Canal Insurance Company
OAP Plan

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MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA) - Non-Quantitative Treatment Limitations (NQTLs)

Federal MHPAEA regulations provide that a plan cannot impose a Non-Quantitative Treatment Limitation (NQTL) on mental health or substance use disorder (MH/SUD) benefits in any classification unless the processes, strategies, evidentiary standards or other factors used in applying the NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, those used in applying the NQTL to medical/surgical benefits in the same classification of benefits as written and in operation under the terms of the plan.

Non-Quantitative Treatment Limitations (NTQLs) include:

- Medical management standards limiting or excluding benefits based on Medical Necessity or whether the treatment is experimental or investigative;
- Prescription drug formulary design;
- Network admission standards;
- Methods for determining in-network and non-network provider reimbursement rates;
- Step therapy, a.k.a. fail-first requirements; and
- Exclusions and/or restrictions based on geographic location, facility type or provider specialty.

A description of your Plan's NQTL methodologies and processes applied to medical/surgical benefits and MH/SUD benefits is available for review by Plan Administrators (e.g. Employers) and covered persons (Members) by accessing the appropriate link below:

Employers (Plan Administrators): https://www.cignaclientresources.com/crp/ - Log in, select Plan Support, then Mental Health Parity.

Covered Persons (Members): www.cigna.com/sp

To determine which document applies to your Plan, select the relevant health plan product; medical management model (inpatient only, or inpatient and outpatient) located in this booklet's HOW DOES THE PLAN WORK? section; and pharmacy coverage (whether or not your Plan includes pharmacy coverage).

INTRODUCTION

■ **Notices**

Discrimination is Against the Law

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free phone number shown on your ID card, and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by sending an email to ACAGrievance@cigna.com or by writing to the following address:

Cigna

Nondiscrimination Complaint Coordinator

P.O. Box 188016

Chattanooga, TN 37422

If you need assistance filing a written grievance, please call the number on the back of your ID card, or send an email to ACAGrievance@cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

INTRODUCTION - Continued

Proficiency of Language Assistance Services

English - ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.800.244.6224 (TTY: Dial 711).

Spanish - ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800-244-6224 (los usuarios de TTY deben llamar al 711.

Chinese – 注意：我们可为您免费提供语言协助服务。对于 Cigna 的现有客户，请致电您的 ID 卡背面的号码。其他客户请致电 1.800.244.6224（听障专线：请拨 711）。

Vietnamese - XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.800.244.6224 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해 주십시오. 기타 다른 경우에는 1.800.244.6244(TTY: 다이얼 711)번으로 전화해 주십시오.

Tagalog - PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.800.244.6224 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.800.244.6224 (TTY: 711).

Arabic- برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون على ظهر بطاقتكم الشخصية. أو اتصل ب 1.800.244.6224 (TTY:اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.800.244.6224 (TTY: Rele 711).

INTRODUCTION - Continued

French - ATTENTION : des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'assuré. Sinon, veuillez appeler le numéro 1.800.244.6224 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.800.244.6224 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1 800 244 6224 (TTY: wybierz 711).

Japanese - 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.800.244.6224（TTY:711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.800.244.6224 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.800.244.6224 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زمانی، به صورت رایگان به شما ارائه می شود. برای مشتریان فعلی Cigna، لطفاً با شماره ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید
(شماره تلفن ویژه ناشنوایان: شماره 711 را شماره گیری کنید).

Cigna Commitment to Quality

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

Women's Health and Cancer Rights Act (WHCRA)

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Member Services at the toll free number listed on your ID card for more information.

INTRODUCTION - Continued

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

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

Notice Regarding Provider Directories and Provider Networks

A list of network providers and network pharmacies is available, without charge, by visiting the website or calling the phone number on your health care ID card. The network(s) consist of providers, including hospitals, of varied specialties as well as general practice, and pharmacies, affiliated or contracted with Cigna or an organization contracting on its behalf.

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit the website or contact customer service at the phone number shown on your ID card.

Selection of a Primary Care Provider

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

Additional Programs

The Plan may from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to Members for the purpose of promoting general health and well-being. The Plan may also arrange for the reimbursement of all or a portion of the cost of services by other parties to the group. Contact Member Services for details regarding any such arrangements.

Care Management and Care Coordination Services

INTRODUCTION - Continued

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

Rebates and Other Payments

Cigna or its affiliates may receive rebates or other remuneration from pharmaceutical manufacturers in connection with certain Medical Pharmaceuticals covered under the Plan and Prescription Drug Products included on the Prescription Drug List. These rebates or remuneration are not obtained on your, the Employer's or Plan's behalf, or for your benefit.

Cigna, its affiliates and the Plan are not obligated to pass these rebates on to you, or apply them to your Plan's deductible, if any, or take them into account in determining your copay/coinsurance.

Cigna and its affiliates or designees may also conduct business with various pharmaceutical manufacturers separate and apart from the Plan's Medical Pharmaceutical and Prescription Drug Product benefits. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to the Plan. Cigna and its affiliates are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, Cigna or its designee may send mailings to you or your Dependents or to your Doctor that communicate a variety of messages, including information about Medical Pharmaceuticals and Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you or your Dependents, at your discretion, to purchase the described Medical Pharmaceutical and Prescription Drug Product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Cigna, its affiliates and the Plan are not responsible in any way for any decision you make in connection with any coupon, incentive or other offer you may receive from a pharmaceutical manufacturer or Doctor.

If Cigna determines that a Pharmacy, pharmaceutical manufacturer or other third party is or has waived, reduced or forgiven any portion of the charges and/or any portion of any deductible, copay and/or coinsurance amount(s) you are required to pay for a Prescription Drug Product without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of Plan benefits in connection with the Prescription Drug Product, or reduce the benefits in proportion to the amount of any deductible, copay and/or coinsurance amount(s) waived, forgiven or reduced, regardless of whether the Pharmacy, pharmaceutical manufacturer or other third party represents that you remain responsible for any amounts that the Plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by the Plan.

For example, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a Prescription Drug Product, Cigna may, in its sole discretion, reduce the benefits provided under the Plan in proportion to the amount of any deductible, copay or coinsurance amount(s) to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any Plan deductible or out-of-pocket maximum the value of any coupon applied to any deductible, copay and/or coinsurance you are required to pay.

INTRODUCTION - Continued

■ About This Plan

Canal Insurance Company (the Employer) has established an Employee Welfare Benefit Plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). As of January 1, 2021, the medical and drug benefits described in this booklet form a part of the Employee Welfare Benefit Plan and are referred to collectively in this booklet as the Plan. The Employee Welfare Benefit Plan will be maintained pursuant to the medical and drug benefit terms described in this booklet. The Plan may be amended from time to time.

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

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

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

Discretionary Authority

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

Plan Modification, Amendment and Termination

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

Rescission

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

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

OPEN ACCESS PLUS MEDICAL BENEFITS SCHEDULE

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

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

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

Multiple Surgical Reduction

Multiple covered surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon Charges - The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed a percentage of the surgeon's allowable charge as specified in Cigna reimbursement policies. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

Co-Surgeon Charges - The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna reimbursement policies.

Out-of-Network Emergency Services Charges

Emergency Services are covered at the in-network cost-sharing level if services are received from a non-participating (out-of-network) provider.

The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an out-of-network Hospital, or by an out-of-network provider in an in-network Hospital, is the amount agreed to by the out-of-network provider and Cigna, or if no amount is agreed to, the greatest of the following, not to exceed the provider's billed charges: (i) the median amount negotiated with in-network providers for the Emergency Service, excluding any in-network copay or coinsurance; (ii) the Maximum Reimbursable Charge; or (iii) the amount payable under the Medicare program.

The Member is responsible for applicable in-network cost-sharing amounts (any deductible, copay or coinsurance). The Member is also responsible for all charges that may be made in excess of the allowable amount. If the out-of-network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

Out-of-Network Charges for Certain Services

Charges for services such as laboratory, radiology, pathology and anesthesia provided by an out-of-network provider in an in-network facility while you are receiving in-network services in that in-network facility, are payable at the in-network cost-sharing level.

Plan Deductible

OPEN ACCESS PLUS MEDICAL BENEFITS SCHEDULE - Continued

The Plan Deductible is the amount of covered medical expenses that must be incurred (paid) by you and/or your Dependents each calendar year before benefits are payable under this Plan. Expenses paid by you and/or your dependents for covered network services will apply to the network deductible, and will also apply to the non-network deductible. Expenses paid by you and/or your Dependents for covered non-network services and covered services outside the network area will apply to the non-network deductible, and will also apply to the network deductible.

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

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

The Plan Deductible applies to all covered expenses except:

- expenses that are subject to the Inpatient Hospital Facility Services Per Admission Deductible
- expenses subject to a copay
- expenses for Network Urgent Care Facility (includes all services rendered as part of the visit)
- expenses for Emergency Room (includes all services rendered as part of the visit)
- expenses for contraceptives from a Network or outside the Network area provider
- expenses for mental health Network and Non-network inpatient professional services
- expenses for substance use disorder Network and Non-network inpatient professional services
- expenses for mental health Network outpatient office visits
- expenses for substance use disorder Network outpatient office visits
- expenses for Network provider office visits (office services are separate from the office visit)

  Note: This refers to office visits other than for, if covered under the Plan, mental health and substance use disorders.
- expenses for surgery, other than surgery related to TMJ treatment performed in a Network provider's office
- expenses for lab tests performed in a Network provider's office
- expenses for x-rays, other than advanced radiology, performed in a Network provider's office
- expenses for other office services (diagnostic services, allergy injections) performed in a Network Doctor's office

  Note: See "Office Visits and Services" in Covered Expenses for information about what is considered to be other office services
- expenses for lab tests performed in a Network independent facility
- expenses for lab tests performed in a Network outpatient facility
- expenses for x-rays, other than advanced radiology, performed in a Network outpatient facility
- expenses for virtual care services received from contracted virtual providers (dedicated virtual providers) as medically appropriate, for minor medical conditions

OPEN ACCESS PLUS MEDICAL BENEFITS SCHEDULE - Continued

Individual Calendar Year Deductible	
- Network	$800.00
- Non-network and outside the Network Area	$1,600.00
Family Calendar Year Deductible	
- Network	$1,600.00
- Non-network and outside the Network Area	$3,200.00

Inpatient Hospital Facility Services Per Admission Deductible

This Per Admission Deductible is the amount of covered facility charges for each inpatient admission in a Hospital or other facility that must be incurred (paid) by you and/or your Dependents before the Plan begins paying benefits for inpatient facility charges. This Per Admission Deductible is separate from the Plan Deductible, and continues to apply after the Plan Deductible is satisfied.

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

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

Per Admission	
- Network	$100.00
- Non-network and outside the Network Area	$500.00

Medical Management Program

Ineligible Expense Penalty per claim	$250.00

Out-of-Pocket Maximum

Plan Deductible, Inpatient Hospital Facility Services Per Admission Deductible, medical expense copays and coinsurance amounts paid by you and your covered Dependents for network services accumulate to the Network Out-of-Pocket Maximum.

Plan Deductible, Inpatient Hospital Facility Services Per Admission Deductible, medical expense copays and coinsurance amounts paid by you and your covered Dependents for non-network services and services outside the network area accumulate to the Non-network and Services outside the Network Area Out-of-Pocket Maximum.

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

- expenses not covered under this Plan.
- expenses the Plan pays at 100%.
- prescription drug benefit expenses.
- Medical Management Ineligible Expense Penalty.

OPEN ACCESS PLUS MEDICAL BENEFITS SCHEDULE - Continued

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

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

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

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

Expenses paid by you and/or your dependents for covered network services will apply to the Network Out-of-Pocket Maximum, and will also apply to the Non-Network Out-of-Pocket Maximum. Expenses paid by you and/or your dependents for covered non-network services and covered services outside the network area will apply to the Non-Network Out-of-Pocket Maximum, and will also apply to the Network Out-of-Pocket Maximum.

Plan Deductible and Inpatient Hospital Services Per Admission Deductible do not apply after the Out-of-Pocket Maximum has been met.

Medical expense copays do not apply after the Out-of-Pocket Maximum has been met.

Individual Calendar Year Out-of-Pocket Maximum	
- Network	$4,000.00
- Non-Network and Services outside the Network Area	$8,000.00
Family Calendar Year Out-of-Pocket Maximum	
- Network	$8,000.00
- Non-Network and Services outside the Network Area	$16,000.00

Benefit Maximum(s)

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

- Home Health Care Services	60 visits
Maximum does not apply to mental health and substance use disorder conditions.	
- Skilled Nursing Facility	30 days
- Outpatient Therapy Services - Physical Therapy	20 visits
- Outpatient Therapy Services - Speech, Hearing and Occupational Therapy	20 visits
Maximum does not apply to mental health and substance use disorder conditions.	
- Outpatient Therapy Services - Chiropractic Care Services	12 visits

OPEN ACCESS PLUS MEDICAL BENEFITS SCHEDULE - Continued

- Transplant Services - Services at facilities that are not designated network facilities (maximums are per transplant)	
* Heart	$150,000.00
* Liver	$230,000.00
* Bone Marrow	$130,000.00
* Heart/Lung	$185,000.00
* Lung	$185,000.00
* Pancreas	$50,000.00
* Kidney	$80,000.00
* Kidney/Pancreas	$80,000.00
- Gene Therapy - Approved Travel Expenses to and from a network facility specifically contracted with Cigna to provide the specific gene therapy	$10,000.00 per episode of gene therapy

Lifetime Benefit Maximum(s)

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

- Transplant Services - Approved Travel Expenses	$10,000.00
Lifetime Maximum Benefit for all Covered Expenses	Unlimited

Copays for Covered Expenses

Copays are amounts to be paid by you and/or your Dependents (the Member) for Covered Expenses.

- Mental Health - Network Outpatient Office Visits (such as individual and group psychotherapy, medication management, virtual care)	$30.00
- Substance Use Disorders - Network Outpatient Office Visits (such as individual and group psychotherapy, medication management, virtual care)	$30.00
- Network Outpatient Therapy Services - Chiropractic Care Services	$60.00
- Virtual Care - Dedicated Virtual Providers - Services available through contracted virtual providers as medically appropriate, for minor medical conditions	$30.00
- Virtual Care - Virtual Physician Services - Services available through Physicians as medically appropriate.	Same as Office Visit
Note: Preventive services covered at the preventive level.	
- Network Urgent Care Facility (includes all services rendered as part of the visit)	$35.00 per day and per provider
- Emergency Room (includes all services rendered as part of the visit, and this copay is waived if the visit is immediately followed by an inpatient admission)	$150.00
- Other Network Office Visits - Primary Care	$30.00
- Other Network Office Visits - Specialist Care	$60.00

OPEN ACCESS PLUS MEDICAL BENEFITS SCHEDULE - Continued

The Other Network Office Visits copay does not apply to office visits for contraceptives, preventive care, outpatient physical, speech, hearing and occupational therapies, and non-network urgent care facility visits.

Coinsurance for all Covered Expenses

"Coinsurance" means the percentage of Covered Expenses that a Member is required to pay under the Plan in addition to Deductible(s), if any. The Plan's percentage is shown here.

	NETWORK	NON-NETWORK
Mental Health - Inpatient	80%	60%
Mental Health - Outpatient		
- Office Visits (such as individual, family and group psychotherapy, medication management, virtual care)	100%	60%
- All Other Outpatient Services (such as partial hospitalization, intensive outpatient services, virtual care)	80%	60%
Substance Use Disorders - Inpatient	80%	60%
Substance Use Disorders - Outpatient		
- Office Visits (such as individual, family and group psychotherapy, medication management, virtual care)	100%	60%
- All Other Outpatient Services (such as partial hospitalization, intensive outpatient services, virtual care)	80%	60%
Preventive Care		
- Preventive Care Office Visits	100%	Not Covered
- Preventive Care Services other than lab tests and x-rays	100%	Not Covered
- Preventive Care lab tests and x-rays ordered as part of Preventive Care and performed in a provider's office	100%	Not Covered
- Preventive Care lab tests and x-rays ordered as part of Preventive Care and performed in an independent or outpatient facility	100%	Not Covered
Office Visits and Office Services		
- Office Visits		
* Primary Care	100%	60%
* Specialist Care	100%	60%
- Lab Tests performed in the provider's office		
* Primary Care	100%	60%
* Specialist Care	100%	60%
- X-rays performed in the provider's office		
* Primary Care	100%	60%

OPEN ACCESS PLUS MEDICAL BENEFITS SCHEDULE - Continued

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

OPEN ACCESS PLUS MEDICAL BENEFITS SCHEDULE - Continued

	NETWORK	NON-NETWORK
Urgent Care Facility (includes all services rendered as part of the visit)	100%	60%
Emergency Room (includes all services rendered as part of the visit)	100%	100%
Ambulance Services	80%	80%
Medical Pharmaceuticals (cost of drug only) administered in these locations:		
- Inpatient Hospital	Same as Inpatient Hospital benefit	Same as Inpatient Hospital benefit
- Outpatient Facility	80%	60%
- Doctor/Physician Office	80%	60%
- Member's Home	80%	60%
Gene Therapy products and services directly related to their administration, when prior authorized and Medically Necessary; must be received at a network facility specifically contracted with Cigna to provide the specific gene therapy		
- Gene therapy product	Same as Medical Pharmaceuticals	Not Covered
- Gene therapy services directly related to product administration		
* Network facility specifically contracted with Cigna to provide the specific gene therapy	Based on place and type of service	Not Covered
* Other Network facilities	Not Covered	Not Covered
* Non-network facilities	Not Covered	Not Covered
- Approved Travel Expenses to and from a network facility specifically contracted with Cigna to provide the specific gene therapy	100%	Not Covered
Home Health Care Services	80%	60%
Skilled Nursing Facility	80%	60%
Hospice Care		
- Inpatient Hospice	Same as Inpatient Hospital	Same as Inpatient Hospital
- Outpatient Hospice	Same as Home Health Care	Same as Home Health Care
Contraceptives	100%	Based on place and type of service
Family Planning	Based on place and type of service	Not Covered

OPEN ACCESS PLUS MEDICAL BENEFITS SCHEDULE - Continued

	NETWORK	NON-NETWORK
Women's Sterilization Procedures, e.g. tubal ligations (excluding reversals)	100%	Not Covered
Breast-Feeding Equipment (rental of one breast pump per pregnancy up to the purchase price, and related supplies, when the pump is ordered or prescribed by a Doctor)	100%	Not Covered
Durable Medical Equipment	80%	60%
TMJ Treatment	Based on place and type of service	Based on place and type of service
Outpatient Therapy Services - includes cognitive therapy, osteopathic manipulation, pulmonary rehabilitation, cardiac rehabilitation, and:		
- Physical Therapy	80%	60%
- Speech, Hearing and Occupational Therapy	80%	60%
- Chiropractic Care Services	100%	60%
Transplant Services		
- Approved Travel Expenses to and from certain designated Network facilities	100%	Not Covered
- Transplant Services		
* Designated Network facilities	80%	Not Covered
* Other Network facilities	60%	Not Covered
* Non-network facilities	Not Covered	60%
Virtual Care - Dedicated Virtual Providers - Services available through contracted virtual providers as medically appropriate, for minor medical conditions	100%	Not Covered
Virtual Care - Wellness Screenings	100%	Not Covered
Note: Lab services supporting a virtual wellness screening must be obtained through dedicated labs.		
Virtual Care - Virtual Physician Services - Services available through Physicians as medically appropriate.	Same as Office Visit	Same as Office Visit
Note: Preventive services covered at the preventive level.		
Other Covered Expenses	80%	60%

Covered Expenses incurred outside the Network service area

Covered Expenses incurred outside the Network service area are payable at 80%, except as indicated below.

OPEN ACCESS PLUS MEDICAL BENEFITS SCHEDULE - Continued

- Preventive Care Office Visits	100%
- Preventive Care Services other than lab tests and x-rays	100%
- Preventive Care lab tests and x-rays ordered as part of Preventive Care and performed in:	
* a provider's office	100%
* an independent or outpatient facility	100%
- Breast-Feeding Equipment (rental of one breast pump per pregnancy up to the purchase price, and related supplies, when the pump is ordered or prescribed by a Doctor)	100%
- Contraceptives	100%
- Ambulance Services	80%
- Emergency Room (includes all services rendered as part of the visit)	100%
- Transplant Services	60%

PRESCRIPTION DRUG BENEFITS SCHEDULE

This Plan provides prescription drug benefits for Prescription Drug Products provided by Pharmacies as described in this booklet. This Schedule provides a general description of prescription drug benefits, but it does not list all benefits. The Plan contains limitations and restrictions that could reduce the benefits payable under the Plan. Please read the entire booklet for details about your benefits. As used in this Schedule, any reference to "you" or "your" means you and your covered Dependent(s) (the Member).

A list of Network Pharmacies is available through the website or by contacting Member Services at the phone number shown on your ID card.

To receive prescription drug benefits, you may be required to pay a portion of the covered expenses for Prescription Drug Products. That portion includes any applicable deductible, copay and/or coinsurance.

You will pay 100% of the cost of any Prescription Drug Product excluded from coverage under this Plan. The amount you pay for any excluded Prescription Drug Product to the dispensing Pharmacy will not count toward your Deductible, if any, or Out-of-Pocket Maximum.

Certain preventive care medications covered under this Plan and required as part of preventive care (details at www.healthcare.gov), are payable at 100% not subject to any deductible, copay or coinsurance, when purchased from a Network Pharmacy. A written prescription is required.

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

Generic oral contraceptives and other prescription and over-the-counter (OTC) contraceptives covered under this Plan and required as part of preventive care (details at www.healthcare.gov), when prescribed by a Doctor for birth control and purchased from a Network Pharmacy are covered at 100% not subject to any deductible, copay or coinsurance. A written prescription is required.

Patient Assurance Program - Your Plan offers additional discounts for certain covered Prescription Drug Products that are dispensed by a retail or home delivery Network Pharmacy included in what is known as the "Patient Assurance Program".

As may be described elsewhere in this Plan, from time to time Cigna may directly or indirectly enter into arrangements with pharmaceutical manufacturers for discounts that result in a reduction of your out-of-pocket expenses for certain covered Prescription Drug Products for which Cigna directly or indirectly earns the discounts.

Specifically, some or all of the Patient Assurance Program discount earned by Cigna for certain covered Prescription Drug Products included in the Patient Assurance Program is applied or credited to a portion of your copay or coinsurance, if any. The copay or coinsurance, if any, otherwise applicable to those certain covered Prescription Drug Products included in the Patient Assurance Program is applied or credited to a portion of your copay or coinsurance, if any.

The copay or coinsurance, if any, otherwise applicable to those certain covered Prescription Drug Products as set forth in this Schedule may be reduced in order for Patient Assurance Program discounts earned by Cigna to be applied or credited to the copay or coinsurance, if any, as described above.

PRESCRIPTION DRUG BENEFITS SCHEDULE - Continued

For example, certain insulin product(s) covered under the Prescription Drug benefit for which Cigna directly or indirectly earns a discount in connection with the Patient Assurance Program shall result in a credit toward some or all of your copay or coinsurance, if any, which, as noted, may be reduced from the amount set forth in this Schedule for the insulin product. In addition, the covered insulin products eligible for Patient Assurance Program discounts shall not be subject to the deductible, if any.

Your copay or coinsurance payment, if any, for covered Prescription Drug Products under the Patient Assurance Program counts toward your out-of-pocket maximum.

Any Patient Assurance Program discount that is used to satisfy your copay or coinsurance, if any, for covered Prescription Drug Products under the Patient Assurance Program counts toward your out-of-pocket maximum.

Please note that the Patient Assurance Program discounts that Cigna may earn for Prescription Drug Products, and may apply or credit to your copay or coinsurance, if any, in connection with the Patient Assurance Program are unrelated to an rebates or other payments that Cigna may earn from a pharmaceutical manufacturer for the same or other Prescription Drug Products. Except as may be noted elsewhere in this Plan, you are not entitled to the benefit of those rebates or other payments earned by Cigna because they are unrelated to the Patient Assurance Program.

Additionally, the availability of the Patient Assurance Program, as well as the Prescription Drug Products included in the Patient Assurance Program and/or your copay or coinsurance, if any, for those eligible Prescription Drug Products, may change from time to time depending on factors including, but not limited to, the continued availability of the Patient Assurance Program discount(s) to Cigna in connection with the Patient Assurance Program. More information about the Patient Assurance Program including the Prescription Drug Products included in the program, is available at the website shown on your ID card or by calling Member Services at the telephone number on your ID card.

Out-of-Pocket Maximum

This out-of-pocket maximum is a separate maximum from the medical out-of-pocket maximum. Prescription drug coinsurance and copay amounts paid by you and your covered Dependents for covered prescription drugs purchased at a Network Pharmacy accumulate toward the Prescription Drug Out-of-Pocket Maximum.

The following prescription drug expenses do **not** accumulate toward the Prescription Drug Out-of-Pocket Maximum:

- expenses for drugs not covered under this Plan.
- expenses for drugs that are payable at 100%.
- prescription drug expenses for prescription drugs purchased at a pharmacy that is not a Network Pharmacy.

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

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

Individual Calendar Year Out-of-Pocket Maximum	$2,000.00

PRESCRIPTION DRUG BENEFITS SCHEDULE - Continued

Family Calendar Year Out-of-Pocket Maximum	$4,000.00

Copays and Coinsurance

Copays are amounts to be paid by you for covered Prescription Drug Products. A coinsurance is the percentage of the Prescription Drug Charge for a covered Prescription Drug Product that you are required to pay under this Plan in addition to the Deductible, if any.

Retail Network Pharmacy - *up to a 30-day supply*

The amount you pay per Prescription Order or Refill for up to a consecutive 30-day supply of a Prescription Drug Product purchased at a Network Pharmacy is shown here.

Tier 1 - Generic Drugs on the Prescription Drug List	$10.00 copay
Tier 2 - Brand Drugs designated as preferred on the Prescription Drug List	$30.00 copay
Tier 3 - Brand Drugs designated as non-preferred on the Prescription Drug List	$50.00 copay

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

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

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

The 90-Day Retail option is not available for Specialty Prescription Drug Products.

The amount you pay per Prescription Order or Refill for up to a consecutive 90-day supply of a Prescription Drug Product purchased at a retail Designated Pharmacy is shown here. In this context, a retail Designated Pharmacy is a retail Network Pharmacy contracted for dispensing covered Prescription Drug Products, including Maintenance Drug Products, in 90-day supplies per Prescription Order or Refill.

Tier 1 - Generic Drugs on the Prescription Drug List	$25.00 copay
Tier 2 - Brand Drugs designated as preferred on the Prescription Drug List	$75.00 copay
Tier 3 - Brand Drugs designated as non-preferred on the Prescription Drug List	$125.00 copay

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

Information about purchasing Prescription Drug Products from a home delivery Network Pharmacy is available through the website or by contacting Member Services at the phone number shown on your ID card.

The amount you pay per Prescription Order or Refill for up to a consecutive 90-day supply of a Prescription Drug Product purchased at a home delivery Network Pharmacy is shown here.

PRESCRIPTION DRUG BENEFITS SCHEDULE - Continued

Tier 1 - Generic drugs on the Prescription Drug List	$25.00 copay
Tier 2 - Brand Drugs designated as preferred on the Prescription Drug List	$75.00 copay
Tier 3 - Brand Drugs designated as non-preferred on the Prescription Drug List	$125.00 copay

Tier 4 - Specialty Prescription Drug Products

Specialty Prescription Drug Products are limited to up to a consecutive 30-day supply per Prescription Order or Refill.

Certain Specialty Prescription Drug Products are only covered when dispensed by a home delivery Pharmacy.

You pay $150.00 per Prescription Order or Refill for up to a consecutive 30-day supply of a Specialty Prescription Drug Product.

ELIGIBILITY

■ Eligible Employees

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

Service

"Service" means work with the Employer on an active basis, as determined by your Employer.

■ Eligible Dependents

If you and your spouse are eligible to be covered as Employees: A person who is eligible as an Employee will not be considered as an eligible Dependent. An eligible Dependent child may be considered as a Dependent of only one Employee.

If you are eligible to be covered as an Employee and as a Dependent child of another Employee: A person who is eligible as an Employee will not be considered as an eligible Dependent. However, if you are eligible to be covered as an Employee's Dependent child because you are under age 26, then you are eligible to be covered as either an Employee or as an Employee's Dependent child.

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

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

Eligible Dependents are:

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

Child

"Child" means:

- your natural child.
- your stepchild.
- your adopted child. This includes a child placed with you for adoption.

  "Placed for adoption" means the assumption and retention of a legal obligation for the total or partial support of a child in anticipation of the adoption of such child. The child's placement is considered terminated upon the termination of such legal obligation.
- a child who is recognized under a medical child support order as having a right to enrollment under the Plan.
- a foster child.

Handicapped/Disabled Child

The age limit does not apply to a child who becomes disabled, or became disabled, before reaching the age limit and who: cannot hold a self-supporting job due to a permanent physical handicap or intellectual disability; and depends on you for financial support.

"Physical handicap/intellectual disability" means permanent physical or mental impairment that is a result of either a congenital or acquired illness or injury leading to the individual being incapable of independent living.

"Permanent physical or mental impairment" means:

ELIGIBILITY - Continued

- a physiological condition, skeletal or motor deficit; or
- intellectual disabilities or organic brain syndrome.

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

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

Medical Child Support Order

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

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

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

WHEN COVERAGE BEGINS & ENDS

■ When Will Coverage Begin?

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

Coverage will begin on the first day of the month coinciding with or next following the date you satisfy any eligibility waiting period(s) as determined by your Employer, if you meet the Service definition in ELIGIBILITY on that day, or if due to your health status you do not meet the Service definition on that day.

Before coverage can start, you must:

- Submit an application within 30 days after becoming eligible;
- Pay any required contribution.

Coverage for a newly acquired Dependent will begin on the date you acquire the Dependent if you are covered and if you apply for coverage within 30 days after acquiring the new Dependent.

If the Dependent is an adoptive child, coverage will start:

- For an adoptive newborn, from the moment of birth if the child's date of placement is within 30 days after the birth; and
- For any other adoptive child, from the date of placement.

■ What If I Don't Apply On Time?

You are a late applicant under the Plan if you don't apply for coverage within 30 days of the date you become eligible for coverage.

Your Dependent is a late applicant if you elect not to cover a Dependent and then later want coverage for that Dependent.

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

Your eligible Dependent is not a late applicant if you did not apply to cover the Dependent within 30 days of the date you became eligible to do so and later are required by a qualified court order to provide coverage under this Plan for that Dependent. If you apply within 30 days of the date the court order is issued, coverage will start on the court ordered date.

Special Enrollment Rights

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

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

A special enrollment event occurs if:

WHEN COVERAGE BEGINS & ENDS - Continued

- You did not apply for coverage for yourself or your eligible Dependent within 30 days of the date you were eligible to do so because at the time you or your eligible Dependent was covered under another health insurance plan or arrangement and coverage under the other plan was lost as a result of:
  - Exhausting the maximum period of COBRA coverage; or
  - Loss of eligibility for the other plan's coverage due to legal separation, divorce, cessation of dependent status, death of a spouse, termination of employment or reduction in the number of hours of employment; or
  - Loss of eligibility for the other plan's coverage because you or your eligible Dependent no longer resides in the service area; or
  - Loss of eligibility for the other plan's coverage because you or your eligible Dependent incurs a claim that meets or exceeds the lifetime maximum for that plan; or
  - Termination of benefits for a class of individuals and you or your eligible Dependent is included in that class; or
  - Termination of the employer's contribution for the other plan's coverage.

  You must have stated in writing that the other health coverage was the reason you declined coverage under this Plan, but only if the Employer required such a statement and notified you of the consequences of the requirement when you declined coverage.
- You did not apply for coverage for yourself or your eligible Dependent within 30 days of the date you were eligible to do so because at the time you or your eligible Dependent was covered under a state Medicaid or Children's Health Insurance Program (CHIP) plan, and such coverage terminates due to a loss of eligibility. In this situation, you may request coverage for yourself and/or any affected eligible Dependent not already enrolled in this Plan. Coverage must be requested within 60 days of the date Medicaid or CHIP coverage terminated.
- You did not apply for coverage for yourself or your eligible Dependent within 30 days of the date you were eligible to do so and you or your eligible Dependent later becomes eligible for employment assistance under a state Medicaid or CHIP plan that helps pay for the cost of this Plan's coverage. In this situation, you may request coverage for yourself and/or any affected eligible Dependent not already enrolled in this Plan. Coverage must be requested within 60 days of the date the Member is determined to be eligible for such assistance.
- You did not apply to cover yourself or an eligible Dependent within 30 days of the date you became eligible to do so and later experience a change in family status because you acquire a Dependent through marriage, birth or adoption. In this case, you may apply for coverage for yourself, your spouse and any newly acquired Dependents.

If you apply within 30 days of the date:

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

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

■ Will My Coverage Change?

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

WHEN COVERAGE BEGINS & ENDS - Continued

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

■ When Will My Coverage End?

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

- The date the Employer terminates the benefits described in this booklet.
- The date you are no longer eligible or your Service ends.
- The due date of the first contribution toward your coverage that you or the Employer fails to make.

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

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

  For your covered Dependent child who reaches the limiting age (see ELIGIBILITY), this is the last day of the calendar year in which the limiting age is reached.

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

Continuation of Coverage under Federal Laws and Regulations

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

OPEN ACCESS PLUS MEDICAL BENEFITS

■ **How Does the Plan Work?**

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

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

See "Medical Management Program" for information about pretreatment authorization.

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

Medical Management Program

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

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

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

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

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

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

Pretreatment authorization is not required prior to receiving Emergency Services. Medical Management must be contacted within 48 hours after care is provided.

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

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

- Air Ambulance, when used for non-Emergency Medical Conditions.
- Durable medical equipment, based on type of equipment.
- Genetic testing.

- Home health care (including IV therapy).
- Hospital admissions.
- Outpatient advanced radiology, such as MRI, MRA, PET, CT-Scan and nuclear medicine.
- Outpatient surgery.
- Certain Medical Pharmaceuticals.
- Renal dialysis.
- Skilled nursing facilities.
- Transplant services.

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

The MEDICAL BENEFITS SCHEDULE shows deductibles and copays, as well as any Plan maximums and Plan coinsurance payment percentages.

The term Covered Expenses means expenses incurred by a person while covered under this Plan for services and supplies listed below for:

- preventive care services; and
- services and supplies that are Medically Necessary for the care and treatment of an Injury or Illness, as determined by Cigna.

As determined by Cigna, Covered Expenses may also include all charges made by an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies listed below.

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

Emergency Room

Emergency Room

The Plan covers Emergency Services. Pretreatment authorization is not required prior to receiving Emergency Services. Medical Management must be contacted within 48 hours after care is provided.

Inpatient Hospital Care immediately following an Emergency Room Visit

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

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

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

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

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

Urgent Care

The Plan covers Urgent Care.

Office Visits and Services

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

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

Primary Care includes Preventive Care and care rendered by Doctors who agree to serve as Primary Care Physicians. In general, Primary Care Physicians include Doctors in the fields of General Practice, Family Practice, Pediatrics and Internal Medicine. OB/GYNs are also included. Members may determine a provider's classification by using the member web site or by calling Member Services.

Preventive Care

The Plan covers the following preventive care services:

- Routine physical exams by a Doctor. This includes x-ray and lab services if part of a physical exam, necessary immunizations and booster shots. Immunizations and booster shots for the purpose of travel or to protect against occupational hazards and risks are not covered.
- Pelvic exams, Pap smears and mammograms.

- Screening prostate-specific antigen (PSA) testing.
- Colorectal cancer screening.

The Plan also covers the following preventive care services as defined by recommendations from the following:

- the U.S. Preventive Services Task Force (A and B recommendations).
- the Advisory Committee on Immunization Practices (ACIP) for immunizations.
- the American Academy of Pediatrics' Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care.
- the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children.
- with respect to women, evidence-informed preventive care and screening guidelines supported by the Health Resources and Services Administration.

Detailed information is available at www.healthcare.gov. For additional information on immunizations, visit the immunization schedule section of www.cdc.gov.

Breast Reconstruction and Breast Prostheses

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

Reconstructive Surgery

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

Maternity Coverage

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

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

Contraceptives

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

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

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

Family Planning

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

Infertility Testing

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

Mental Health

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

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

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

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

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

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

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

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

Substance Use Disorders

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

The Plan covers substance use disorder services. A substance use disorder is a psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care and treatment.

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

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

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

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

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

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

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

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

<u>Outpatient Therapy Services</u>

The Plan covers:

- Charges for therapy services when provided as part of a program of treatment: cognitive therapy, hearing therapy, occupational therapy, osteopathic manipulation, physical therapy, pulmonary rehabilitation, speech therapy.
- *Cardiac Rehabilitation* - Charges for Phase II cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when Medically Necessary. Phase II is a Hospital-based outpatient program following an inpatient Hospital discharge. The Phase II program must be Doctor-directed with active treatment and EKG monitoring.

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

- *Chiropractic Care Services* - Charges for diagnostic and treatment services utilized in an office setting by chiropractic Doctors. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function. For these services you have direct access to qualified chiropractic Doctors.

Coverage for Outpatient Therapy Services is provided when Medically Necessary in the most medically appropriate setting to:

- Restore function (called “rehabilitative”):
  - to restore function that has been impaired or lost.
  - to reduce pain as a result of Illness, Injury or loss of a body part.
- Improve, adapt or attain function (sometimes called “habilitative”):
  - to improve, adapt or attain function that has been impaired or was never achieved as a result of congenital abnormality (birth defect).
  - to improve, adapt or attain function that has been impaired or was never achieved because of mental health and substance use disorder conditions.

    This includes conditions such as autism and intellectual disability, or mental health and substance use disorder conditions that result in a developmental delay.

Coverage for Outpatient Therapy Services is provided as part of a program of treatment when the following criteria are met:

- The individual's condition has the potential to improve or is improving in response to therapy, and maximum improvement is yet to be attained.
- There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
- The therapy is provided by, or under the direct supervision of, a licensed health care professional acting within the scope of the license.
- The therapy is Medically Necessary and medically appropriate for the diagnosed condition.

Coverage for occupational therapy is provided only for the purposes of enabling individuals to perform the activities of daily living after an Illness or Injury.

Therapy services that are not covered include:

- Sensory integration therapy.
- Treatment of dyslexia.
- Maintenance or preventive treatment provided to prevent recurrence or to maintain the patient's current status.
- Charges for Chiropractic Care not provided in an office setting.
- Vitamin therapy.

Coverage is administered according to the following:

- Multiple therapy services provided on the same day constitute one day of service for each therapy type.
- A separate copay applies to the services provided by each provider per visit.

<u>Home Health Care Services</u>

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

The Plan covers Home Health Care Services when the Member requires skilled care, is unable to obtain the required care as an ambulatory outpatient and does not require confinement in a Hospital or Other Health Care Facility.

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

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

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

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

Hospice Care

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

Durable Medical Equipment

The Plan covers durable medical equipment, including orthopedic and prosthetic devices, that are not useful in the absence of an Illness or Injury, not disposable, able to withstand repeated use and appropriate for use in a Member's home.

Coverage includes repair or replacement of covered equipment only when repair or replacement is required as a result of normal usage. Coverage for equipment rental will not exceed the equipment's purchase price.

Transplant Services

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

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

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

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

Transplant services received at any other facility are payable as shown on the SCHEDULE.

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

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

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

Medical Pharmaceuticals

The Plan covers charges made for Medical Pharmaceuticals that are administered in an inpatient setting, outpatient setting, a provider's office or in your home.

As used in this benefit provision, any reference to “you” or “your” means you and your covered Dependent(s) (the Member).

Benefits under this provision are provided only for Medical Pharmaceuticals which, due to their characteristics (as determined by Cigna), are required to be administered, or the administration of which must be directly supervised, by a qualified Doctor.

Benefits payable under this provision include Medical Pharmaceuticals whose administration may initially, or typically, require Doctor oversight but may be self-administered under certain conditions specified in the product's U.S. Food and Drug Administration (FDA) labeling.

Certain Medical Pharmaceuticals are subject to prior authorization requirements or other coverage conditions. Additionally, certain Medical Pharmaceuticals are subject to step therapy requirements. This means that in order to receive benefits for such Medical Pharmaceuticals, you are required to try a different Medical Pharmaceutical(s) and/or Prescription Drug Product(s) first.

Utilization management requirements or other coverage conditions are based on a number of factors which may include clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of Medical Pharmaceuticals, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Medical Pharmaceutical cost including, but not limited to, assessments on the cost effectiveness of the Medical Pharmaceutical and available rebates. Regardless of its eligibility for coverage under the Plan, whether a particular Prescription Drug Product is appropriate for you is a determination that is made by you and the prescribing Doctor.

The coverage criteria of a Medical Pharmaceutical may change periodically for various reasons. For example, a Medical Pharmaceutical may be removed from the market, a new Medical Pharmaceutical in the same therapeutic class as a Medical Pharmaceutical may become available, or other market events may occur. Market events that may affect the coverage status of a Medical Pharmaceutical include, but are not limited to, an increase in the acquisition cost of a Medical Pharmaceutical.

Gene Therapy

The Plan covers charges for gene therapy products and services directly related to their administration when Medically Necessary. Gene therapy is a category of pharmaceutical products approved by the U.S. Food and Drug Administration (FDA) to treat or cure a disease by:

- replacing a disease-causing gene with a healthy copy of the gene.
- inactivating a disease-causing gene that may not be functioning properly.
- introducing a new or modified gene into the body to help treat a disease.

Each gene therapy product is specific to a particular disease and is administered in a specialized manner. Cigna determines which products are in the category of gene therapy, based in part on the nature of the treatment and how it is distributed and administered.

Coverage includes the cost of the gene therapy product; medical, surgical, and facility services directly related to administration of the gene therapy product; and professional services.

Gene therapy products and their administration are covered when prior authorized to be received at network facilities specifically contracted with Cigna for the specific gene therapy service. Gene therapy products and their administration received at other facilities are not covered.

Gene Therapy Travel Services - Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized gene therapy procedure are covered subject to the following conditions and limitations.

Benefits for transportation and lodging are available to you only when you are the recipient of a prior authorized gene therapy; and when the gene therapy products and services directly related to their administration are received at a participating network facility specifically contracted with Cigna for the specific gene therapy service. The term recipient is defined to include a person receiving prior authorized gene therapy related services during any of the following: evaluation, candidacy, event, or post care.

Travel expenses for the person receiving the gene therapy include charges for: transportation to and from the gene therapy site (including charges for a rental car used during a period of care at the facility); and lodging while at, or traveling to and from, the site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.

The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

Nutritional Counseling

The Plan covers charges made for nutritional counseling when diet is a part of the medical management of a medical or behavioral condition.

Enteral Nutrition

The Plan covers enteral nutrition, including medically approved formulas prescribed by a Doctor for treatment of inborn errors of metabolism (e.g. disorders of amino acid or organic acid metabolism).

Enteral nutrition means medical foods that are specially formulated for enteral feedings or oral consumption.

Clinical Trials

The Plan covers routine patient care costs and services related to an approved clinical trial for a qualified individual. The individual must be eligible to participate according to the trial protocol and **either** of the following conditions must be met:

- the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate; or
- the individual provides medical and scientific information establishing that the individual's participation in the qualified trial would be appropriate.

In addition to qualifying as an individual, the clinical trial must also meet certain criteria in order for patient care costs and services to be covered.

The clinical trial must be a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition that meets **any** of the following criteria:

- it is a federally funded trial. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH).
  - Centers for Disease Control and Prevention (CDC).
  - Agency for Health Care Research and Quality (AHRQ).
  - Centers for Medicare and Medicaid Services (CMS).
  - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA).
  - a qualified non-governmental research entity identified in NIH guidelines for center support grants.
  - any of the following: Department of Energy, Department of Defense, Department of Veterans Affairs, if **both** of the following conditions are met:

  * the study or investigation has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and
  * the study or investigation assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA).
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application.

The Plan does not cover any of the following services associated with a clinical trial:

- services that are not considered routine patient care costs and services, including the following:
  - the investigational drug, device, item, or service that is provided solely to satisfy data collection and analysis needs.
  - an item or service that is not used in the direct clinical management of the individual.
  - a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- an item or service provided by the research sponsors free of charge for any person enrolled in the trial.
- travel and transportation expenses, unless otherwise covered under the Plan, including but not limited to the following: fees for personal vehicle, rental car, taxi, medical van, ambulance, commercial airline, train; mileage reimbursement for driving a personal vehicle; lodging; meals.
- routine patient costs obtained out-of-network when out-of-network (non-network) benefits do not exist under the Plan.

Examples of routine patient care costs and services include:

- radiological services.
- laboratory services.
- intravenous therapy.
- anesthesia services.
- Doctor services.
- office services.
- Hospital services.
- Room and Board, and medical supplies that typically would be covered under the Plan for an individual who is not enrolled in a clinical trial.

Clinical trials conducted by out-of-network (non-network) providers will be covered only when the following conditions are met:

- in-network providers are not participating in the clinical trial; or
- the clinical trial is conducted outside the individual's state of residence.

<u>Miscellaneous Medical Services and Supplies</u>

- charges for inpatient Room and Board and other Necessary Services and Supplies made by a Hospital.
- charges for inpatient Room and Board and other Necessary Services and Supplies made by an Other Health Care Facility, including a Skilled Nursing Facility, a rehabilitation Hospital or a subacute facility.
- charges for licensed Ambulance service to the nearest Hospital where the needed medical care and treatment can be provided.
- charges for outpatient medical care and treatment received at a Hospital.
- charges for outpatient medical care and treatment at a Free-Standing Surgical Facility.
- charges by a Doctor for professional services.

OPEN ACCESS PLUS MEDICAL BENEFITS - Continued

- charges by a nurse for professional nursing services.
- charges for anesthetics, including, but not limited to supplies and their administration.
- charges for diagnostic x-ray.
- charges for advanced radiological imaging, including for example CT Scans, MRI, MRA and PET scans and laboratory examinations, x-ray, radiation therapy and radium and radioactive isotope treatment and other therapeutic radiological procedures.
- charges for laboratory services, radiation therapy and other diagnostic radiological procedures.
- charges for chemotherapy.
- charges for blood transfusions.
- charges for oxygen and other gases and their administration.
- charges for Medically Necessary foot care for diabetes, peripheral neuropathies, and peripheral vascular disease.
- charges for surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ).
- charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies.
- charges for the delivery of medical and health-related services and consultations as medically appropriate through audio, video, and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting.
- charges for behavioral consultations and services via secure telecommunications technologies that include video capability, including telephones and internet, when delivered through a behavioral provider.
- charges for general anesthesia and associated facility charges for dental procedures when determined to be Medically Necessary.

PRESCRIPTION DRUG BENEFITS

■ What's Covered? (Covered Expenses)

As used in this Prescription Drug Benefits section, any reference to “you” or “your” means you and your covered Dependent(s) (the Member).

The Plan provides benefits for Prescription Drug Products dispensed by a Pharmacy. Details regarding the Plan's covered expenses, which for the purpose of Prescription Drug Benefits includes Medically Necessary Prescription Drug Products ordered by a Doctor, limitations and exclusions are provided in the PRESCRIPTION DRUG BENEFITS SCHEDULE and as described in this booklet.

If you, while covered under the Plan for prescription drug benefits, incur expenses for charges made by a Pharmacy for Medically Necessary Prescription Drug Products ordered by a Doctor, the Plan provides coverage for those expenses as shown in the PRESCRIPTION DRUG BENEFITS SCHEDULE. Your benefits may vary depending on which of the Prescription Drug List tiers the Prescription Drug Product is listed, or the Pharmacy that provides the Prescription Drug Product.

The drug benefit includes coverage of contraceptives.

Coverage under the Plan's prescription drug benefit also includes Medically Necessary Prescription Drug Products dispensed pursuant to a Prescription Order or Refill issued to you by a licensed Dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you are issued a Prescription Order or Refill for Medically Necessary Prescription Drug Products as part of the rendering of Emergency Services and Cigna determines that it cannot reasonably be filled by a Network Pharmacy, the Prescription Order or Refill will be covered by the Plan at the cost-share requirements applicable to a Network Pharmacy.

Covered Prescription Drug Products purchased at a Pharmacy are subject to any applicable deductible, copay and/or coinsurance shown on the PRESCRIPTION DRUG BENEFITS SCHEDULE. Please refer to that SCHEDULE for any required deductible, copay and/or coinsurance, and any out-of-pocket maximums.

Copay - Your Plan requires that you pay a copay for covered Prescription Drug Products as set forth in the PRESCRIPTION DRUG BENEFITS SCHEDULE. After satisfying any applicable annual deductible set forth in the SCHEDULE, your costs under the Plan for a covered Prescription Drug Product dispensed by a Network Pharmacy and that is subject to a copay requirement will be the lowest of the following amounts:

- the copay for the Prescription Drug Product set forth in the SCHEDULE; or
- the Prescription Drug Charge; or
- the Network Pharmacy's submitted Usual and Customary (U&C) Charge, if any.

Coinsurance - Your Plan requires that you pay a coinsurance amount for covered Prescription Drug Products as set forth in the PRESCRIPTION DRUG BENEFITS SCHEDULE. After satisfying any applicable annual deductible set forth in the SCHEDULE, your costs under the Plan for a covered Prescription Drug Product dispensed by a Network Pharmacy and that is subject to a coinsurance requirement will be the lowest of the following amounts:

- the amount that results from applying the applicable coinsurance percentage set forth in the SCHEDULE to the Prescription Drug Charge; or
- the Network Pharmacy's submitted Usual and Customary (U&C) Charge, if any.

When a treatment regimen contains more than one type of Prescription Drug Product packaged together for your convenience, any applicable copay and/or coinsurance may apply to each Prescription Drug Product.

PRESCRIPTION DRUG BENEFITS - Continued

You will need to obtain prior approval from Cigna or its Review Organization for a Prescription Drug Product not listed on the Prescription Drug List that is not otherwise excluded. If Cigna or its Review Organization approves coverage for a Prescription Drug Product because it meets the applicable coverage exception criteria, the Prescription Drug Product shall be covered at the applicable coverage tier as set forth in the PRESCRIPTION DRUG BENEFITS SCHEDULE.

Your Plan includes a Brand Drug for Generic Drug dispensing program. This program allows certain Brand Drugs to be dispensed in place of the Therapeutic Equivalent Generic Drug at the time your Prescription Order or Refill is processed by a Network Pharmacy. Brand Drug for Generic Drug substitution will occur only for certain Brand Drugs included in the program. When this substitution program is applied, the Network Pharmacy will dispense the Brand Drug to you in place of the available Generic Drug. You will be responsible for payment of only a Generic Drug copay and/or coinsurance, after satisfying your deductible, if any.

Prescription Drug List Management

Your Plan's Prescription Drug List coverage tiers may contain Prescription Drug Products that are Generic Drugs, Brand Drugs or Specialty Prescription Drug Products. Determination of inclusion of a Prescription Drug Product to a certain coverage tier on the Prescription Drug List and utilization management requirements or other coverage conditions are based on a number of factors which may include clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or other utilization management requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, assessments on the cost effectiveness of the Prescription Drug Product and available rebates. Regardless of its eligibility for coverage under the Plan, whether a particular Prescription Drug Product is appropriate for you is a determination that is made by you and the prescribing Doctor.

The coverage status of a Prescription Drug Product may change periodically for various reasons. For example, a Prescription Drug Product may be removed from the market, a New Prescription Drug Product in the same therapeutic class as a Prescription Drug Product may become available, or other market events may occur. Market events that may affect the coverage status of a Prescription Drug Product include, but are not limited to, an increase in the acquisition cost of a Prescription Drug Product. As a result of coverage changes, for the purpose of benefits the Plan may require you to pay more or less for that Prescription Drug Product, to obtain the Prescription Drug Product from a certain Pharmacy(ies) for coverage, or try another covered Prescription Drug Product(s). You may access the website or contact Member Services at the phone number on your ID card for the most up-to-date tier status, utilization management, or other coverage limitations for a Prescription Drug Product.

New Prescription Drug Products

New Prescription Drug Products may or may not be placed on a Prescription Drug List tier upon market entry. Cigna will use reasonable efforts to make a tier placement decision for a New Prescription Drug Product within six months of its market availability. Cigna's tier placement decision shall be based on consideration of, without limitation, the P&T Committee's clinical review of the New Prescription Drug Product and economic factors. If a New Prescription Drug Product not listed on the Prescription Drug List is approved by Cigna or its Review Organization as Medically Necessary in the interim, the New Prescription Drug Product shall be covered at the applicable coverage tier as set forth in the Schedule.

PRESCRIPTION DRUG BENEFITS - Continued

Prior Authorization Requirements

Coverage for certain Prescription Drug Products prescribed to you requires your Doctor to obtain prior authorization from Cigna or its Review Organization. The reason for obtaining prior authorization is to determine whether the Prescription Drug Product is Medically Necessary in accordance with coverage criteria. Coverage criteria for a Prescription Drug Product may vary based on the clinical use for which the Prescription Order or Refill is submitted, and may change periodically based on changes in, without limitation, clinical guidelines or practice standards, or market factors.

If Cigna or its Review Organization reviews the documentation provided and determines that the Prescription Drug Product is not Medically Necessary or is otherwise excluded, the Plan will not cover the Prescription Drug Product. Cigna, or its Review Organization, will not review claims for excluded Prescription Drug Products or other services to determine if they are Medically Necessary, unless required by law.

When Prescription Drug Products that require prior authorization are dispensed at a Pharmacy, you or your prescribing Doctor are responsible for obtaining prior authorization from Cigna. If you do not obtain prior authorization from Cigna or its Review Organization before the Prescription Drug Product is dispensed by the Pharmacy, you can ask Cigna or its Review Organization to consider reimbursement after you pay for and receive the Prescription Drug Product. You will need to pay for the Prescription Drug Product at the Pharmacy prior to submitting a reimbursement request.

When you submit a claim on this basis, you will need to submit a paper claim using the form that appears on the website shown on your ID card.

If a prior authorization request is approved, your Doctor will receive confirmation. The authorization will be processed in the claim system to allow you to have coverage for the Prescription Drug Product. The length of the authorization may depend on the diagnosis and the Prescription Drug Product. The authorization will at all times be subject to the Plan's terms of coverage for the Prescription Drug Product, which may change from time to time. When your Doctor advises you that coverage for the Prescription Drug Product has been approved, you can contact a Pharmacy to fill the covered Prescription Order or Refill.

If the prior authorization request is denied, you and your Doctor will be notified that coverage for the Prescription Drug Product is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with Plan provisions by submitting a written request stating why the Prescription Drug Product should be covered.

Step Therapy

Certain Prescription Drug Products are subject to step therapy requirements. This means that in order to receive benefits for such Prescription Drug Products you are required to try a different Prescription Drug Product(s) first, unless you satisfy the Plan's exception criteria. You may identify whether a particular Prescription Drug Product is subject to step therapy requirements through the website or by contacting Member Services at the phone number shown on your ID card.

Supply Limits

Benefits for Prescription Drug Products are subject to supply limits stated in the SCHEDULE. For a single Prescription Order or Refill, you may receive a Prescription Drug Product up to the stated supply limit.

PRESCRIPTION DRUG BENEFITS - Continued

Some products are subject to additional supply limits, quantity limits or dosage limits based on coverage criteria that have been approved based on consideration of the P&T Committee's clinical findings. Coverage criteria are subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a dispensing supply limit, or similar limit or requirement through the website or by contacting Member Services at the phone number shown on your ID card.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products. If you require Specialty Drug Products, you may be directed to a Designated Pharmacy with whom Cigna has an arrangement to provide those Specialty Drug Products.

Designated Pharmacies

If you require certain Prescription Drug Products, including but not limited to, Specialty Prescription Drug Products, you may be directed to a Designated Pharmacy with whom Cigna has an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy the Prescription Drug Product may not be covered, or the Prescription Drug Product may be subject to the non-network pharmacy benefit as shown on the SCHEDULE.

BENEFIT LIMITATIONS

General Limitations and Exclusions

No amount will be payable for:

- any charge not included as a covered expense under the Plan.
- charges which would not have been made if the Member did not have coverage.
- charges which the Member is not obligated to pay, or for which the Member is not billed or for which the Member would not have been billed except that they were covered under the Plan. For example, if Cigna, in its role as benefits administrator, determines that a provider or Pharmacy is waiving, discounting, reducing, forgiving or has waived, discounted, reduced, or forgiven any portion of its charges and/or any portion of deductible, copay, coinsurance amount(s) you are required to pay for a Covered Expense without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of Plan benefits in connection with the Covered Expense, or reduce the benefits in proportion to the amount of the deductible, copay or coinsurance amount(s) waived, discounted, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that the Plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any Plan benefits. This exclusion includes, but is not limited to, charges of a provider who is not a Participating Provider who has agreed to charge you, or has charged you at a network benefit level or a benefits level not otherwise applicable to the services received. Provided further, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a prescription medication or other product, Cigna may, in its sole discretion, reduce the benefits provided under the Plan in proportion to the amount of any deductible, copay and/or coinsurance amount(s) to which the value of the coupon has been applied by the Pharmacy or other third party, and/or exclude from accumulation toward any Plan deductible or out-of-pocket maximum the value of any coupon applied to any deductible, copay and/or coinsurance you are required to pay.
- charges arising out of, or relating to, any violation of a healthcare-related state or federal law, or which themselves are a violation of a healthcare-related state or federal law.
- treatment of an Illness or Injury which is due to war, declared or undeclared, riot or insurrection.
- services, drugs and supplies that are not Medically Necessary.
- experimental, investigational or unproven services, or in connection with experimental, investigational or unproven services.

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drugs or Biologic therapies or devices that are determined by the utilization review Doctor to be:

  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition, sickness, Injury or Illness for which its use is proposed; or
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in this Plan's Clinical Trial benefit provision; or
  - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in this Plan's Clinical Trial benefit provision.

BENEFIT LIMITATIONS - Continued

In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational and/or unproven, the utilization review Doctor may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

- care for health conditions required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if the Member is legally entitled to such treatment and facilities are reasonably available.
- charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Illness.
- expenses for care provided through or by a public program, to the extent that a Member is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- to the extent of the exclusions imposed by any certification requirement (such as Medical Management requirements) shown in this Plan.
- expenses incurred outside the United States other than expenses for Medically Necessary urgent or emergent care while temporarily traveling abroad.
- charges made by any covered provider who is a member of your family or your Dependent's family.
- for or in connection with an Injury or Illness arising out of, or in the course of, any employment for wage or profit.
- unless otherwise covered in this Plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Doctor and listed as covered in this Plan.
- health care expenses for the infant child of a Dependent, unless the infant child is otherwise eligible under this Plan.

Medical Benefit Limitations and Exclusions

No amount will be payable for:

- any amount that is more than the Maximum Reimbursable Charge.
- Dependent children maternity services.
- custodial care of a Member whose health is stabilized and whose current condition is not expected to significantly or objectively improve or progress over a specified period of time. Custodial care does not seek a cure, can be provided in any setting and may be provided between periods of acute or inter-current health care needs. Custodial care includes any skilled or non-skilled health services or personal comfort and convenience services which provide general maintenance, supportive, preventive and/or protective care. This includes assistance with, performance of, or supervision of: walking, transferring or positioning in bed and range of motion exercises; self-administered medications; meal preparation and feeding by utensil, tube or gastrostomy; oral hygiene, skin and nail care, toilet use, routine enemas; nasal oxygen applications, dressing changes, maintenance of in-dwelling bladder catheters, general maintenance of colostomy, ileostomy, gastrostomy, tracheostomy and casts.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem. However, reconstructive surgery and therapy are covered as provided in the “Reconstructive Surgery” benefit.

BENEFIT LIMITATIONS - Continued

- the following are excluded from coverage regardless of clinical indications (except as may be covered under the "Reconstructive Surgery" benefit): macromastia or gynecomastia surgeries; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy, movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, facility charges and charges for general anesthesia or deep sedation which cannot be administered in a dental office are covered when Medically Necessary. Charges made for services or supplies provided for or in connection with an accidental Injury to teeth are also covered provided a continuous course of dental treatment is started within six months of an accident.
- for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Doctor or under medical supervision.
- infertility testing (except as described in the Infertility Testing provision), infertility services, infertility drugs, surgical or medical treatment programs for infertility, including in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- reversal of male or female voluntary sterilization procedures.
- any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- non-medical counseling and/or ancillary services, including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Care Services" or "Breast Reconstruction and Breast Prostheses" benefits.
- private Hospital rooms and/or private duty nursing except as provided in the "Home Health Care Services" benefit.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Illness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- aids, devices or other adaptive equipment that assist with non-verbal communications, including, but not limited to communication boards, pre- recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.

BENEFIT LIMITATIONS - Continued

- eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses or the first set of eyeglass lenses and frames, and associated services, for treatment of keratoconus or following cataract surgery).
- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- treatment by acupuncture.
- routine foot care, including the paring and removing of corns and calluses and toenail maintenance. However, foot care services for diabetes, peripheral neuropathies and peripheral vascular disease are covered when Medically Necessary.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Medical Management review opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.
- enteral feedings, supplies and specially formulated medical foods that are prescribed and non-prescribed, except for infant formula needed for the treatment of inborn errors of metabolism.
- massage therapy.
- all non-injectable prescription drugs unless Doctor administration or oversight is required, injectable prescription drugs to the extent they do not require Doctor supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in the Plan.
- expenses incurred by a participant to the extent reimbursable under automobile insurance coverage. Coverage under this Plan is secondary to automobile no-fault insurance or similar coverage. The coverage provided under this Plan does not constitute “Qualified Health Coverage” under Michigan law and therefore does not replace Personal Injury Protection (PIP) coverage provided under an automobile insurance policy issued to a Michigan resident. This Plan will cover expenses only not otherwise covered by the PIP coverage.

Prescription Drug Benefit Limitations and Exclusions

Coverage exclusions listed under “Medical Benefit Limitations and Exclusions” and “General Limitations and Exclusions” also apply to benefits for Prescription Drug Products. In addition, the exclusions listed below apply to benefits for Prescription Drug Products. When an exclusion or limitation applies to only certain Prescription Drug Products, you can access the Prescription Drug List through the website shown on your ID card or call Member Services at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

No amount will be payable for:

- coverage for Prescription Drug Products for an amount dispensed (days' supply) which exceeds the applicable supply limit or is less than any applicable supply minimum as set forth in the SCHEDULE, or which exceeds quantity limit(s) or dosage limit(s) set by the P&T Committee.
- more than one Prescription Order or Refill for a given prescription supply period for the same Prescription Drug Product prescribed by one or more Doctors and dispensed by one or more Pharmacies.

BENEFIT LIMITATIONS - Continued

- Prescription Drug Products dispensed outside the jurisdiction of the United States, except as required for emergency or urgent care treatment.
- Prescription Drug Products which are prescribed, dispensed or intended to be taken by or administered to a Member who is a patient in a licensed Hospital, Skilled Nursing Facility, rest home, rehabilitation facility, or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceutical products.
- Prescription Drug Products furnished by the local, state or federal government (except for a Network Pharmacy owned or operated by local, state or federal government).
- any product dispensed for the purpose of appetite suppression (anorectics) or weight loss.
- prescription and non-prescription supplies other than supplies covered as Prescription Drug Products.
- medications used for cosmetic purposes, including, without limitation, medications used to reduce wrinkles, medications used to promote hair growth, and fade cream products.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Prescription Drug Products used for the treatment of infertility.
- Medical Pharmaceuticals covered solely under the Plan's medical benefit.
- Prescription Drug Products used for the treatment of male or female sexual dysfunction, including but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, hypoactive sexual desire disorder and decreased libido.
- Any ingredient(s) in a compounded Prescription Drug Product that has not been approved by the U.S. Food and Drug Administration (FDA).
- medications available over-the-counter (OTC) that do not require a Prescription Order or Refill by state or federal law before being dispensed, unless state or federal law requires coverage of such medications or the OTC medication has been designated as eligible for coverage as if it were a Prescription Drug Product.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to an over-the-counter (OTC) drug(s), or are available in OTC form. Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
- any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Illness or Injury, unless coverage for such product(s) is required by state or federal law.
- medications used for travel prophylaxis, immunization agents, virus detection testing, virus antibody testing, biological products for allergy immunization, biological sera, blood, blood plasma, and other blood products or fractions unless specifically identified on the Prescription Drug List.
- smoking cessation medications, except those required by federal law to be covered as preventive medications.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to another covered Prescription Drug Product(s). Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
- medications that are experimental, investigational or unproven as described in the Plan's General Limitations section.

CLAIMS & LEGAL ACTION

■ How To File Claims

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

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

Timely Filing of Claims

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

Medical Benefits

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

Prescription Drug Benefits

When you purchase covered Prescription Drug Products through a Network Pharmacy, you pay at the time of purchase any applicable deductible, copay or coinsurance shown in the SCHEDULE. You do not need to file a claim form for a Prescription Drug Product obtained at a Network Pharmacy, unless you pay the full cost of a Prescription Drug Product at a Network Pharmacy and later seek reimbursement for the Prescription Drug Product under the Plan or you dispute the accuracy of your payment.

For example, if you must pay the full cost of a Prescription Drug Product to the retail Network Pharmacy because you did not have your ID card, then you must submit a claim to Cigna for any reimbursement or benefit you believe is due to you under this Plan. If, under this example, your payment to the retail Network Pharmacy for the covered Prescription Drug Product exceeds any applicable copay, then you will be reimbursed the difference, if any, between the applicable copay and the Prescription Drug Charge for the Prescription Drug Product.

If you obtain a covered Prescription Drug Product dispensed by a non-network Pharmacy, then you must pay the non-network Pharmacy for the Prescription Drug Product and then submit a claim to Cigna for any reimbursement or benefit you believe is due to you under this Plan. You can obtain a claim form through the website or by calling Members Services at the phone number shown on your ID card.

■ Claim Determinations and Appeal Procedures

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

CLAIMS & LEGAL ACTION - Continued

You may appoint an authorized representative to assist you in submitting a claim or appealing a claim denial. However, Cigna in its role as benefits administrator, may require you to designate your authorized representative in writing using a form approved by Cigna. At all times, the appointment of an authorized representative is revocable by you. To ensure that a prior appointment remains valid, Cigna may require you to re-appoint your authorized representative, from time to time.

Cigna reserves the right to refuse to honor the appointment of a representative if Cigna reasonably determines that the signature on an authorized representative form may not be yours; or the authorized representative may not have disclosed to you all of the relevant facts and circumstances relating to the overpayment or underpayment of any claim, including, for example, that the billing practices of the provider of services may have jeopardized your coverage through the waiver of the cost-sharing amounts that you are required to pay under the Plan.

If your designation of an authorized representative is revoked, or Cigna does not honor your designation, you may appoint a new authorized representative at any time, in writing, using a form approved by Cigna.

Medical Necessity Determinations

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

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

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

Note: An oral statement made to you by a representative of Cigna or its designee that indicates, for example, a particular service is a covered expense, is authorized for coverage by the Plan, or that you are eligible for coverage is not a guarantee that you will receive benefits for services under this Plan. Cigna will make a benefit determination after a claim is received from you or your authorized representative, and the benefit determination will be based on your eligibility as of the date services were rendered to you and the terms and conditions of the Plan in effective as of the date services were rendered to you.

Pre-Service Determinations

CLAIMS & LEGAL ACTION - Continued

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

If the determination periods above would seriously jeopardize your life or health, ability to regain maximum function; or in the opinion of a health care provider with knowledge of your health condition, cause you severe pain which cannot be managed without the requested care; then Cigna will make the pre-service determination on an expedited basis. Cigna will defer to the determination of the treating health care provider, regarding whether an expedited determination is necessary. Cigna will notify you or your representative of an expedited determination within 72 hours after receiving the request.

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

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

Concurrent Determinations

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

Post-Service Determinations

CLAIMS & LEGAL ACTION - Continued

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

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that apply to the determination: information sufficient to identify the claim, including, if applicable, the date of service, provider and claim amount; the specific reason or reasons for the adverse determination including, if applicable, the denial code and its meaning and a description of any standard that was used in the denial; reference to the specific Plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the Plan's review procedures and the applicable time limits, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal, if applicable; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on Medical Necessity, experimental treatment or other similar exclusion or limit; a description of any available internal appeal and/or external review process(es); information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

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

Start with Customer Service

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

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

Internal Appeals Procedure

CLAIMS & LEGAL ACTION - Continued

To initiate an appeal of an adverse benefit determination, you must submit a request for an appeal to Cigna within 180 days of receipt of a denial notice. If you appeal a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal.

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone. Call Customer Service at the phone number shown on your ID card, explanation of benefits or claim form.

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

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

In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the appeal, this information will be provided automatically to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

You may request that the appeal process be expedited if the timeframes under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your health care provider would cause you severe pain which cannot be managed without the requested care. If you request that your appeal be expedited, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited internal appeal would be detrimental to your medical condition.

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

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

External Review Procedure

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

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

CLAIMS & LEGAL ACTION - Continued

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

Notice of Benefit Determination on Appeal

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

If your Plan is governed by ERISA, you have the right to bring a civil action under ERISA Section 502(a) if you are not satisfied with the decision on review. You or your Plan may have other voluntary dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office. You may also contact the Plan Administrator.

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

Legal Action

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

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

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

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

CLAIMS & LEGAL ACTION - Continued

This provision does not apply to your Prescription Drug Benefits.

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

Definitions

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

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

  Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.
- "Closed Panel Plan" means a Plan that provides health care benefits primarily in the form of services or supplies through a panel of employed or contracted providers, and that limits or excludes benefits provided outside of the panel, except in the case of emergency or if referred by a provider within the panel.
- "Primary Plan" means the Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.
- "Secondary Plan" means a Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.
- "Allowable Expense" means the amount of charges considered for payment under the Plan for a covered service prior to any reductions due to deductible, copay or coinsurance amount(s). If Cigna contracts with an entity to arrange for the provision of covered services through that entity's contracted network of health care providers, the amount that Cigna has agreed to pay that entity is the allowable amount used to determine your deductible, copay or coinsurance payment(s). If the Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

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

  - An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
  - The difference between the cost of a private Hospital room and a semiprivate Hospital room, unless the patient's stay in a private Hospital room is Medically Necessary, is not an Allowable Expense.
  - If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
  - If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement is the Allowable Expense.

CLAIMS & LEGAL ACTION - Continued

- If your benefits are reduced under the Primary Plan (through imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

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

Order of Benefit Determination Rules

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

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

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

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

CLAIMS & LEGAL ACTION - Continued

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

Effect on the Benefits of This Plan

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

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

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

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

When the benefits of a government Plan are taken into consideration, the Allowable Expense is limited to the benefits provided by that Plan.

When the Coordination of Benefits provision reduces the benefits payable under this Plan, each benefit will be reduced proportionately and only the reduced amount will be charged against any benefit limits under this Plan.

Recovery of Excess Benefits

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

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

Right to Receive and Release Information

Without consent or notice to you, information may be obtained from you, and information may be released to any other Plan with respect to you, in order to coordinate your benefits pursuant to this provision. You must provide any information requested in order to coordinate your benefits pursuant to this provision. This request may occur in connection with a submitted claim; if so you will be advised that the “other coverage” information, including an explanation of benefits paid under another Plan, is required before the claim will be processed for payment. If no response is received within 55 days of the request, the claim will be closed. If the requested information is subsequently received, the claim will be processed.

■ Coordination of Benefits with Medicare

If you, your spouse or your Dependent is covered under this Plan and qualify for Medicare, federal law determines which plan is the primary payer and which is the secondary payer. The primary payer always determines covered benefits first, without considering what any other coverage will pay. The secondary payer determines its coverage only after the primary plan has completed its determination.

CLAIMS & LEGAL ACTION - Continued

When Medicare is the Primary Payer

Medicare will be the primary payer and this Plan will be the secondary payer, even if you or your spouse or your Dependent do not elect to enroll in Medicare or you or your spouse or your Dependent receive services from a provider who does not accept Medicare payments (see IMPORTANT NOTE below), in the following situations:

- *COBRA or State Continuation*: You, your spouse or your covered Dependent qualify for Medicare for any reason and are covered under this Plan due to COBRA or state continuation of coverage.
- *Retirement or Termination of Employment*: You, your spouse or your covered Dependent qualify for Medicare for any reason and are covered under this Plan due to your retirement or termination of employment.
- *Disability*: You, your spouse or your covered Dependent qualify for Medicare due to a disability, you are an active Employee, and your Employer has fewer than 100 employees.
- *Age*: You, your spouse or your covered Dependent qualify for Medicare due to age, you are an active Employee, and your Employer has fewer than 20 employees.
- *End Stage Renal Disease (ESRD)*: You, your spouse or your covered Dependent qualify for Medicare due to End Stage Renal Disease (ESRD) and you are an active or retired Employee. This Plan will be the primary payer for the first 30 months. Beginning with the 31st month, Medicare will be the primary payer.

When this Plan is the Primary Payer

This Plan will be the primary payer and Medicare will be the secondary payer in the following situations:

- *Disability*: You, your spouse or your covered Dependent qualify for Medicare due to a disability, you are an active Employee, and your Employer has 100 or more employees.
- *Age*: You, your spouse or your covered Dependent qualify for Medicare due to age, you are an active Employee, and your Employer has 20 or more employees.
- *End Stage Renal Disease (ESRD)*: You, your spouse or your covered Dependent qualify for Medicare due to End Stage Renal Disease (ESRD) and you are an active or retired Employee. This Plan is the primary payer for the first 30 months. Beginning with the 31st month, Medicare will be the primary payer.

Domestic Partners

Under federal law, when Medicare coverage is due to age, Medicare is always the primary payer and this Plan is the secondary payer for a person covered under this Plan as a domestic partner. However, when Medicare coverage is due to disability, the Disability payer explanations above will apply.

IMPORTANT NOTE

If you, your spouse or your Dependent do not elect to enroll in Medicare Parts A and/or B when first eligible, or receive services from a provider who does not accept Medicare payments, this Plan will calculate payment based on what should have been paid by Medicare as the primary payer if the person had been enrolled or had received services from a provider who accepts Medicare payments. A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective.

Failure to Enroll in Medicare

CLAIMS & LEGAL ACTION - Continued

If you, your spouse or your Dependent do not enroll in Medicare Parts A and/or B during the person's initial Medicare enrollment period, or the person opts out of coverage, the person may be subject to Medicare late enrollment penalties, which can cause a delay in coverage and result in higher Medicare premiums when the person does enroll. It can also result in a reduction in coverage under Medicare Parts A and B. If you are planning to retire or terminate employment and you will be eligible for any COBRA or state continuation or retiree coverage under this Plan, you should enroll in Medicare before you terminate employment to avoid penalties and to receive the maximum coverage under Medicare. Please consult Medicare or the Social Security Administration for more information.

Assistance with Medicare Questions

For more information on Medicare's rules and regulations, contact Medicare toll-free at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. You may also contact the Social Security Administration toll-free at 1-800-772-1213, at www.ssa.gov, or call your local Social Security Administration office.

■ Expenses For Which A Third Party May Be Responsible

This Plan does not cover:

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

■ Subrogation/Right of Reimbursement

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

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

■ Lien of the Plan

By accepting benefits under this Plan, a Participant:

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

CLAIMS & LEGAL ACTION - Continued

■ Additional Terms

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

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

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

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

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

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

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

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

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

■ Payment of Benefits

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

<u>Assignment and Payment of Benefits</u>

CLAIMS & LEGAL ACTION - Continued

You may not assign to any party, including but not limited to, a provider of health care services/items, your right to benefits under this Plan, nor may you assign any administrative, statutory, or legal rights or causes of action you may have under ERISA, if ERISA is applicable, including but not limited to, any right to make a claim for Plan benefits, to request Plan or other documents, to file appeals of denied claims or grievances, or to file lawsuits under ERISA, if ERISA is applicable. Any attempt to assign such rights shall be void and unenforceable under all circumstances.

You may, however, authorize payment of any health care benefits under this Plan to a Participating Provider or a provider who is not a Participating Provider. When you authorize the payment of your health care benefits to a Participating Provider or a provider who is not a Participating Provider, you authorize payment of the entire amount of the benefits due on that claim. If a provider is overpaid because of accepting duplicate payments from you and Cigna, it is the provider's responsibility to reimburse the overpayment to you. Cigna may pay all health care benefits for Covered Expenses directly to a Participating Provider without your authorization. You may not interpret or rely upon this discrete authorization or permission to pay any health care benefits to a Participating Provider or a provider who is not a Participating Provider as the authority to assign any other rights under this Plan to any party, including but not limited to, a provider of health care service/items.

Even if the payment of health care benefits to a provider who is not a Participating Provider has been authorized by you, Cigna may, at its option, make payment of benefits to you. When benefits are paid to you or your Dependents, you or your Dependents are responsible for reimbursing the provider who is not a Participating Provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna, is not able to give a valid receipt for any payment due him, such payment may be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person appearing to have assumed his custody and support.

When a Plan participant passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as the participant and benefit payments for unassigned claims should be made payable to the executor.

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

Recovery of Overpayment

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

Calculation of Covered Expenses

Cigna in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology.
- the methodologies as reported by generally recognized professionals or publications.

CLAIMS & LEGAL ACTION - Continued

■ **Other Information a Member Needs to Know**

Legal Actions

A Member may bring a legal action to recover under the Plan. For legal actions not related to the Plan's Appeals Procedure, such legal action may be brought no sooner than 60 days, and no later than 3 years, after the time written proof of loss is required to be given under the terms of the Plan.

Physical Examinations

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

Relationship Between Cigna and Network Providers

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

GLOSSARY

Ambulance

Licensed ambulance transportation services involve the use of specially designed and equipped vehicles for transporting ill or injured patients. It includes ground, air, or sea transportation when Medically Necessary and clinically appropriate.

Biologic

A virus, therapeutic serum, toxin, antitoxin, vaccine, blood, blood component or derivative, allergenic product, protein (except any chemically synthesized polypeptide), or analogous product, or arsphenamine or derivative of arsphenamine (or any other trivalent organic arsenic compound), used for the prevention, treatment, or cure of a disease or condition of human beings, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Section 7002 (2010), and as may be amended thereafter).

Biosimilar

A Biologic that is highly similar to the reference Biologic product notwithstanding minor differences in clinically inactive components, and has no clinically meaningful differences from the reference Biologic in terms of its safety, purity, and potency, as defined under Section 351(i) of the Public Health Service Act (42 USC 262(i)) (as amended by the Biologics Price Competition and Innovation Act of 2009, title VII of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Section 7002 (2010), and as may be amended thereafter).

Brand Drug

A Prescription Drug Product that Cigna identifies as a Brand Drug product across its book-of-business, principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or Biologics as either brand or generic based on a number of factors. Not all products identified as a “brand name” by the manufacturer, Pharmacy or the Doctor may be classified as a Brand Drug under the Plan.

Business Decision Team

A committee comprised of voting and non-voting representatives across various Cigna business units such as clinical, medical and business leadership that is duly authorized by Cigna to effect changes regarding coverage treatment of Prescription Drug Products and Medical Pharmaceuticals based on clinical findings provided by the P&T Committee, including, but not limited to, changes regarding tier placement and application of utilization management to Prescription Drug Products and Medical Pharmaceuticals.

Charges

The actual billed charges; except when Cigna has contracted directly or indirectly for a different amount including where Cigna has directly or indirectly contracted with an entity to arrange for the provision of services and/or supplies through contracts with providers of such services and/or supplies.

GLOSSARY - Continued

Custodial Services

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

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

Dentist

A person licensed to practice dentistry.

Dependent

See ELIGIBILITY.

Designated Pharmacy

A Network Pharmacy that has entered into an agreement with Cigna, or with an entity contracting on Cigna's behalf, to provide Prescription Drug Products or services, including, without limitation, specific Prescription Drug Products, to Plan enrollees on a preferred or exclusive basis. For example, a Designated Pharmacy may provide enrollees certain Specialty Prescription Drug Products that have limited distribution availability, provide enrollees with an extended days' supply of Prescription Drug Products or provide enrollees with Prescription Drug Products on a preferred cost-share basis. The fact that a Pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Doctor/Physician

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

Emergency Medical Condition

A medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or serious impairment to bodily functions; or serious dysfunction of a bodily part or organ.

Emergency Services

GLOSSARY - Continued

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

Employee

See ELIGIBILITY.

Employer

- Canal Insurance Company; and
- Any affiliated companies listed in the application of the Employer. The Employer may add an affiliated company after the effective date of the Plan. For that company only, the effective date of the Plan will be considered to be the effective date of the amendment that adds that company.

Free-Standing Surgical Facility

An institution which meets all of the following requirements:

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

A Free-Standing Surgical Facility, unless specifically noted otherwise, is covered with the same cost share as an Outpatient Facility.

Generic Drug

A Prescription Drug Product that Cigna identifies as a Generic Drug product at a book-of-business level principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or Biologics (including Biosimilars) as either brand or generic based on a number of factors. Not all products identified as a “generic” by the manufacturer, Pharmacy or the Doctor may be classified as a Generic Drug under the Plan. A Biosimilar may be classified as a Generic Drug for the purposes of benefits under the Plan even if it is identified as a “brand name” drug by the manufacturer, Pharmacy or the Doctor.

Hospice Facility

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

GLOSSARY - Continued

Hospital

An institution:

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

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

Hospital Confinement or Confined in a Hospital

A person is considered Confined in a Hospital if he is a registered bed patient in a Hospital upon the recommendation of a Doctor receiving treatment for Mental Health and Substance Use Disorder Services in a Mental Health or Substance Use Disorder Residential Treatment Center.

Illness

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

Injury

A sudden and unforeseen event from an external agent or trauma, resulting in injuries to the physical structure of the body. It is definite as to time and place and it happens involuntarily or, if the result of a voluntary act, entails unforeseen consequences. It does not include harm resulting from disease.

Maintenance Drug Product

A Prescription Drug Product that is prescribed for use over an extended period of time for the treatment of chronic or long-term conditions such as asthma, hypertension, diabetes and heart disease, and is identified principally based on consideration of available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source and clinical factors. For the purposes of benefits, the list of your Plan's Maintenance Drug Products does not include compounded medications, Specialty Prescription Drug Products or Prescription Drug Products, such as certain narcotics, that a Pharmacy cannot dispense above certain supply limits per Prescription Drug Order or Refill under applicable federal or state law. You may contact Member Services at the phone number shown on your ID card to determine whether a drug is a Maintenance Medication.

Maximum Reimbursable Charge

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

If the provider is not a network provider, the Maximum Reimbursable Charge for covered expenses is determined based on the lesser of:

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

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

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

- the provider's normal charge for a similar service or supply; or
- the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used.

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

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

Medical Pharmaceutical

A U.S. Food and Drug Administration (FDA)-approved prescription pharmaceutical product, including a Specialty Prescription Drug Product, required to be administered in connection with a covered service by a Doctor or Other Health Professional within the scope of the provider's license. This definition includes certain pharmaceutical products whose administration may initially or typically require Doctor oversight but may be self-administered under certain conditions specified in the product's FDA labeling. This definition does not include any charges for mobile, web-based or other electronic applications or software, even if approved for marketing as a prescription product by the FDA.

Medically Necessary/Medical Necessity

Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:

- required to diagnose or treat an Illness, Injury, disease or its symptoms; and
- in accordance with generally accepted standards of medical practice; and
- clinically appropriate in terms of type, frequency, extent, site and duration; and
- not primarily for the convenience of the patient, Doctor or Other Health Professional; and

- not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of the Illness, Injury, condition, disease or its symptoms; and
- rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining the least intensive setting.

In determining whether health care services, supplies, or medications are Medically Necessary, the Medical Director or Review Organization may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

Medicare

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

Member

An Employee and any covered Dependent.

Necessary Services and Supplies

The term Necessary Services and Supplies includes any charges, except charges for Room and Board, made by a Hospital for medical services and supplies actually used during Hospital Confinement.

The term Necessary Services and Supplies does not include any charges for special nursing fees, dental fees, or medical fees.

Network Pharmacy

A retail or home delivery Pharmacy that has: entered into an agreement with Cigna or an entity contracting on Cigna's behalf to provide Prescription Drug Products to Plan enrollees; agreed to accept specified reimbursement rates for dispensing Prescription Drug Products; and been designated as a Network Pharmacy for the purpose of coverage under the Plan.

This term may also include, as applicable, an entity that has directly or indirectly contracted with Cigna to arrange for the provision of any Prescription Drug Products the charges for which are Covered Expenses.

New Prescription Drug Product

A Prescription Drug Product, or new use or dosage form of a previously U.S. Food and Drug Administration (FDA)-approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or newly-approved use or dosage form becomes available on the market following approval by the FDA and ending on the date Cigna makes a Prescription Drug List coverage status decision.

Other Health Care Facility

GLOSSARY - Continued

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

Other Health Professional

An individual other than a Doctor who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses.

Other Health Professionals do not include providers such as certified first assistants, certificated operating room technicians, certified surgical assistants/technicians, licensed certified surgical assistants/technicians, licensed surgical assistants, orthopedic physician assistants and surgical first assistants.

Participating Provider

A person or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services and/or supplies, the charges for which are Covered Expenses. It includes an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies, the charges for which are Covered Expenses.

Pharmacy

A duly licensed pharmacy that dispenses Prescription Drug Products in a retail setting or by way of home delivery. A home delivery Pharmacy is a Pharmacy that primarily provides Prescription Drug Products through mail order.

Pharmacy & Therapeutics (P&T) Committee

A committee comprised of physicians and an independent pharmacist that represent a range of clinical specialties. The committee regularly reviews Medical Pharmaceuticals and Prescription Drug Products, including New Prescription Drug Products, for safety and efficacy, the findings of which clinical reviews inform coverage determinations made by the Business Decision Team. The P&T Committee's review may be based on consideration of, without limitation, U.S. Food and Drug Administration (FDA)-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.

Plan

The medical and drug benefits described in this booklet.

Prescription Drug Charge

The Prescription Drug Charge is the amount that, prior to application of the Plan's cost-share requirement(s), the Plan sponsor is obligated to pay for a covered Prescription Drug Product dispensed at a Network Pharmacy, including any applicable dispensing fee, service fee and tax.

Prescription Drug List

GLOSSARY - Continued

A list that categorizes drugs, Biologics (including Biosimilars) or other products covered under the Plan's Prescription Drug Benefit that have been approved by the U.S. Food and Drug Administration (FDA) into coverage tiers. This list is adopted by your Employer as part of the Plan. The list is subject to periodic review and change, and is subject to the limitations and exclusions of the Plan. You may determine to which tier a particular Prescription Drug Product has been assigned through the website shown on your ID card or by calling Customer Service at the telephone number on your card.

Prescription Drug Product

A drug, Biologic (including a Biosimilar), or other product that has been approved by the U.S. Food and Drug Administration (FDA), certain products approved under the Drug Efficacy Study Implementation review, or products marketed prior to 1938 and not subject to review and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill.

A Prescription Drug Product includes a drug, Biologic or product that, due to its characteristics, is approved by the FDA for self-administration or administration by a non-skilled caregiver. For the purpose of benefits under the Plan, this definition also includes:

- the following diabetic supplies: alcohol pads, swabs, wipes, Glucagon/Glucagen, injection aids, insulin pump accessories (but excluding insulin pumps), needles including pen needles, syringes, test strips, lancets, urine glucose and ketone strips.
- needles and syringes for self-administered medications or biologics covered under the Plan's Prescription Drug Benefit.
- inhaler assistance devices and accessories, peak flow meters.

This definition does not include any charges for mobile, web-based or other electronic applications or software, even if approved by the FDA for marketing as a prescription product.

Prescription Order or Refill

The lawful directive to dispense a Prescription Drug Product issued by a Doctor whose scope of practice permits issuing such a directive.

Review Organization

The term Review Organization refers to an affiliate of Cigna or another entity to which Cigna has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Doctors, registered graduate nurses, licensed mental health and substance use disorder professionals, and other trained staff members who perform utilization review services.

Room and Board

All charges made by a Hospital for room and meals and for all general services and activities needed for the care of registered bed patients.

Service

See ELIGIBILITY.

GLOSSARY - Continued

Specialty Prescription Drug Product

A Prescription Drug Product or Medical Pharmaceutical considered by Cigna to be a Specialty Prescription Drug Product based on consideration of the following factors, subject to applicable law:

- whether the Prescription Drug Product or Medical Pharmaceutical is prescribed and used for the treatment of a complex, chronic or rare condition;
- whether the Prescription Drug Product or Medical Pharmaceutical has a high acquisition cost; and
- whether the Prescription Drug Product or Medical Pharmaceutical is subject to limited or restricted distribution, requires special handling and/or requires enhanced patient education, provider coordination or clinical oversight.

A Specialty Prescription Drug Product may not possess all or most of the foregoing characteristics, and the presence of any one such characteristic does not guarantee that a Prescription Drug Product or Medical Pharmaceutical will be considered a Specialty Prescription Drug Product. Specialty Prescription Drug Products may vary by Plan benefit assignment based on factors such as method or site of clinical administration, or by tier assignment, or utilization management requirements based on factors such as acquisition cost. You may access the website or contact Member Services at the phone number shown on your ID card to determine whether a medication is a Specialty Prescription Drug Product.

Stabilize

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

Terminal Illness

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

Therapeutic Alternative

A Prescription Drug Product or Medical Pharmaceutical that is of the same therapeutic or pharmacological class, and usually can be expected to have similar outcomes and adverse reaction profiles when administered in therapeutically equivalent doses as, another Prescription Drug Product, Medical Pharmaceutical or over-the-counter (OTC) medication.

Therapeutic Equivalent

A Prescription Drug Product or Medical Pharmaceutical that is a pharmaceutical equivalent to another Prescription Drug Product, Medical Pharmaceutical or over-the-counter (OTC) medication.

Totally Disabled and Total Disability

Active Employees

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

GLOSSARY - Continued

Dependents

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

Urgent Care

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by Medical Management in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Doctor's recommendation that the patient should not travel due to any medical condition.

Usual and Customary (U&C) Charge - for Prescription Drug Benefits

The usual fee that a Pharmacy charges individuals for a Prescription Drug Product (and any services related to the dispensing thereof) without reference to reimbursement to the Pharmacy by third parties. The Usual and Customary (U&C) Charge includes a dispensing fee and any applicable sales tax.

You and Your

An Employee.

USERRA RIGHTS AND RESPONSIBILITIES

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

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

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

Continued Medical and Prescription Drug Coverage

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

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

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

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

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

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

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

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

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

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

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

USERRA RIGHTS AND RESPONSIBILITIES - Continued

Period of Continued Coverage

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

Cost of Continued Coverage

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

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

COBRA Coverage

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

Reinstatement of Coverage

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

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

CONTINUATION OF COVERAGE - FMLA

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

CONTINUATION RIGHTS UNDER FEDERAL LAW - COBRA

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

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

CONTINUATION RIGHTS UNDER FEDERAL LAW - COBRA - Continued

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

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

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

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

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

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

Secondary Qualifying Events

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

Disability Extension

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

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

- SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and

CONTINUATION RIGHTS UNDER FEDERAL LAW - COBRA - Continued

- a copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

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

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

Medicare Extension

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

Termination of COBRA Continuation Coverage

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

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

Employer Notice Requirements

The Employer is required to provide the following notices:

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

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

CONTINUATION RIGHTS UNDER FEDERAL LAW - COBRA - Continued

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

Electing COBRA Continuation Coverage

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

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

Cost of COBRA Continuation Coverage

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

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

The first COBRA continuation coverage payment must be made no later than 45 calendar days after the date of your election (if mailed, this is the date the election notice is postmarked). The qualified beneficiary is responsible for making sure that the amount of the first payment is enough to cover the entire initial period from the date coverage would have otherwise terminated, up to the date the qualified beneficiary makes the first payment. If the first payment is not made within the 45-day period, all COBRA continuation rights under the Plan will be lost. Claims incurred during the period covered by the initial payment period will not be processed until the payment is made.

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

CONTINUATION RIGHTS UNDER FEDERAL LAW - COBRA - Continued

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

You Must Give Notice of Certain Qualifying Events

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

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

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

Newly Acquired Dependents

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

Health FSA

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

EFFECT OF SECTION 125 TAX REGULATIONS ON THIS PLAN

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

EFFECT OF SECTION 125 TAX REGULATIONS ON THIS PLAN - Continued

Coverage Elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed .

Change of Status

A change in status is defined as:

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

Court Order

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

Medicare or Medicaid Eligibility/Entitlement

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

Change in Cost of Coverage

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

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

EFFECT OF SECTION 125 TAX REGULATIONS ON THIS PLAN - Continued

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

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

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

ERISA GENERAL INFORMATION

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

The name of the Plan is: Canal Insurance Company

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

Canal Insurance Company

400 East Stone Avenue

Greenville, SC 29601

864-250-9283

The Employer Identification Number (EIN) is: 57-0133332

The Plan Number assigned by the Employer is: 501

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

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

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

Contributions are determined by the Employer. Employee contributions, if any, for a time period for which the Employee is not covered under the Plan may be refunded by the Employer. Please see your Plan Administrator for details.

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

The fiscal records of the Plan are maintained on the basis of Plan years ending December 31.

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

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

ERISA GENERAL INFORMATION - Continued

Plan Type

The Plan is a health care benefit plan.

Plan Trustee(s)

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

Collective Bargaining Agreement(s)

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

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

- You may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest Annual Report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- You may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- You may receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

  However, employers with fewer than 100 plan participants at the beginning of the plan year are not required to: furnish statements of the plan's assets and liabilities and receipts and disbursements or allow examination of the Annual Report, or furnish copies of the Annual Report or any Terminal Report.

Continue Group Health Plan Coverage

If a group health plan is subject to COBRA, you may be eligible to continue health care coverage for yourself or your Dependents if there is a loss of coverage under the plan as a result of a COBRA qualifying event. You or your Dependents may have to pay for such coverage. You may review the documents governing the plan or the rules governing COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

STATEMENT OF ERISA RIGHTS - Continued

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

Enforce Your Rights

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

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

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

Assistance With Your Questions

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