please contact CIGNA Dental member services at: 1-800-CIGNA-24 or at *www.CIGNA.com*

* Orthodontic treatment is limited to a maximum benefit of 24 months. Additional charges apply for retention and/or interceptive orthodontic treatment. Patient charges listed are not applicable to orthodontics in progress. With CIGNA Dental Care, you'll know exactly what you pay—even for specialty care with a referral approved for payment.

Healthy Gums May Lead to a Healthier You!

Did you know that your oral health could be an indicator of your overall health?

Regular visits to the dentist may do more than brighten your smile. Research has linked periodontal (gum) disease to complications for heart disease, stroke, diabetes, preterm birth and other health issues. Healthy gums support healthy teeth. Follow the suggestions provided to help prevent gum disease. And if you are diagnosed with gum disease, it's important to complete the periodontal treatment plan recommended by your dentist.

Healthy Gums May Mean a Healthier Heart

People with advanced gum disease may be more likely to have heart disease than those with healthy gums.[1] Bacteria and their byproducts from the gum tissues may enter the blood stream, causing small blood clots that may contribute to the clogging of arteries. Clots in the coronary arteries can lead to heart attacks. A blood clot in the brain can cause a stroke. Bottom line: care for your gums, and they may help guard your heart!

Healthy Gums May Help Control Blood Sugar

Those with diabetes may have more complications with gum disease. Why? As a general rule, diabetics have a tougher time healing. And research shows they suffer greater tooth loss than patients without diabetes. One study[2] found that when diabetic patients gum infections were treated, they found it easier to manage their blood sugar. Good dental health may be linked to a reduced risk of diabetic complications!

Healthy Gums May Help Reduce the Risk of Pre-term Birth

Mom's gum disease may increase the probability of a pre-term birth. Pregnant women with chronic periodontal (gum) disease during the second trimester are up to seven times more likely to give birth prematurely.[3,4] It's recommended that pregnant women should focus on brushing and flossing and getting regular dental check ups. This possible link between gum disease and preterm birth is another reason to protect your dental health!

Prevention is Powerful!

The American Dental Association (ADA) suggests the following behaviors to help prevent gum disease.[5]

- Brush your teeth twice a day with a softbristle toothbrush
- Floss daily
- Eat a healthy diet and limit snacks between meals
- See your dentist regularly

Gum disease may be painless, but symptoms can appear, such as:

- Tender, swollen or bleeding gums when you brush your teeth
- Dark red or receding gums
- Bad breath or a bad taste in your mouth
- Loose teeth

Gum disease is treatable. Be sure to visit your dentist on a regular basis.

For more information, visit us on the web at *www.CIGNA.com*
1.800.CIGNA24

1 American Academy of Periodontology (www.perio.org), Feb. 2002.
2 Journal of the American Dental Association, Oct. 2003.
3 American Dental Association News Releases, Sept. 2001.
4 Journal of the American Dental Association, July 2001 "Oral Health During Pregnancy: An Analysis of Information."
5 American Dental Association Frequently Asked Questions.

"CIGNA Dental" refers to the following operating subsidiaries of CIGNA Corporation: Connecticut General Life Insurance Company, and CIGNA Dental Health, Inc. and its operating subsidiaries and affiliates. This document is provided by CIGNA solely for informational purposes to promote consumer health. It does not constitute medical advice and is not intended to be a substitute for proper dental care provided by a dentist. CIGNA assumes no responsibility for any circumstances arising out of the use, misuse, interpretation or application of any information supplied in this document. Always consult with your doctor for appropriate examinations, treatment, testing, and care recommendations. Healthy Gums / Healthier You 03/07 ©2007 CIGNA

Vision Care

Vision Care Program/Vision Service Plan (VSP)

Vision care is necessary to maintain good health. Periodic eye exams not only determine the need for corrective eye wear, but also detect the presence of general health problems in their earliest stages. Through Vision Service Plan (VSP), you and your covered family members are entitled to a wide range of professional vision care benefits and services from participating providers.

Vision Coverage is provided by Vision Service Plan (VSP). VSP has a nationwide network of providers that provide you with affordable eye care. VSP also provides benefits for non-network providers; however, because of negotiated discounts you will receive a greater benefit by using network providers.

For claims or benefits questions, please contact VSP member services at: 1-800-877-7195 or at *www.VSP.com*.

How Vision Service Plan Works

1. When you want to use Vision Service Plan (VSP), and you need to locate a VSP participating doctor, call VSP at 1-800-877-7195 or visit *www.VSP.com*. You will not receive benefit cards for vision coverage.
2. Call a VSP participating doctor to make an appointment. Make sure you identify yourself as a VSP member.
3. The VSP participating doctor will contact Vision Service Plan to verify your eligibility and plan coverage. The VSP participating doctor will also obtain authorization so you can receive an eye examination and corrective eyewear, if necessary. **If you are not currently eligible for services, the VSP participating doctor will notify you of this.**
4. During your eye examination, the VSP participating doctor will determine if eyewear is necessary. If so, the VSP participating doctor will coordinate your prescription with a VSP laboratory and dispense your eyewear.
5. Although more than 90 percent of VSP patients receive services from participating doctors, VSP will reimburse you for services received from any licensed optometrist, ophthalmologist, or optician. If you receive services from a non-participating provider, you are responsible for paying the provider in full, and submitting itemized receipts to VSP for reimbursement. It is important to note that your reimbursement schedule does not guarantee full payment, and VSP cannot guarantee your satisfaction when services are received from a non-participating provider.

Please refer to page 39 of this guide for benefit summary.

Summary of Vision Care Benefits

Benefits	*In-Network VSP Providers*	*Non-Network Providers Max Allowable Reimbursement*	*Limitations (In or out of network)*
Vision Exam	100% after $20 copayment	Up to $43	Once every 12 months
Lenses	100% after $20 copayment	Lenses: Single Vision up to $35 Bifocal Lenses up to $55 Trifocal Lenses up to $68 Lenticular Lenses up to $80	Lenses: once every 12 months Frames: once every 12 months
Frames	100% up to $120	Frames up to $45	Frames: once every 12 months
Contact Lenses (in lieu of frames and lenses) Materials, Evaluation Fee and Fitting Costs	100% up to $120 In-network providers offer an additional 15% discount on professional fees	Up to $105	Once every 12 months
"Necessary" Contact Lenses as determined by VSP	100% after $20 copay	Up to $210	Once every 12 months

Limitations and restrictions apply.

Flexible Spending Accounts (FSA)

Flexible Spending Accounts/Benefit Concepts

☑ There are three different types of Flexible Spending Accounts (FSAs). One pays for eligible Health Care expenses; the second pays for eligible Dependent Care expenses and the third pays for eligible commuting expenses. You can choose to participate in one or all of these accounts.

These plans offer you a unique way to save money on qualified health care, dependent care expenses for you and your dependents and your commuting expenses. **Expenses incurred by a dependent Domestic Partner are not eligible for reimbursement.** ⚠

You fund the accounts via a payroll deduction each pay period. Money which you contribute to your FSA is not subject to social security taxes, federal and, in most cases, state income taxes. This lowers the taxes you pay and gives you more spendable income.

Review your expenses for health and dependent care, and you will probably find ways to make the FSAs work for you. You should remember, however, that money paid into your Health Care FSA cannot be used for Dependent Care expenses or vice versa.

Estimate Your Savings

Here is an example of a FSA participant with $3,000 of eligible expenses. The chart shows that the participant would have over $700 of additional salary to take home by using the Flexible Spending Account.

Tax Savings Using the Flexible Spending Accounts

In Network	*Traditional Employee*	*FSA Participant*
Gross Pay	$25,000	$25,000
Voluntary Salary Reduction	0	-3,000
Taxable Income	25,000	22,000
Taxes*	-6,413	-5,643
Income after Taxes	18,587	16,357
Dependent Care Expenses	-3,000	-3,000
Available Income Before Reimbursement	15,587	13,357
Tax-Free Reimbursement	0	3,000
Available Income	$15,587	$16,357

The flexible Spending Account participant has a tax savings and has increased his or her take-home salary by $770.

*Assumes federal withholding equals 15%, state withholding equals 20% of federal, and social security withholding equals 7.65%.

The FSA election you make during open enrollment will be effective for the January 1 – December 31, 2009 plan year. The coverage period for newly hired employees who elect an FSA when first eligible but after January 1st will be from the effective date of the coverage period through the end of the calendar year. You should carefully consider your election amount.

BENEFIT CONCEPTS

Our FSA vendor is Benefit Concepts. You can check balances, submit claims (and upload your scanned receipts) and manage your accounts online at *www.AvantServe.com*. Be sure to access a full listing of eligible and ineligible expenses while you are logged in.

For assistance, call 1-800-969-2009 from 8:30 AM to 9:30 PM Eastern Time.

Flexible Spending Accounts (FSA)—Benefit Summary

	Health Care	*Dependent Care*	*Mass Transit*	*Parking*
Maximum Contributions	$5,000 annually	$5,000 annually ($2,500 if married and filing separately)	$120 a month or $1,440 a year	$230 a month or $2760 a year
Use of Account	• To pay (with pretax money) for health-related expenses that are not covered or partially covered by your health plan, including expenses for your spouse or children not enrolled in your medical, dental or vision plans • To pay for over-the-counter medications that will be used to treat an existing or imminent condition • Benny Card is available for healthcare FSA's (additional information on page 42)	• To pay for care (inside or outside your home) provided for your children under the age 13 for whom you have custody, • To pay for care for a physically or mentally handicapped spouse, elderly parent or dependent who is incapable of self-care • Dependent care provided so that you can work	• TransitCheck QuickPay Card (a Visa debit card) to use your pretax and post tax deductions to pay for mass transit. • TransitCheck Vouchers mailed to your home to assist you in purchasing transit passes or tickets and to pay for eligible vanpool expenses.	• TransitCheck QuickPay Card (a Visa debit card) to use your pretax and post tax deductions to pay for parking.
Samples of Eligible Expenses	• Copayments • Deductibles • Dental fees • Eyeglasses, exam fees, contact lenses and solution, Lasik surgery • Orthodontia • Certain Over-the-Counter medications	• Services provided by a licensed day care facility • Babysitting services while you work • Practical nursing care • After school care • Preschool	• Bus Fare • Ferry Service Fees • Train/Subway Fare	• Commuter Parking Fees
What's Not Covered	• Premiums for medical, dental or vision plans • Items not eligible for health care tax exemptions by IRS (e.g. cosmetic surgery) • Long-term Care expenses	• Private school tuition including kindergarten • Overnight camp expenses • Babysitting when you are not working • Transportation and other separately billed services • Residential nursing home care		
Restrictions/Other Information	• See separate Magellan Sample Eligible/Ineligible Expenses and Over-the-Counter Medication Listing for additional information • Also see IRS Publication 502 for specific details on what expenses are allowed • Your election amount may be increased if you experience a Qualified Status Change	• See IRS Publication 503 for specific details on what expenses are allowed • You may not use the account to pay your spouse, your child who is under age 18 or a person whom you could claim as a dependent for tax purposes • If you are married, your spouse must work full or part-time, looking for employment, must be a full-time student for at least 5 months of the year, or must be disabled • Your election may be changed if you experience a qualified Status Change	• For transit operators that do not accept the TransitChek QuickPay Card, TransitChek Cashback Service is available to you through our specialized unit designed to expedite monthly reimbursements. • You may enroll and disenroll at any time	• For parking locations that do not accept the TransitChek QuickPay Card, TransitChek Cashback Service is available to you through our specialized unit designed to expedite monthly reimbursements. • You may enroll and disenroll at any time
IMPORTANT NOTE:	**This is a "use it or lose it" plan. Any unused dollars in your account at the end of the plan year will be forfeited. You will have until March 31, 2010 to submit your 2009 plan year claims for reimbursement.**			

FSA continued

"Benny" card for Health Care FSA Only

If you enroll in a healthcare flexible spending account, you can choose to access your money using your "Benny" card. The "Benny" card works like a debit card to pay for eligible expenses without using cash or submitting claims and waiting for reimbursements.

Here is how it works:

- When you enroll in a HealthCare FSA, you will receive the "Benny" card at your home address.
- Read the disclosure and sign the card.
- Use the card to pay for qualified unreimbursed medical expenses, and qualified over-the-counter medicines at locations that accept Mastercard.
- The card will not work at locations that do not accept Mastercard and you cannot get a cash advance. (There is no pin number associated with the card).
- Save all your receipts: the IRS requires collection of receipts for all card purchases that are not equal to your copayments.
- Attach the receipts from purchases that do not equal copayments and send to Benefit Concepts, our FSA vendor.

You can even use your "Benny" card for your mail order prescriptions. Simply enter your card number online or on the form.

Tax Credit vs. Flexible Spending Account

You may be eligible for a dependent care tax credit on your income taxes. You can claim a tax credit up to $3,000 a year for one dependent or $6,000 a year for two or more dependents. But you cannot use your Dependent Care FSA and the tax credit for the same expenses. If you use a combination of tax credits and the FSA, the tax credit will be reduced, dollar for dollar, by the amount you put into your account.

Generally, if your family's taxable income is $40,000 or more, the FSA will save you more in taxes. If your total household income is less than $40,000 it may be better to take the tax credit. Complete the worksheet Estimating your dependent care expenses or consult your tax advisor to determine which method is best for your situation. The worksheet can be found at *www.MyMagellanBenefits.com*.

⚠ *Qualified Status Changes*

The IRS prohibits you from changing your enrollment or the amount of your election during the plan year unless you have a Qualified Status Change. Only benefits changes which are consistent with a Status Change are permitted. Status Changes which may warrant a change in benefits elections are described in this benefits guide.

FSA continued

Transportation FSA with Transit Center

No matter how you commute Premium TransitChek works for you.

Whether you commute by train, subway, bus, ferry, or car, Premium TransitChek has many money-saving products to pay for your commute. Visit *www.MyTransitChek.com* for information on services available in your area.

To Enroll:

1. Notify *HRBenefits@MagellanHealth.com*
2. You will be notified when you can go online at *www.MyTransitChek.com* to enroll or call Transit Center at 1-800-576-1171.
3. To enroll you will need:
   - your social security number
   - your last name as it appears on your paystub
   - your birth date
   - your home mailing zip code
   - your regularly used transit services and vanpool names
   - your monthly mass transit and vanpool costs

Magellan *LifeResources*

Magellan *LifeResources* was developed to help you and your family cope with the ever increasing pressures of life that all of us face. It is designed both to enhance and support your work-life balance as well as provide behavioral health assistance to you and your family. The intent of Magellan *LifeResources* is to give you an array of specialized services that will help you deal with everyday personal problems, or help you be proactive as you face potentially difficult personal situations. Magellan *LifeResources* can assist you in many ways and includes the following programs:

Programs	*Eligibility*	*Services*	*Call*
Employee Assistance Program (EAP) ♥	All active employees, dependents, permanent household members, college students	Brief therapeutic counseling sessions for assessment, consultation and/or referral for treatment of personal issues including personal, emotional, family, drug/alcohol, etc. issues.	1-866-266-2376, 24 hours/7 days a week (you must call prior to receiving care to obtain a network referral)
Mental Health/ Substance Abuse ⚠	Employees and dependents who select and enroll in a Magellan sponsored health plan	Inpatient, alternative care, and outpatient services for mental health and substance abuse treatment In-network and out-of network options (refer to the benefit plan information following this section—exclusions apply) If you are enrolled in a Magellan-sponsored plan, you do not receive mental health & substance abuse care through your medical plan.	1-866-266-2376, 24 hours/7 days a week (you must call prior to receiving care and/or to pre-certify network care)
***LifeManagement* Resource & Referral** ♥	All active employees, dependents, permanent household members, college students	Phone consultation with work-life care specialist to assess and determine referrals to community resources supporting numerous work/life events including pregnancy, child care, elder care, home health care, academic and special needs, etc. Database includes regulated resources for a number of convenience service providers including pet care, health clubs, automotive, relocation, home improvement, etc. Members only web-site access to multitude of resources including articles, resource lists, and interactive tools.	1-866-266-2376 24 hours/7 days a week

Magellan *LifeResources*

Programs	*Eligibility*	*Services*	*Call*
Legal Services	All active employees, dependents, permanent household members, college students	Free initial phone or face-to-face consultation with network attorney; 25% discount for retained services; members only web-site access to legal library including forms, information and research articles, and on-line self-services. (Exclusions: disputes with employer or vendor; issues lacking legal merit)	1-866-266-2376 (available during extended business hours with after-hours emergency services)
Financial Services	All active employees, dependents, permanent household members, college students	Free initial phone or face-to-face consultation with network financial professional; 25% discount for retained services; members only web-site access to financial resources library including articles, forms, calculators, and on-line referrals to financial professionals. Services range from consumer credit counseling, to estate planning, to tax and business investment plans.	1-866-266-2376 (available during business hours)
NurseAccessSM	All active employees, dependents, permanent household members, college students living away from college	Speak to a registered nurse, 24 hours a day, seven days a week to make smarter decisions about your own health Access an extensive audio library on a variety of topics—access code 6473.	1-866-266-2376

MagellanHealth.com with MyMagellan Benefits • Online access to all services available at toll-free number • Additional information and resources on large array of healthy living topics • Hyperlink access to EAP, LifeManagement, Legal & Financial, NurseAccess[SM] web pages • Library & Resources • Access via link on MagNet under MyMagellan • *www.MagellanHealth.com*

Employee Assistance Program (EAP)

Confidentiality

Our EAP benefits are internally administered. In a sense, we are our own customer. This structure takes advantage of our comprehensive programs and network of providers. As with any such benefit, your confidentiality is an absolute top priority, and a system of confidential codes is in place to ensure your privacy.

Any and all EAP services that Magellan Health Services' employees or their dependents receive will be handled confidentially. Because we recognize the sensitivity of handling an internally administered benefit, we have implemented several additional measures to provide confidentiality for our employees.

The key element of ensuring confidentiality is the use of your code. When calling Magellan *LifeResources* for a referral or authorization of services, or when submitting a claim or treatment request form, neither you nor your provider will need to give your name to the Customer Service Representative (CSR) or Care Manager. You will be identified only by a numeric code. As an employee, your code will be your full Social Security Number (SSN) and your date of birth. Your dependents' or household members' codes will use your full SSN and their dates of birth. You will, however, be asked your name and other identifying information at the provider appointment. This information is not passed back to Magellan *LifeResources* or Magellan Health Services. Claim forms submitted by providers will only include employee Social Security Number and dates of birth.

Employee Assistance Program (EAP)

Magellan's EAP is available to you, your dependents, and other members of your household. After receiving a confidential referral through the *LifeResources* line, an Employee Assistance professional counselor will conduct a thorough bio-psycho-social assessment to determine the best interventions to help you resolve your personal concerns. If your assessment determines that your issues can be quickly resolved with practical interventions, the EAP counselor may use up to 8 sessions to provide a brief course of solution-focused interventions to assist in the resolution of your problem. If your assessment determines a longer, more intensive or specialized course of treatment is appropriate, the EAP counselor will refer you to the most appropriate treatment provider best qualified to address your concerns. Most referrals will be covered by the company-sponsored Mental Health/Substance Abuse or Medical Benefit. With your permission, the EAP counselor may consult with the *LifeResources* Care Manager to identify and certify treatment with a covered provider.

Your EAP counseling services are confidential. You never give your name to the *LifeResources* staff, and all *LifeResources* clinicians, consultants, and EAP counselors are bound by all ethical and statutory rules of confidentiality. Your written consent is required to reveal to anyone your participation in the program.

The EAP counseling program is provided at no cost to you. Magellan has prepaid these services and strives to insure all practitioners meet the highest training and professional credentialing standards. By calling the *LifeResources* number, you can access the program 24 hours a day, every day of the year. Specially trained clinicians are available to talk to you anytime when the pressures of everyday living become overwhelming and unmanageable.

♥ My EAP as a Wellness Plan? Absolutely… It's Your Life
We can help you live it—better!

It's All About Balance

We know that living a productive and fulfilling life requires a healthy mind and a healthy body. Unfortunately, managing the daily stresses of work, home and family can have a negative effect on our overall health and well-being. For many of us, life is quite simply "out of balance," leaving us feeling overwhelmed and stressed-out.

A Wealth of Practical, Solution-Focused Resources

Your program has the resources and the experience to help you bring things back into balance. From online resources to confidential telephonic consultations to referrals and licensed behavioral health professionals, we're here to help you make the changes necessary to reduce stress, strengthen relationships, increase productivity and improve the overall quality of your life.

Go to *www.MagellanHealth.com/Member* or call 866-266-2376.

EAP and *LifeManagement*

Face-to-face EAP counseling sessions are available to you on a per-problem-type basis. If your problem is persistent or recurring, additional assessment will be made to refer you to an MBH treatment provider. The EAP program is designed to help you address a variety of issues that impinge on healthy living including but not limited to:

- Family and Child Concerns
- Alcohol/drug abuse
- Marital or Relationship Difficulties
- Stress, Anxiety, Depression
- Behavioral Concerns
- Parenting Issues
- Occupational Issues
- Workplace Issues
- Communication Problems
- Life Management Issues

The focus of the EAP is prevention and assistance. The goal is to help you regain control of your circumstances when the challenges of everyday life become less than manageable. By addressing these interferences early, you can develop effective coping skills that prevent small issues from becoming big, costly problems.

LifeManagement Resource & Referral

In addition to personal, confidential counseling, Magellan *LifeResources* also offers an abundance of services and resources to help you manage the demands of daily living. Support and resources to assist you with dependent care and educational needs, health and wellness issues, and personal conveniences are available to you at the same toll-free number. Through its LifeManagement program, resources and confirmed referrals for child, adult, and eldercare are just a phone call away.

Likewise, educational resources from preschool to graduate school are also available through the LifeManagement program, as are resources for personal services such as auto repair, dry cleaning, house cleaning, event planning, etc. Specialists are available 24 hours a day to help identify the most appropriate resources available in your area. Additional information, tips and tools are also available through the life event links on *MagellanHealth.com*.

Legal and Financial Services

Legal and Financial consultation with legal and financial professionals are likewise just a call or click away. The initial consultation is at no charge, and may be in-person or by telephone. Subsequent retained services are offered at a discounted rate. A convenient link on *MagellanHealth.com* opens further research options for your legal and financial questions.

NurseAccess℠

Questions on general health and wellness issues are readily answered by registered nurses 24 hours a day through the NurseAccess℠ program. By calling the toll-free number, you can automatically be connected with a nurse ready to hear your concern, answer immediate questions, and direct you to additional resources for support and information. Alternately, you may connect to an audio library of over 80 healthcare topics by using the 6473 access code. As with the other work-life programs, a convenient link on *MagellanHealth.com* will take you to the same library of topics on-line.

The work-life services offered through your Magellan *LifeResources* program are designed to provide you with multiple resources for healthy living.

How Does Your EAP Work as a Wellness Plan?

Here are just a few of the challenges where your program can help:

- Managing stress
- Handling relationship issues
- Balancing work and life
- Caring for children or aging parents
- Exploring career development options
- Working through grief and loss issues
- Controlling depression and anxiety

Living Healthy Working Well®

Living your healthiest, most productive and fulfilling life is within your control.

Click or call now, and you're on your way to living the life you want to live. *MagellanHealth.com/Member* or 866-266-2376

Accessing EAP Benefits

To access EAP benefits, you must call Magellan *LifeResources* at 1-866-266-2376 before you make an appointment or receive care for EAP services. If you have a provider in mind, you must also call this number to verify that the counselor you have selected is part of the EAP network. There is no out-of-network benefit for EAP. You will NOT need to give your name to the CSR or Care Manager, only your identification code (Social Security Number and date of birth). Day and evening appointments are available. In an emergency, EAP counselors are available 24 hours a day/7 days a week.

At no time during your call to Magellan *LifeResources*, will you need to use your name, only Social Security Number and date of birth. Names are not requested on any documentation, including claim forms used for EAP services. To protect your confidentiality, you must take a claim form to your first appointment. Forms are found on MagNet under Human Resources > MyMagellan > Magellan *LifeResources* or at *www.MagellanHealth.com* under "My Program Services" > Preparing for Your First Session > What to take to First Appointment.

Accessing Mental Health/Substance Abuse Benefits

If you and/or your dependents are enrolled in a Magellan sponsored medical plan, you will receive mental health and substance abuse benefits through the Magellan *LifeResources* program, not through your medical plan.

You must call 1-866-266-2376 **before** you make an appointment or receive care. CSRs and Care Managers are available 24 hours a day, 7 days a week. You may choose to receive care from a licensed provider regardless of network status. If you choose to receive care from an in-network provider, the in-network level of benefits will apply at the time of claim payment. If you choose to receive care from an out-of-network provider, the out-of-network level of benefits will apply.

You may print your personal MH/SA identification card from MyMagellan for use when accessing services through the Magellan *LifeResources* program.

☑ Accessing MagellanHealth.com

We have a customized web site with multiple educational and informational resources including quick tips and articles addressing home and work health and wellness; interactive self-assessment and personal planning tools; links to other *LifeResources* websites:

- Provider/Caregiver information and searches.
- Information on How to Prepare for your first EAP session.
- Benefit information about your EAP, Legal Services, Financial Services, LifeManagement and NurseAccess℠.
- Library & Resources including topics of interest, library catalog, self-assessments, tools & calculators, medications, community resources, monthly health observances, prevention programs and glossary.
- Care guide for how to initiate care, managing and preparing for your care, member rights & responsibilities and confidentiality.

Once you have established your personal login, you can simply login to access self-assessment tools, interactive personal plans, and the personal coaching series.

⚠ Accessing the website (*www.MagellanHealth.com*) is an easy login process:

1. Click the 'I'm a Member' button.
2. Go to Member Sign In, if you are a new or unregistered user enter the Magellan *LifeResources* toll free number: 1-866-266-2376
3. Register and create your personal user name and password.

Outpatient and Intensive Outpatient Services:

Call the Magellan *LifeResources* line at 1-866-266-2376 to speak with a Care Manager to verify the status of your provider (in-network or out-of-network) and receive pre-authorization for in-network care. If you don't know the provider that you want to see, the Care Manager will help you by searching for appropriate network referrals.

To continue outpatient services after the first few authorized visits, your provider is required to submit a completed Treatment Request Form (designed to protect your confidentiality—the form will not include a space for your name, only your code).

Partial Hospitalization and Alternative Care Services:

For other services like partial hospitalization or alternative care services, you are responsible for calling Magellan *LifeResources* for pre-authorization of these services.

Inpatient Services:

Inpatient care, whether in-network or out-of-network, is always managed and, except in the case of emergency, needs to be preauthorized. To access any inpatient services you MUST have your provider or the facility call Magellan *LifeResources* at 1-866-266-2376 to pre-authorize care.

Throughout the inpatient stay, the Care Manager conducts ongoing reviews with the facility representative to determine authorization of services. The patient is not required to call Magellan *LifeResources*. The patient's name is not required for the review, only the patient's code.

Emergency Services:

In the event of a life-threatening emergency, you should call 911 or go to the nearest hospital emergency room. You do not need to call Magellan *LifeResources* prior to seeking emergency treatment for pre-authorization of care. However, to access any inpatient services, you MUST have your provider or the facility call Magellan *LifeResources* at 1-866-266-2376 to authorize care within 24 hours after seeking emergency services.

If you are not sure that it's an emergency, call Magellan *LifeResources* at 1-866-266-2376 and speak with a clinician immediately to help you decide what to do.

Once the provider or the facility calls Magellan to authorize emergency inpatient care, the Care Manager will contact the facility representative to conduct a concurrent review to determine if a continued stay will be authorized. Throughout the stay, the Care Manager conducts ongoing reviews with the facility representative to determine medical necessity and authorization of services. The patient is not required to call Magellan *LifeResources*. The patient's name is not required for the review, only the patient's code.

Providers and members are required to file all claims (EAP and managed care) within 90 days from the date of service. Members are required to take all paperwork to providers at their first appointment. Claims filed beyond that date will not be considered for payment.

Please refer to the summary plan description for detailed information regarding how to file an appeal. Members or your personal representative must file appeals within 180 days from the receipt of an adverse determination.

MHSA Benefits

Type of Service	*Pre-certified Treatment, In-Network Provider*	*Pre-certified Treatment, Out-of-Network Provider4*	*Treatment Not Pre-certified*
INPATIENT[1]			
Inpatient Psychiatric, Substance Abuse Detox/Withdrawal Halfway House, Residential Treatment, Partial Hospitalization, or Substance Abuse Rehabilitation	★100% less $350 co-payment per admission Combined total 30 days per year[1]	Subject to $250 annual deductible per individual, then 50% of usual, customary, and reasonable fee allowance[4] Combined total 30 days per year[1]	Not covered
OUTPATIENT[2]			
Individual sessions (mental health and substance abuse), Group sessions (mental health and substance abuse), Psychological Testing and Intensive Outpatient Treatment in outpatient rehabilitation	★100% less $25 co-payment per session[3] No limit on in network outpatient sessions[2]	Subject to $250 annual deductible per individual, then 50% of usual, customary, and reasonable fee allowance[4] No limit on in network outpatient sessions[2]	Subject to $250 annual deductible per individual, then 50% of usual, customary, and reasonable fee allowance[4] No limit on in network outpatient sessions[2]

Timely Filing of EAP Claims

At your first EAP visit, you are required to provide your EAP counselor with the EAP Claim and Case Closing Form found on MagNet under MyMagellan/Benefits. Providers must submit claims within 90 days of the date of service in order to be reimbursed (instructions are included on the EAP Claim and Case Closing Form).

Timely Filing of MHSA Claims

At your first outpatient visit, you are required to provide your MHSA provider with the MHSA Pre-certification Confirmation form found on MagNet under MyMagellan/Benefits. All network inpatient and outpatient providers must submit claims within 90 days of the date of service in order to be reimbursed (instructions are included on the form). All MLR members must submit out-of-network claims within 365 days of the date of service in order to be reimbursed.

Please see the summary plan description for Magellan *LifeResources* for specific covered and non-covered services.

There is no annual out-of-pocket, annual dollar maximum or lifetime dollar maximum per individual or family.

1 Annual Benefit Limit for any combination of mental health/substance abuse treatment, in-network and out-of-network: 30 inpatient days total per year. Two days of alternative levels of care (either partial hospitalization and halfway house) count as one inpatient day. Each day of residential treatment or substance abuse rehabilitation is counted as one inpatient day. Three outpatient electroconvulsive treatment (ECT) sessions count as one inpatient day.

2 Annual Benefit Limit for any combination of mental health/substance abuse treatment, in-network and out-of-network: 30 outpatient sessions total per year. Medication management visits (20 minutes or less) do not count toward the annual 30-session limit.

3 To receive in-network benefits for treatment with an in-network provider, pre-certification must be obtained within 30 days of the first appointment.

4 The $250 annual deductible per individual for out-of-network care is for any combination of out-of-network care.

Retirement Savings Plan 401(k)

Eligibility

Full-time, part-time and float employees are eligible upon date of hire. Intermittent, temporary, PRN, leased and as-needed/ on-call employees are not eligible to participate in the Plan.

Employee Contributions

You may contribute between 1% to 75% of your compensation each pay period, up to the annual maximum established by the IRS. If you are over age 50 you can contribute an additional $5,500 per year in catch-up contributions.

Company Matching Contributions

Magellan will contribute 50% of the first 6% of your Employee Contributions on a per paycheck basis.

Vesting

Matching Contributions will be vested according to the schedule below:

Years of Service	Percent Vested
0 – less than 1	0%
1 – less than 2	33 1/3%
2 – less than 3	66 2/3%
3 or more	100%

Your account balance becomes 100% vested automatically upon your retirement or after age 65, at death, or if you become totally disabled.

Changing Contributions

You may increase, decrease, or stop your 401(k) contributions anytime by calling the Prudential Phone Line at 1-877-PRU-2100. These changes will become effective the first payroll of the next month if you call by the 20th of the month; changes called in after the 20th will be effective the first payroll of the next following month.

Changing Investment Fund Options

You may reallocate your existing balances between the investment fund options daily by calling the toll-free Prudential Phone Line at 1-877-PRU-2100.

Rollover Funds

Distributions from another employer's qualified plan may be rolled into the Magellan Health Services Retirement Savings Plan at any time while you are employed with Magellan Health Services. Contact Prudential at 1-877-PRU-2100.

Loans and Withdrawls

Hardship withdrawls and up to two (2) loans are permitted. IRS restrictions apply. For additional information please contact Prudential at 1-877-PRU-2100 or online at *www.Prudential.com/Online/Retirement*.

For questions please contact Prudential at 1-877-PRU-2100 or online at *www.Prudential.com/Online/Retirement*.

2009 Limits

401(k)	$16,500 ★
Ages 50 & up catch up	$5,500 ★

You can also manage your 401(k) account online at *www.Prudential.com/Online/Retirement*.

Go online to:

- change contributions
- change investments
- apply for loans
- get existing balances

Voluntary Accidental Death and Dismemberment/CIGNA

Employee Only Coverage ☑

You may choose any amount of insurance, in multiples of $10,000 from $10,000 to $500,000. However, amounts above $150,000 cannot exceed 10 times your Annual Salary. Your Principal Sum equals the amount of insurance you choose (subject to the reduction schedule for covered persons over the age of 70). "Annual Salary" means your base annual salary exclusive of overtime, bonuses, tips, commission and special compensation.

Employee, Spouse and Dependent Children Family Coverage ☑

You may choose an amount of insurance for yourself as described above. You may also choose coverage for your family members. The Principal Sum applicable to your covered dependents is an amount based upon the composition of your family at the time of loss and is expressed as a percentage of your Principal Sum as follows:

If	*And*	*Then The Plan Pays*
You suffer a loss		Your Principal Sum
Your covered spouse suffers a loss	You have a covered child up to $250,000	50% of your Principal Sum
Your covered spouse suffers a loss	You do not have a covered child up to $300,000	60% of your Principal Sum
Your covered child suffers a loss	You have a covered spouse up to $50,000	10% of your Principal Sum
Your covered child suffers a loss	You do not have a covered spouse up to $50,000	15% of your Principal Sum

>> The Principal Sum may be reduced, based on the schedule of benefits. Please refer to your certificate of insurability for additional information.

Benefit Highlights

- **Accidental Death, Dismemberment And Paralysis Benefits**: Pays benefits if a covered person suffers a covered accidental death, dismemberment or paralysis.
- **Common Disaster Benefit***: Increases your covered spouse's Principal Sum if you and your spouse both suffer a covered accidental death in the same accident within a specified time after the accident.
- Seat Belt Benefit: Pays an additional benefit if a covered person suffers a covered accidental death while operating or riding as a passenger in a private passenger automobile if it is verified that such person was wearing a properly-fastened, original, factory-installed seat belt.
- **Tuition Benefit***: Pays an additional benefit if you suffer a covered accidental death so that your covered spouse and/or covered eligible dependent children can continue or commence under certain circumstances their education in an institution of higher learning or so that your covered eligible spouse can enroll in a professional or trade training program to obtain an independent source of support or to enrich his/her ability to earn a living.
- **Travel Assist**: This option is provided when you travel 100 miles or more away from your residence or permanent place of assignment. It offers services such as legal assistance, emergency cash, pre-departure services and lost baggage aid, among others.
- **Exclusions**: Some exclusions may apply. Please refer to your certificate of insurability. Please note, Voluntary AD&D is not portable.

*Only available with Employee, Spouse and Dependent Children Family Coverage

Voluntary Group Universal Life/CIGNA

Voluntary Group Universal Life is provided through Connecticut General Life Insurance Company (a CIGNA company). Group Universal Life (GUL) is a unique form of life insurance that provides unmatched flexibility in meeting the individual needs of your family. You can increase your life insurance coverage as your income grows, expand benefits to include new family members, or reduce coverage as your family matures and you near retirement.

GUL is convenient. You can purchase this insurance protection through payroll deduction. Your premium amounts are simply deducted from your paycheck automatically. Rates vary based on age. With GUL you can take advantage of an optional cash accumulation fund* that earns income tax-deferred interest. Use your cash accumulation fund* for retirement, a home, or a child's education. GUL coverage is yours to keep even if you retire or leave your employer (to age 99 as long as the group plan is in effect). Premiums will be billed to you, at the portable rates then in effect.

GUL provides advance payment of up to 50 percent of your elected death benefit if you are diagnosed with a terminal illness with a life expectancy of 12 months or less.

Eligibility

All regular full-time employees and regular part-time employees (working at least 20 hours per week) may apply for coverage. An employee must be actively at work at Magellan Health Services and able to perform normal activities on both the date the enrollment form is completed and the effective date of coverage.

All spouses (age 64 and younger) of eligible Magellan Health Services employees may be enrolled in the GUL program. A spouse may be enrolled even if the employee does not enroll in the program. If a spouse is also a Magellan Health Services employee, he or she can enroll as a spouse or an employee, but not both.

Enrollment

New employees must enroll within 31 days of your date of hire. Applications are accepted at any time. However, all applications received after the open enrollment period has expired will be subject to Evidence of Insurability and approval by CIGNA before coverage can be issued.

Effective Date of Coverage

Approved coverage that does not require Evidence of Insurability will become effective the day your enrollment form is received. All other coverage will become effective the first of the month in which payroll deductions can be arranged following approval by CIGNA.

If you and/or your dependents apply for an amount of life insurance coverage greater than the guaranteed issue amount, and/or apply 30 days or more after becoming eligible, coverage is subject to approval from the insurance carrier. If approved, coverage will take effect on the date agreed to in writing by the insurance carrier to cover you and/or your dependents.

Certificate

Once your application for coverage is approved, you will receive a certificate which provides complete details about your GUL coverage.

Evidence of Insurability:

If you wish to purchase life insurance for the first time other than as a new hire or wish to increase your current amounts, you may be required by the insurance company to fill out a medical questionnaire called an evidence of insurability form. You will be sent an evidence of insurability form to complete and send directly to CIGNA. The amounts you have elected for 2008 are not effective until you are approved.

*The cash value of the certificate minus any withdrawals or loans.

For claims, rates or benefits questions, please contact CIGNA member services at: 1-800-828-3485 or at *www.CIGNA.com*

Coverage options for you and your family:

☑ *Coverage for You*

You are eligible for GUL insurance as long as you are a full-time or part-time employee of Magellan Health Services, and you are actively at work at least 20 hours a week.

- Coverage amounts available: 1, 2, 3, 4 or 5 times your base annual salary, rounded to the next higher $10,000.
- Maximum amount of guaranteed insurance available within 30 days of your eligibility date, without evidence of insurability: Two times your base annual salary, rounded to the next higher $10,000, or $300,000, whichever is less.

If you provide evidence of insurability, you can:

- Purchase over the guaranteed amount—up to five times your base annual salary, rounded to the next higher $10,000, or $1,000,000 whichever is less.
- Increase your life insurance coverage at any time. Just call CIGNA's Customer Service Center at 1-800-828-3485 to request a change form or go online at *www.CIGNA.com*.

☑ *Coverage for Your Spouse*

You can purchase coverage for your spouse in the following amounts:*

- In $10,000 units, up to the maximum.
- Maximum amount of guaranteed insurance available for spouses of eligible new hires or for new spouses who enroll within 30 days of marriage date, without evidence of insurability: $50,000

If you provide evidence of insurability, you can purchase:

- Coverage of up to $150,000.

To be eligible for coverage, your spouse must be under age 65. For coverage to become effective, your spouse must not be: hospitalized, confined at home under the care of a doctor, or unable to perform the normal daily activities of a person of the same age and sex.

☑ *Coverage for Your Children*

If you elect GUL for yourself and your spouse, you may also purchase term insurance for all your unmarried, dependent children who are at least 15 days and less than 19 years old, or through age 24 if the child is a full-time student and primarily supported by the employee.*

For just one premium, you can cover all your dependent children for one of the following amounts:

- You can obtain $5,000 or $10,000 of guaranteed term insurance coverage if you enroll your child(ren) within 30 days of your eligible date if you are a new employee, or within 30 days of your child's birth.

For your children's coverage to be effective, they must not be hospitalized, confined at home under the care of a doctor, or unable to perform the normal daily activities of a person of the same age and sex.

*Texas and Florida residents: State law requires that the employee purchase GUL in order for the spouse and dependent children to be eligible for coverage. State law limits spouse/dependent children coverage to a maximum of 50% of the employee's selected coverage amount.

Please note that in certain other states, restrictions may apply.

MetLife Voluntary Benefits

☑ Magellan currently offers several voluntary benefits through MetLife. Please login to *www.MetLife.com/MyBenefits* or call 1-800-GET-MET8 (1-800-438-6388) for more information on the products listed below and to find out how to enroll.

Long Term Care Insurance

The need for long-term care can arise whether you are in your 20's, your 60's or any age in-between. The fact is, 40% of the people who require long-term care are between age 18 and 64. Long-term care is the kind of care you or your family may need as a result of an injury, illness or aging. People require long-term care services when they are unable to perform everyday activities of living like bathing, dressing and eating. Unfortunately, many people believe that medical, disability income or other types of insurance will cover the cost of this care. The fact is, these plans were not designed to cover long-term care. Check out all the facts about Long Term Care insurance today.

Banking Services

The products that are available from MetLife will bring you banking that fits your life. Benefit from competitive interest rates, low or no minimum balance requirements, free online banking and more.

Veterinary Pet Insurance

This insurance coverage helps pay for diagnostic tests, office visits, prescriptions, treatments, x-rays, lab fees, hospitalization and surgeries. The insurance is endorsed by The American Humane Association.

Auto and Home Insurance

This product offer provides you with the potential to save 10% or more over your current carrier.

Product offerings include:

- Auto
- Boat owners
- Landlord's Rental Dwelling
- Renters
- Mobile Home
- Homeowners
- Recreational Vehicle
- Personal Excess Liability ('Umbrella')
- Condominium
- Fire

MetDesk—Met's Division of Estate Planning for Special Kids

Available to employees at no cost, MetDesk provides confidential, personalized information and advice to help employees ensure lifetime care and future quality of life for their dependents with special needs. Protect the future your children and other dependents with special needs

Check out more at:
www.MetLife.com/MyBenefits
or 1-800-438-6388.

Educational Assistance Program

Eligibility

To be eligible to participate in the Educational Assistance Program, employees must meet the following requirements:

- Be a full-time employee regularly scheduled to work 30 hours or more per week (or a part-time employee regularly scheduled to work 20 – 29.5 hours per week for tuition reimbursement only),
- Be employed prior to incurring the expenses and be employed at the time of reimbursement, and
- Agree to reimburse the Company for any expenses paid under this policy during the twelve-month period preceding their voluntary termination of employment.

Magellan's Educational Assistance Program includes two types of reimbursements:

- Continuing Education, Licensures, Certifications, or Memberships
- Degreed Programs

Continuing Education, Licensures, Certifications, or Memberships

Magellan may reimburse employees for continuing education, licensures, certifications, or memberships up to a maximum amount of $800 per Benefit year. Only the cost of the CEU course is reimbursable. Additional fees such as meals or other administrative fees are not reimbursable.

Reimbursement will only be approved if the following requirements are met:

- The Continuing Education Units (CEU's) are being obtained for the renewal of a license that is required, per the employee's job description, to perform their job responsibilities.
- Professional association membership dues, licensures, or certifications must be a requirement per the employee's job description.
- The license or certification must be issued by a recognized authority such as a municipal, state or federal regulatory board or commission and conveys to the holder specific privilege or authority in the practice of a profession which would otherwise be denied by law, regulatory code or specification.
- The license or certification must be valid for geographical locations in which the company performs work and must be a requirement in order to perform work in that area.

All reimbursement requests from the current year must be submitted within the first 5 business days of the following year to be eligible for reimbursement.

Educational Assistance Program continued

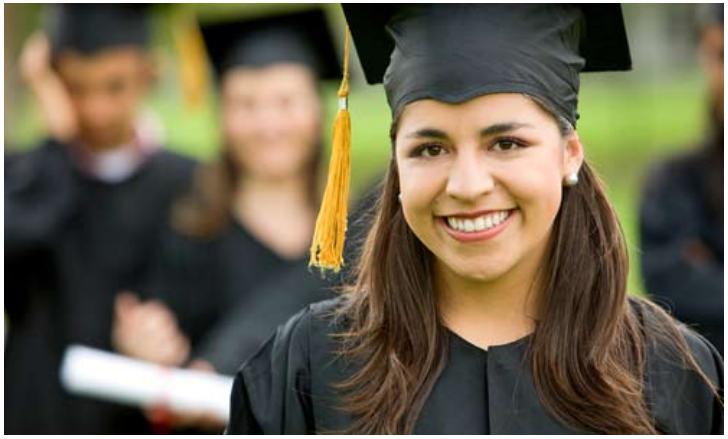
Degreed Program

Magellan may cover the cost of tuition for credit bearing courses, offered by accredited colleges or universities, which benefit the employee and the Company by being part of a degree program that may enhance the employee's qualifications for their current position or for possible advancement within the Company. The course(s) must be approved by the Department Manager and Cost Center Head. Tuition will be reimbursed for PreApproved courses as follows:

- 100% for obtaining a grade of A to a B- or "Pass".
- At 50% for obtaining a grade of a C.
- At 0% for obtaining a grade of C- or "Fail".

The maximum amount you will be reimbursed during any one Benefit year is $2,500 for a full-time employee and $1,250 for a part-time employee. Only course tuition is reimbursable. Books, registration, activity, lab, parking, or other administrative fees are not reimbursable. The amount of reimbursement to the employee is deducted from the Benefit year in which the class is completed. Course tuition in excess of the annual maximum reimbursement amount may not be submitted for reimbursement in the subsequent year.

All reimbursement requests from the current year must be submitted within the first 5 business days of the following year to be eligible for reimbursement.



⚠ Should an employee voluntarily terminate within 12 months of receiving reimbursement, the employee is expected to pay back monetary benefits received under this policy during the prior 12 months. Magellan reserves the right to adjust an employees remaining pay(s) or require repayment upon termination in order to recoup the reimbursement.

Professional Development Assistance Program

Magellan is committed to the professional growth and development of all employees. Magellan provides both formal and informal internal development opportunities. When internal resources cannot meet the needs for professional growth and development, employees may utilize local outside programs, and lastly programs that require travel. All training and/or development programs must be approved prior to commencement of the program.

Professional Development

The cost of training, including seminars, workshops, and conferences may be reimbursed from 0% to 100%. Advanced planning is recommended in order to assure cost is included in the employee's cost center budget. The educational event must be linked to business requirements and/or to the employee's Individual Development Plan that has been approved by the Department Manager and Cost Center Head.

PreApproval/Reimbursement Process—Expenses for Professional Development are allocated to the employee's department. Employees are advised to discuss Professional Development opportunities with their manager prior to enrolling.

Adoption Assistance

Eligibility

Full-time employees who have completed one year of employment.

Magellan Health Services will reimburse you for up to $2,500 per child to cover some of the costs of legal adoption. You must complete a reimbursement form to receive reimbursement of eligible costs. Eligible costs include adoption agency fees, placement fees, legal expenses, maternity fees for the child's natural mother (not covered through medical expenses) and temporary foster care or emergency housing. The program does not cover travel expenses, voluntary donations or legal fees to obtain custody of your own child or to adopt a stepchild.

Please contact your HR Generalist for additional information. The adoption Assistance Reimbursement form can be found on *MagNet > MyMagellan > Benefits*.

Paid Time Off and Other Paid Time Off

Paid Time Off (Calendar Year)

- Available for vacation, sick, personal needs
- Replaces separate vacation and sick benefits
- Should be planned ahead whenever possible
- Allotted at the beginning of each calendar year
- Time allotment based on years of service completed in the calendar year and management status
- Treated as accrued in year employee terminates employment with company
- Can be taken after 90 days of employment

Standard Benefits		*Manager & Above Benefits*	
Year of Service	Number of Days	Years of Service	Number of Days
1<5	18	1<5	23
5<10	23	5<10	26
10+	28	10+	28

Emergency/Sick Fund

- Automatic rollover up to 3 days per calendar year into an emergency/sick fund
- Maximum number of days in fund at any time is 5 days
- Days held in emergency/sick fund will not be paid out upon termination

Other Paid Time Off

The Company will provide additional paid time off to employees for absences related to jury service, bereavement and annual military reserve duty training or emergency activation.

Eligibility

These additional paid time off benefits are available to regular full-time employees in the amounts specified. For regular part-time employees, benefits will be adjusted equitably in proportion to the percentage of full-time status worked or the number of days worked per week. There is no waiting or qualifying time period for these benefits.

Time Off Allotments

Funeral/Bereavement Leave

Immediate Relative, as defined to the right, is up to four (4) days of paid leave.
Close Relative, as defined to the right, is up to two (2) days of paid leave.
Other Relative, as defined to the right, is up to one (1) day of paid leave.

Jury Duty Leave

Employees will be paid regular salary for all workdays where the employee was required to be present to serve.

Annual Reserve Training / Emergency Activation

Employees will receive regular pay for up to two (2) work weeks per year when activated for annual training or emergency service. For mandatory training / activation beyond this amount, employees may elect to either use available PTO time or be placed in a leave without pay status. (See also policy on Military Leave)

Definitions

Immediate Relative:
Spouse or Significant Other, children, parents, siblings, others with whom a "child-parent" relationship exists. Employee eligibility also extends to any of these relatives of a spouse.

Close Relative:
Grandparents, grandchildren. Employee eligibility also extends to any of these relatives of a spouse.

Other Relative:
Aunt, uncles, nieces, nephews and other blood relatives living in the home. Employee eligibility also extends to any of these relatives of a spouse.

Jury Duty:
A summons to serve jury duty.

Annual Reserve Training:
Traditionally, an annual two-week activation for training as evidenced by official military orders.

Emergency Activation:
Activation of an individual or guard/ reserve unit for emergency service as evidenced by official military orders.

Holidays and Holiday Schedule

Holidays (Calendar Year Benefit)

- 8 paid holidays per calendar year
- 2 floating holidays subject to scheduling approval by supervisor
- Floating Holidays do not get paid out upon employment termination
- New Hires after June 30 receive one floating holiday to be taken before the end of the calendar year

2009 Holiday Schedule

New Year's Day	Thursday, January 1, 2009
Memorial Day	Monday, May 25, 2009
Independence Day	Friday, July 3, 2009
Labor Day	Monday, September 7, 2009
Thanksgiving	Thursday, November 26, 2009
The day after Thanksgiving	Friday, November 27, 2009
Christmas Eve Day	Thursday, December 24, 2009
Christmas Day	Friday, December 25, 2009

COBRA

On April 7, 1986, a federal law was enacted (Public Law 99-272, Title X, commonly known as COBRA) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. This notice reflects certain law changes which became effective January 1,1997. Both you and your spouse should take time to read this notice carefully.

If you are an employee of Magellan covered by the Magellan group health plan, you have the right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee and you are covered under the plan, you have the right to choose continuation coverage for yourself if you lose group coverage under the plan for any of the following four reasons:

1. The death of your spouse;
2. Termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes entitled to (i.e. covered by) Medicare.

In the case of a dependent child of an employee covered by the plan, he or she has the right to continuation coverage if group health coverage under the plan is lost for any of the five following reasons:

1. The death of a parent;
2. Termination of a parent's employment (for reasons other than gross misconduct) or a reduction in a parent's hours of employment with Magellan;
3. Parent's divorce or legal separation;
4. A parent becomes entitled to (i.e. covered by) Medicare; or
5. The dependent child ceases to be a "dependent child" under the plan (e.g. age attainment, school status change).

Each individual who is eligible for continuation coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child is entitled to elect continuation coverage even if the covered employee does not make that election.

Under the law, the employee or family member has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing dependent status under the plan within 60 days of the later of the date of the event or the date on which coverage would be lost because of the event. Magellan has the responsibility to notify the Plan Administrator of the employee's death, termination of employment or reduction in hours, or Medicare entitlement.

Rights similar to those described above may apply to certain retirees, spouses and dependents if Magellan commences a bankruptcy proceeding and these individuals lose coverage.

COBRA continued

When the Plan Administrator is notified that one of these events has happened, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage. Under the law, you have 60 days from the date you would lose coverage because of one of the events described above to inform the Plan Administrator that you want continuation coverage.

If you do not choose continuation coverage, your group health insurance coverage will end.

If you choose continuation coverage, Magellan is required to provide you coverage that is identical to the coverage being provided to similarly situated employees and their enrolled dependents. This means that if coverage for similarly situated employees and/or their enrolled dependents is modified, your coverage will also be modified. Generally, the law requires that you be afforded the opportunity to maintain continuation coverage for up to 18 months. In the event of a secondary qualifying event, your covered dependents may be able to continue coverage for up to 36 months. In the event you become entitled to Medicare due to disability, you may be eligible to increase the continuation coverage for yourself and your covered dependents for up to 29 months. Refer to the chart below for a synopsis of the general continuation coverage rules.

Qualifying Event	*Beneficiary **	*Coverage Period **
Termination or reduction in hours of employment	Employee Spouse Dependent Child	Up to 18 months
Termination or reduction in hours of employment with SSA disability determination	Employee Spouse Dependent Child	Up to 29 months
Employee entitled to Medicare Divorce or legal separation Death of covered employee	Spouse Dependent Child	Up to 36 months
Cessation of dependent status	Dependent Child	Up to 36 months
Bankruptcy proceeding	Surviving Spouse Dependent Child	Lifetime Lifetime

* Domestic Partners are not qualified beneficiaries under COBRA, therefore they are not eligible for coverage.

COBRA regulations are complex and encompass many situations that can not be addressed in a simple chart. Please refer to your Human Resources Department with questions on how COBRA may apply to you and your specific situation.

COBRA continued

However, the law also provides that your continuation coverage may be cut short for any of the following reasons:

1. Magellan no longer provides group health coverage to any of its employees;
2. The premium for your continuation coverage is not paid on time;
3. You become covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition you may have;
4. You become entitled to Medicare; however, Medicare entitlement does not end the continuation coverage period for your family members that are not entitled to Medicare, and their continuation coverage period may be extended to 36 months from the earlier of the date you became entitled to Medicare or the date of the first qualifying event; or
5. You extended coverage for up to 29 months due to your disability and there has been a final determination that you are no longer disabled.

Children born to, or placed for adoption with, a qualified beneficiary during a continuation coverage period also have the right to elect COBRA continuation coverage.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage.

The Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

Under the law, you will be responsible for the payment of 100% of the applicable premium plus a 2% administration charge. Magellan may charge up to 150% of the applicable premium for the 11 month disability extension (from the 19th month to the 29th month). There is a grace period of 30 days for the regularly scheduled premium. At the end of the continuation coverage period, you are allowed to enroll in an individual conversion health plan if provided under the plan.

This notice represents our best effort to provide you with the rights and obligations of you and your dependents under the law. In the event of inconsistencies between this notice and federal law, federal law will control.