

G&A Partners

CIGNA OPEN ACCESS PLUS IN-
NETWORK MEDICAL INSURANCE

For Ohio Residents

Plan 18

\$0 Deductible

EFFECTIVE DATE: July 1, 2024

This certificate is not a medicare supplement certificate. If you are eligible for medicare, review the “Guide to Health Insurance for People with Medicare” available from the company.

CN067

3344327

This document printed in July, 2024 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

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

CIGNA HEALTH AND LIFE INSURANCE COMPANY

a Cigna company (hereinafter called Cigna) certifies that it insures certain Employees for the benefits provided by the following policy(s):

POLICYHOLDER: G&A Partners

GROUP POLICY(S) — COVERAGE

3344327 - IN0 OPEN ACCESS PLUS IN-NETWORK MEDICAL BENEFITS

EFFECTIVE DATE: July 1, 2024

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

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



Geneva Cambell Brown, Corporate Secretary

Explanation of Terms

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

The Schedule

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

Special Plan Provisions

Participating Providers include Physicians, Hospitals and Other Health Professionals and Other Health Care Facilities. Consult your Physician Guide for a list of Participating Providers in your area. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

Services Available in Conjunction With Your Medical Plan

The following pages describe helpful services available in conjunction with your medical plan. You can access these services by calling the toll-free number shown on the back of your ID card.

HC-SPP63

01-20

Case Management

Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your Dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

- You, your Dependent or an attending Physician can request Case Management services by calling the **toll-free number** shown on your ID card during normal business hours,

Monday through Friday. In addition, your employer, a claim office or a utilization review program may refer an individual for Case Management.

- The Review Organization assesses each case to determine whether Case Management is appropriate.
- You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.
- Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
- The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

We have opioid education information and tools available to coordinate care of high-risk insureds with opioid-use disorders. Please call us at the number on the back of your ID card or visit www.cigna.com for more information.

HC-SPP74

Additional Programs

We may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to our members for the purpose of promoting the general health and well being of our members. We may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to the Policyholder. Contact us for details regarding any such arrangements.

HC-SPP3

04-10

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Incentives to Participating Providers

Cigna continuously develops programs to help our customers access quality, cost-effective health care. Some programs include Participating Providers receiving financial incentives from Cigna for providing care to Members in a way that meets or exceeds certain quality and/or cost-efficiency standards, when, in the Participating Provider's professional judgment, it is appropriate to do so within the applicable standard of care. For example, some Participating Providers could receive financial incentives for utilizing or referring you to alternative sites of care as determined by your plan rather than in a more expensive setting, or achieving particular outcomes for certain health conditions. Participating Providers may also receive purchasing discounts when purchasing certain prescription drugs from Cigna affiliates. Such programs can help make you healthier, decrease your health care costs, or both. These programs are not intended to affect your access to the health care that you need. We encourage you to talk to your Participating Provider if you have questions about whether they receive financial incentives from Cigna and whether those incentives apply to your care.

HC-SPP81

01-24

Notice Regarding Emergency Services and Urgent Care

In the event of an Emergency, get help immediately. Go to the nearest emergency room, the nearest Hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help. We will cover Emergency Services if you have an Emergency Medical Condition without regard to the day or time the Emergency Services are rendered or whether you have received prior authorization for such Services. Out of Network Emergency Services will be paid the same as In Network Emergency Services and cannot be Balance Billed.

HC-SPP42

V1

Care Management and Care Coordination Services

Cigna 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.

HC-SPP27

06-15

V1

Important Notices

Important Information

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 your plan and Prescription Drug Products included on the Prescription Drug List. These rebates or remuneration are not obtained on you or your 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 Copayments and/or Coinsurance. Cigna and its affiliates or designees may also, conduct business with various pharmaceutical manufacturers separate and apart from this 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 this 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 Physician 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 Physician.

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 Copayment, Deductible, 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 the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the Pharmacy, pharmaceutical manufacturer or other third party represents that you remain responsible for any amounts that your 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 the Copayment, Deductible, and/or Coinsurance amounts 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 Copayment, Deductible and/or Coinsurance you are required to pay.

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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>.

HC-NOT96

07-17

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：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224（聽障專線：請撥 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 연락해주시고. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

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 علي ظهر بطاقتكم الشخصية. او 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).

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'identité. 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 زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.800.244.6224 تماس بگیرید (شماره تلفن ویژه ناشنوايان: شماره 711 را شماره‌گیری کنید).

HC-NOT97

07-17

Federal CAA - Consolidated Appropriations Act and TIC - Transparency in Coverage Notice

Cigna will make available an internet-based self-service tool for use by individual customers, as well as certain data in machine-readable file format on a public website, as required under the Transparency in Coverage rule. Customers can access the cost estimator tool on myCigna.com. Updated machine-readable files can be found on Cigna.com and/or CignaForEmployers.com on a monthly basis.

Pursuant to Consolidated Appropriations Act (CAA), Section 106, Cigna will submit certain air ambulance claim information to the Department of Health and Human Services (HHS) in accordance with guidance issued by HHS.

Subject to change based on government guidance for CAA Section 204, Cigna will submit certain prescription drug and health care spending information to HHS through Plan Lists Files (P1-P3) and Data Files (D1-D8) (D1-D2) for an Employer without an integrated pharmacy product aggregated at the market segment and state level, as outlined in guidance.

HC-IMP324

01-23

Federal CAA - Consolidated Appropriations Act Continuity of Care

In certain circumstances, if you are receiving continued care from an in-network provider or facility, and that provider's network status changes from in-network to out-of-network, you may be eligible to continue to receive care from the

provider at the in-network cost-sharing amount for up to 90 days from the date you are notified of your provider's termination. A continuing care patient is an individual who is:

- Undergoing treatment for a serious and complex condition
- Pregnant and undergoing treatment for the pregnancy
- Receiving inpatient care
- Scheduled to undergo urgent or emergent surgery, including postoperative
- Terminally ill (having a life expectancy of 6 months or less) and receiving treatment from the provider for the illness

If applicable, Cigna will notify you of your continuity of care options.

Appeals

Any external review process available under the plan will apply to any adverse determination regarding claims subject to the No Surprises Act.

Provider Directories and Provider Networks

A list of network providers is available to you, without charge, by visiting the website or calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as generic practice, affiliated or contracted with Cigna or an organization contracting on its behalf.

A list of network pharmacies is available to you, without charge, by visiting the website or calling the phone number on your ID card. The network consists of pharmacies affiliated or contracted with Cigna or an organization contracting on its behalf.

Provider directory content is verified and updated, and processes are established for responding to provider network status inquiries, in accordance with applicable requirements of the No Surprises Act.

If you rely on a provider's in-network status in the provider directory or by contacting Cigna at the website or phone number on your ID card to receive covered services from that provider, and that network status is incorrect, then your plan cannot impose out-of-network cost shares to that covered service. In-network cost share must be applied as if the covered service were provided by an in-network provider.

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 our 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, access the website or call the phone number on your ID card.

Selection of a Primary Care Provider

This plan generally 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 children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, access the website or call the phone number on your ID card.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these situations, you should not be charged more than your plan's copayments, coinsurance, and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

"Out-of-network" means providers and facilities that have not signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**". This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you cannot control who is involved in your care – such as when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

- **Emergency services** – If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as a copayments, coinsurance, and deductibles). You cannot be balanced billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

- **Certain non-emergency services at an in-network hospital or ambulatory surgical center** – When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **cannot** balance bill you and may **not** ask you to give up your protections not to be balanced billed.

If you get other types of services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you have these protections:

- You are only responsible for paying your share of the cost (such as copayments, coinsurance, and deductibles that you would pay if the provider were in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - Cover emergency services without requiring you to get approval in advance for services (also known as prior authorization).
 - Cover emergency services provided by out-of-network providers.
 - Base what you owe the provider or facility (cost sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits (EOB).
 - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you have been wrongly billed, contact Cigna at the phone number on your ID card. You can also contact No Surprises Help Desk at 1-800-985-3059 or <http://www.cms.gov/nosurprises> for more information about your rights under federal law.

Ohio Notices

Cigna Claim Offices Serving Ohio

We are here to serve you...

As our certificate holder, your satisfaction is very important to us. Should you have a valid claim, we fully expect to provide a fair settlement within 30 days.

This notice is to advise you that should any complaints arise regarding your insurance, you may contact Customer Service at the toll-free number or address that appears on your Benefit Identification Card, explanation of benefits, or claim form or contact the following:

Medical Questions

Claims Resolution Unit

P.O. Box 188016

Chattanooga, TN 37422

Facsimile: 860.731.2984

Email: chccustomeradvocacy@cigna.com

Telephone: (888) 992.4462 or call the toll-free number which appears on your Benefit Identification Card

Important Telephone Numbers

Should you need general information or more specific information on how services may be obtained, please make contact using the telephone number listed below. Note that there are different numbers depending upon which area/type of insurance your questions concern.

Managed Medical Care - 800.Cigna.24 (800.244.6224)

RxPrime Prescription Drug Coverage - 800.622.5579

Cigna Behavioral Health/Mental Health Care - 800.876.3053

Cigna shall notify you of the termination of a contract for the provision of health care services between Cigna and a Participating Provider or hospital, by mail, within thirty (30) days after the termination of the contract.

In the event of Cigna's insolvency or discontinuance of operations, Cigna will continue to cover any Medically Necessary procedures commenced but unfinished at that time, for up to thirty (30) days after its insolvency or discontinuance of operations. The completion of a Medically Necessary procedure shall include the rendering of all covered health care services that constitute Medically Necessary follow-up care for that procedure. If you or your Dependents are receiving necessary inpatient care at a hospital, Cigna may limit the covered health care services relating to that inpatient care in accordance with division (D)(3) of section 1751.11 of the Revised Code. You or your Dependents may be financially responsible for health care services rendered by a provider or health care facility that is not under contract to Cigna, whether or not Cigna authorized the use of the provider or health care facility.

HC-IMP219

10-16

Ohio state law requires insurers to deliver the following notice to customers.

**NOTICE CONCERNING COVERAGE
LIMITATIONS AND EXCLUSIONS UNDER THE OHIO LIFE
AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT**

Residents of Ohio who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Ohio Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

The Ohio Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Ohio. You should not rely on coverage by the Ohio Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is *NOT* provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus. You should check with your insurance company representative to determine if you are only covered in part or not covered at all.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

**Ohio Life and Health Insurance Guaranty Association
485 Metro Place S, Ste 270
Dublin, OH 43017
Ohio Department of Insurance
50 West Town Street
Third Floor-Suite 300
Columbus, OH 43215**

The state law that provides for this safety-net coverage is called the Ohio Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, individuals will be protected by the life and health insurance guaranty association if they live in Ohio and hold a life or health insurance contract, annuity contract, unallocated annuity contract; if they are insured under a group insurance contract, issued by a member insurer; or if they are the payee or beneficiary of a structured settlement annuity contract. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a medical or health care corporation, an HMO, a fraternal benefit society, a mutual protective association or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Association is obligated to pay out: The Association cannot pay more than the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of \$300,000, except as specified below, no matter how many policies and contracts there were with same company, even if they provided different types of coverages. The association will not pay more than \$100,000 in cash surrender values, \$500,000 in major medical insurance benefits, \$300,000 in disability or long-term care insurance benefits, \$100,000 in other health insurance benefits, \$250,000 in present value of annuities, or \$300,000 in life insurance death benefits — again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages the association will pay a maximum of \$300,000, except for coverage involving major medical insurance benefits, for which the maximum of all coverages is \$500,000.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the act: For unallocated annuities that fund governmental retirement plans under §§401, 403(b), or 457 of the Internal Revenue Code, the limit is \$250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual, except as noted above. For covered unallocated annuities that fund other plans, a special limit of \$1,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

How To File Your Claim

There's no paperwork for In-Network care. Just show your identification card and pay your share of the cost, if any; your provider will submit a claim to Cigna for reimbursement.

Claim Forms

You may get the required claim forms for Out-of-Network care from the website listed on your identification card or by calling Customer Service using the toll-free number on your identification card. If Cigna does not provide you with a claim form within 15 days of your request, you will be considered to have met the proof of loss requirements of submitting a claim form. But you will still need to submit your itemized bill and any other information necessary for Cigna to be able to process your claim.

Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

Statement Not Warranties

All statements made by the Policyholder or by an insured Employee will, in the absence of fraud, be deemed representations and not warranties. No statement made by the Policyholder or by the Employee to obtain insurance under this policy will be used to avoid or reduce the insurance, unless it is made in a written application for the insurance, a copy of which is attached to the policy.

Physical Examination

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

Legal Actions

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

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Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee. To be insured, you will have to pay part of the cost.

Note: You will not be prohibited from enrolling based on the results of genetic screenings or testing.

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least 30 hours a week; and
- you pay any required contribution.

If you were previously insured and your insurance ceased, you must satisfy the Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

Eligibility for Dependent Insurance

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

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

Waiting Period

Service waiting periods imposed may not exceed 90 days.

The first day of the month following 60 days from date of hire.

Classes of Eligible Employees

Each Employee as reported to the insurance company by your Employer.

Effective Date of Employee Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date you become eligible.

You will become insured on your first day of eligibility, following your election, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status.

Note: Employer groups must provide an open enrollment period for a minimum of 30 consecutive days each year.

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or
- you again elect it after you cancel your payroll deduction (if required).

Dependent Insurance

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form (if required), but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

Your Dependents will be insured only if you are insured.

Late Entrant – Dependent

You are a Late Entrant for Dependent Insurance if:

- you elect that insurance more than 30 days after you become eligible for it; or
- you again elect it after you cancel your payroll deduction (if required).

Exception for Newborns

Newborns are automatically covered for the first 31 days after birth. In order to continue the child's coverage after the end of that 31-day period, you must elect to insure your newborn child within 31 days after the date of birth. If you do not elect to insure your newborn child within such 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

Court Ordered Children

- Either parent must be permitted to enroll court ordered children without any enrollment period restrictions.
- Employers must enroll court ordered children when parent does not.
- Either parent must be permitted to enroll court ordered dependent children living outside of the plan's approved service area.

Important Information About Your Medical Plan

Details of your medical benefits are described on the following pages.

Opportunity to Select a Primary Care Physician

This medical plan does not require that you select a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available to you under this medical plan. Notwithstanding, a Primary Care Physician may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependents. For this reason, we encourage the use of Primary Care Physicians and provide you with the opportunity to select a Primary Care Physician from a list provided by Cigna for yourself and your Dependents. If you choose to select a Primary Care Physician, the Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents. If you need assistance selecting your Primary Care Physician, please visit our website at www.cigna.com or call the number on the back of your ID Card.

The Primary Care Physician's role is to provide or arrange for medical care for you and any of your Dependents.

You and your Dependents are allowed direct access to Participating Physicians for covered services. Even if you select a Primary Care Physician, there is no requirement to obtain an authorization of care from your Primary Care Physician for visits to the Participating Physician of your choice, including Participating Specialist Physicians, for covered services.

Changing Primary Care Physicians

You may request a transfer from one Primary Care Physician to another by visiting our website at www.cigna.com or calling the number on the back of your ID Card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician, if you choose.

Direct Access For Mental Health and Substance Use Disorder Services

You are allowed direct access to a licensed/certified Participating Provider for covered Mental Health and Substance Use Disorder Services. There is no requirement to obtain an authorization of care from your Primary Care Physician for individual or group therapy visits to the



Participating Provider of your choice for Mental Health and
Substance Use Disorder.

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Open Access Plus In-Network Medical Benefits

The Schedule

For You and Your Dependents

Open Access Plus In-Network Medical Benefits provide coverage for care In-Network. To receive Open Access Plus In-Network Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.

With respect to Basic Health Care Services that are covered under this Certificate, you will not have to pay more than the copay, Deductible or Coinsurance set forth in this Certificate, and you will be held harmless from other bills and charges. This does not prevent a health care provider from collecting Copayments, Deductibles or cost-sharing amounts as provided for in this Certificate, for fees and charges for services that are not Basic Health Care Services, or for uncovered health care services.

If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.

Federal Preventive Services are not subject to any cost share, In-Network.

Coinsurance

The term Coinsurance means the percentage of Covered Expenses that an insured person is required to pay under the plan. The percentage of charges for Covered Expenses shown in this Schedule is what the Plan pays in addition to the Deductible, if any.

Copayments/Deductibles

Copayments are amounts to be paid by you or your Dependent for covered services. Deductibles are Covered Expenses to be paid by you or your Dependent before benefits are payable under this plan. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance.

Out-of-Pocket Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any Deductibles, Copayments or Coinsurance. Such Covered Expenses accumulate to the Out-of-Pocket Maximum shown in The Schedule. When the Out-of-Pocket Maximum is reached, all Covered Expenses, except charges for non-compliance penalties, are payable by the benefit plan at 100%.

Open Access Plus In-Network Medical Benefits

The Schedule

Out-of-Pocket Maximum

In no event will Copayments/Coinsurance for you or your Dependents exceed, in any Calendar Year, two hundred (200) percent of (twice) the average annual premium cost to an individual or family. This limitation does not include Copayments/Coinsurance imposed on Supplemental Medical Benefits and Specialty Medical Benefits.

Basic Health Care Services include Physician services, inpatient hospital, outpatient medical, emergency health, urgent care, preventive health care, diagnostic laboratory, diagnostic and therapeutic radiologic services.

Supplemental Medical Benefits and Specialty Medical Benefits include intermediate or long-term care, optometric including lenses and frames, podiatric care or foot care, mental health and psychological, short term outpatient evaluative and crisis-intervention mental health, medical or psychological treatment and referral for alcohol or drug abuse or addiction, home health, nursing, dietician, physical therapy, durable medical equipment and external prosthetic appliances and chiropractic services.

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed 20 percent of the surgeon's allowable charge. (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

The maximum amount payable will be limited to 62.5 percent of the surgeon's allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeons prior to any reductions due to coinsurance or deductible amounts.)

Out-of-Network Emergency Services Charges

1. Emergency Services are covered at the In-Network cost-sharing level if services are received from a non-Participating (Out-of-Network) provider.
2. 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 as required by applicable state or Federal law.
3. The allowable amount used to determine the Plan's benefit payment when Out-of-Network Emergency Services result in an inpatient admission is the median amount negotiated with In-Network facilities.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any 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.

Open Access Plus In-Network Medical Benefits

The Schedule

Out-of-Network Air Ambulance Services Charges

1. Covered air ambulance services are payable at the In-Network cost-sharing level if services are received from a non-Participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered air ambulance services rendered by an Out-of-Network provider is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or Federal law.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any 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.

Non-Essential Benefits

Hearing Aids are not an essential benefit.

BENEFIT HIGHLIGHTS		IN-NETWORK
Lifetime Maximum		Unlimited
The Percentage of Covered Expenses the Plan Pays		100%
Out-of-Pocket Maximum Individual Family Maximum Family Maximum Calculation Individual Calculation: Family members meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.		\$5,500 per person \$11,000 per family



BENEFIT HIGHLIGHTS	IN-NETWORK
Physician's Services	
Primary Care Physician's Office Visit	\$35 per visit copay, then 100%
Specialty Care Physician's Office Visit	\$65 per visit copay, then 100%
Consultant and Referral Physician's Services	
Note: OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with Cigna.	
Surgery Performed in the Physician's Office	
Primary Care Physician	\$35 per visit copay, then 100%
Specialty Care Physician	\$65 per visit copay, then 100%
Second Opinion Consultations (provided on a voluntary basis)	
Primary Care Physician's Office Visit	\$35 per visit copay, then 100%
Specialty Care Physician's Office Visit	\$65 per visit copay, then 100%
Allergy Treatment/Injections	
Primary Care Physician's Office Visit	\$35 per visit copay, then 100%
Specialty Care Physician's Office Visit	\$65 per visit copay, then 100%
Allergy Serum (dispensed by the Physician in the office)	
Primary Care Physician	100%
Specialty Care Physician	100%
Convenience Care Clinic (includes any related lab and x-ray services and surgery)	\$35 per visit copay, then 100%

BENEFIT HIGHLIGHTS	IN-NETWORK
<p>Virtual Care</p> <p>Dedicated Virtual Providers</p> <p>Dedicated virtual care services may be provided by MDLIVE, a Cigna affiliate.</p> <p>Services available through contracted virtual providers as medically appropriate.</p> <p>Notes:</p> <ul style="list-style-type: none"> • Primary Care cost share applies to routine care. Virtual wellness screenings are payable under preventive care. • MDLIVE Behavioral Services, please refer to the Mental Health and Substance Use Disorder section (below). • Lab services supporting a virtual visit must be obtained through dedicated labs. <p>MDLIVE Urgent Care Services</p> <p>MDLIVE Primary Care Services</p> <p>MDLIVE Specialty Care Services</p> <p>Virtual Physician Services</p> <p>Services available through Physicians as medically appropriate.</p> <p>Note:</p> <p>Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services).</p> <p>Primary Care Physician Virtual Office Visit</p> <p>Specialty Care Physician Virtual Office Visit</p>	<p>\$35 per visit copay, then 100%</p> <p>\$35 per visit copay, then 100%</p> <p>\$65 per visit copay, then 100%</p> <p>\$35 per visit copay, then 100%</p> <p>\$65 per visit copay, then 100%</p>

BENEFIT HIGHLIGHTS		IN-NETWORK
Preventive Care Routine Preventive Care - all ages Note: OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with Cigna. Immunizations - all ages		100%
Mammograms, PSA, PAP Smear Preventive Care Related Services (i.e. "routine" services) Diagnostic Related Services (i.e. "non-routine" services)		100% Subject to the plan's x-ray benefit & lab benefit; based on place of service
Women's Surgical Sterilization Procedures (e.g. tubal ligation) Excludes reversals Primary Care Physician's Office Visit Specialty Care Physician's Office Visit Inpatient Facility Outpatient Facility Inpatient Professional Services Outpatient Professional Services		100% 100% 100% 100% 100% 100%
The Patient Protection and Affordable Care Act (PPACA) requires group plans to cover certain preventive services with no cost sharing. Details on required preventive care services are available on the following website: http://www.healthcare.gov/coverage/preventive-care-benefits/ *a 60-day notice will be provided if a benefit is removed from the federal preventive care services list.		
Inpatient Hospital - Facility Services Semi-Private Room and Board Private Room Special Care Units (ICU/CCU)		\$500 per day copay, then 100% Limited to the semi-private negotiated rate Limited to the semi-private negotiated rate Limited to the negotiated rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room		100%

BENEFIT HIGHLIGHTS		IN-NETWORK
Inpatient Hospital Physician's Visits/Consultations		100%
Inpatient Professional Services Surgeon Radiologist, Pathologist, Anesthesiologist		100%
Outpatient Professional Services Surgeon Radiologist, Pathologist, Anesthesiologist		100%
Urgent Care Services Urgent Care Facility or Outpatient Facility Includes Outpatient Professional Services, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the UC visit. Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) billed by the facility as part of the UC visit		\$40 per visit copay, then 100% \$40 per visit copay, then 100%
Emergency Services Hospital Emergency Room Includes Outpatient Professional Services, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit. Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) billed by the facility as part of the ER visit		\$250 per visit copay (waived if admitted), then 90% \$250 per visit copay (waived if admitted), then 90%
Air Ambulance		100%
Ambulance		100%

BENEFIT HIGHLIGHTS	IN-NETWORK
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: 30 days combined	100%
Laboratory Services Primary Care Physician's Office Visit Specialty Care Physician's Office Visit Outpatient Hospital Facility Independent Lab Facility	\$35 per visit copay, then 100% \$65 per visit copay, then 100% 100% 100%
Radiology Services Primary Care Physician's Office Visit Specialty Care Physician's Office Visit Outpatient Hospital Facility	\$35 per visit copay, then 100% \$65 per visit copay, then 100% 100%
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans) Primary Care Physician's Office Visit Specialty Care Physician's Office Visit Inpatient Facility Outpatient Facility	\$35 per visit copay, then 100% \$65 per visit copay, then 100% \$500 per day copay, then 100% 100%

BENEFIT HIGHLIGHTS	IN-NETWORK
<p>Outpatient Therapy Services</p> <p>Calendar Year Maximum: 36 days for all therapies combined</p> <p>Note: The Short-Term Rehabilitative Therapy maximum does not apply to the treatment of autism or mental health conditions.</p> <p>Includes: Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy</p> <p>Primary Care Physician's Office Visit</p> <p>Specialty Care Physician's Office Visit</p>	<p>\$35 per visit copay*, then 100%</p> <p>\$65 per visit copay*, then 100%</p> <p>*Note: Outpatient Therapy Services copay applies, regardless of place of service, including the home.</p>
<p>Outpatient Cardiac Rehabilitation</p> <p>Calendar Year Maximum: 36 days</p> <p>Primary Care Physician's Office Visit</p> <p>Specialty Care Physician's Office Visit</p>	<p>\$35 per visit copay, then 100%</p> <p>\$65 per visit copay, then 100%</p>
<p>Chiropractic Care</p> <p>Calendar Year Maximum: 35 days</p> <p>Primary Care Physician's Office Visit</p> <p>Specialty Care Physician's Office Visit</p>	<p>\$35 per visit copay, then 100%</p> <p>\$65 per visit copay, then 100%</p>

BENEFIT HIGHLIGHTS	IN-NETWORK
Home Health Care Services Calendar Year Maximum: 60 days (includes outpatient private nursing when approved as Medically Necessary) Dialysis services in the home setting will not accumulate to the Home Health Care maximum	100%
Hospice Inpatient Services Outpatient Services (same coinsurance level as Home Health Care Services)	100% 100%
Bereavement Counseling Services provided as part of Hospice Care Inpatient Outpatient Services provided by Mental Health Professional	100% 100% Covered under Mental Health benefit
Medical Pharmaceuticals Inpatient Facility Cigna Pathwell Specialty Medical Pharmaceuticals Other Medical Pharmaceuticals	100% Cigna Pathwell Specialty Network provider: 100% Non-Cigna Pathwell Specialty Network Providers: Not Covered 100%

BENEFIT HIGHLIGHTS	IN-NETWORK
<p>Gene Therapy Includes prior authorized gene therapy products and services directly related to their administration, when Medically Necessary.</p> <p>Gene Therapy Product</p> <p>Inpatient Hospital Facility Services</p> <p>Outpatient Facility</p> <p>Inpatient Professional Services</p> <p>Outpatient Professional Services</p> <p>Travel Maximum: \$10,000 per episode of gene therapy</p>	<p>Covered same as Medical Pharmaceuticals</p> <p>\$500 per day copay, then 100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>(available only for travel when prior authorized to receive gene therapy at a participating In-Network facility specifically contracted with Cigna to provide the specific gene therapy)</p>
<p>Advanced Cellular Therapy Includes prior authorized advanced cellular therapy products and related services when Medically Necessary.</p> <p>Advanced Cellular Therapy Product</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Inpatient Professional Services</p> <p>Outpatient Professional Services</p> <p>Advanced Cellular Therapy Travel Maximum: \$10,000 per episode of advanced cellular therapy (Available only for travel when prior authorized to receive advanced cellular therapy from a provider located more than 60 miles of your primary residence and is contracted with Cigna for the specific advanced cellular therapy product and related services.)</p>	<p>Covered Same as Medical Pharmaceuticals</p> <p>\$500 per day copay, then 100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p>

BENEFIT HIGHLIGHTS	IN-NETWORK
<p>Maternity Care Services</p> <p>Initial Visit to Confirm Pregnancy Note: OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with Cigna.</p> <p>Primary Care Physician's Office Visit</p> <p>Specialty Care Physician's Office Visit</p> <p>All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)</p> <p>Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist</p> <p>Primary Care Physician's Office Visit</p> <p>Specialty Care Physician's Office Visit</p> <p>Delivery - Facility (Inpatient Hospital, Birthing Center)</p>	<p></p> <p>\$35 per visit copay, then 100%</p> <p>\$65 per visit copay, then 100%</p> <p>100%</p> <p></p> <p>\$35 per visit copay, then 100%</p> <p>\$65 per visit copay, then 100%</p> <p>\$500 per day copay, then 100%</p>
<p>Abortion</p> <p>Includes only non-elective procedures</p> <p>Primary Care Physician's Office Visit</p> <p>Specialty Care Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Inpatient Professional Services</p> <p>Outpatient Professional Services</p>	<p></p> <p>\$35 per visit copay, then 100%</p> <p>\$65 per visit copay, then 100%</p> <p>\$500 per day copay, then 100%</p> <p>100%</p> <p>100%</p> <p>100%</p>

BENEFIT HIGHLIGHTS		IN-NETWORK
Infertility Services Coverage will be provided for the following services: <ul style="list-style-type: none"> • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial Insemination, In-vitro, GIFT, ZIFT, etc. 		
Physician's Office Visit (Lab and Radiology Tests, Counseling) Primary Care Physician Specialty Care Physician Inpatient Facility Outpatient Facility Inpatient Professional Services Outpatient Professional Services Lifetime Maximum: Unlimited Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility).		\$35 per visit copay, then 100% \$65 per visit copay, then 100% \$500 per day copay, then 100% 100% 100% 100%
Transplant Services and Related Specialty Care Includes all medically appropriate, non-experimental transplants Primary Care Physician's Office Visit Specialty Care Physician's Office Visit Inpatient Facility Inpatient Professional Services Lifetime Travel Maximum: Unlimited		\$35 per visit copay, then 100% \$65 per visit copay, then 100% \$500 per day copay, then 100% at LifeSOURCE center, otherwise \$500 per day copay, then 100% 100% at LifeSOURCE center, otherwise 100% 100% (only available when using LifeSOURCE facility)
Durable Medical Equipment Calendar Year Maximum: Unlimited		100%

BENEFIT HIGHLIGHTS	IN-NETWORK
Outpatient Dialysis Services Primary Care Physician's Office Visit Specialty Care Physician's Office Visit Outpatient Facility Services Home Setting	\$35 per visit copay, then 100% \$65 per visit copay, then 100% 100% 100%
External Prosthetic Appliances Including Orthotics Calendar Year Maximum: Unlimited	100%
Nutritional Counseling Calendar Year Maximum: 3 visits per person however, the 3 visit limit will not apply to treatment of diabetes and/or to mental health and substance use disorder conditions. Primary Care Physician's Office Visit Specialty Care Physician's Office Visit Inpatient Facility Outpatient Facility Inpatient Professional Services Outpatient Professional Services	\$35 per visit copay, then 100% \$65 per visit copay, then 100% \$500 per day copay, then 100% 100% 100% 100%

BENEFIT HIGHLIGHTS	IN-NETWORK
<p>Genetic Counseling</p> <p>Calendar Year Maximum: 3 visits per person for Genetic Counseling for both pre- and post-genetic testing; however, the 3 visit limit will not apply to Mental Health and Substance Use Disorder conditions.</p> <p>Primary Care Physician's Office Visit</p> <p>Specialty Care Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Inpatient Professional Services</p> <p>Outpatient Professional Services</p>	<p></p> <p>\$35 per visit copay, then 100%</p> <p>\$65 per visit copay, then 100%</p> <p>\$500 per day copay, then 100%</p> <p>100%</p> <p>100%</p> <p>100%</p>
<p>Dental Care</p> <p>Limited to charges made for a continuous course of dental treatment for an Injury to teeth.</p> <p>Primary Care Physician's Office Visit</p> <p>Specialty Care Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Inpatient Professional Services</p> <p>Outpatient Professional Services</p>	<p></p> <p>\$35 per visit copay, then 100%</p> <p>\$65 per visit copay, then 100%</p> <p>\$500 per day copay, then 100%</p> <p>100%</p> <p>100%</p> <p>100%</p>

BENEFIT HIGHLIGHTS		IN-NETWORK
TMJ Surgical and Non-Surgical Always excludes appliances and orthodontic treatment. Primary Care Physician’s Office Visit Specialty Care Physician’s Office Visit Inpatient Facility Outpatient Facility Inpatient Professional Services Outpatient Professional Services	 <	



BENEFIT HIGHLIGHTS	IN-NETWORK
Mental Health, including Biologically Based Mental Illness Inpatient Includes Acute Inpatient and Residential Treatment Calendar Year Maximum: Unlimited	\$500 per day copay, then 100%
Outpatient Outpatient - Office Visits Includes individual, family and group psychotherapy; medication management, virtual care, etc. Calendar Year Maximum: Unlimited	\$65 per visit copay, then 100%
Dedicated Virtual Providers MDLIVE Behavioral Services	\$65 per visit copay, then 100%
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, virtual care, etc. Calendar Year Maximum: Unlimited	100%

BENEFIT HIGHLIGHTS	IN-NETWORK
<p>Substance Use Disorder</p> <p>Inpatient Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment</p> <p>Calendar Year Maximum: Unlimited</p> <p>Outpatient Outpatient - Office Visits</p> <p>Includes individual, family and group psychotherapy; medication management, virtual care, etc.</p> <p>Calendar Year Maximum: Unlimited</p> <p>Dedicated Virtual Providers MDLIVE Behavioral Services</p> <p>Outpatient - All Other Services</p> <p>Includes Partial Hospitalization, Intensive Outpatient Services, virtual care, etc.</p> <p>Calendar Year Maximum: Unlimited</p>	<p>\$500 per day copay, then 100%</p> <p>\$65 per visit copay, then 100%</p> <p>\$65 per visit copay, then plan deductible, then 100%</p> <p>100%</p>

Open Access Plus In-Network Medical Benefits

Prior Authorization/Pre-Authorized - Requirements Applicable to In Network Services

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy. If the health care practitioner submits the request for Prior Authorization electronically, we will respond with an approval or denial within 48 hours for urgent requests and within 10 calendar days of receipt of the request for non-urgent requests.

The member will not be billed for services for which the Participating Provider fails to receive Prior Authorization/Pre-Authorization for.

When a member utilizes a non-Participating Provider, the member is responsible to ensure the non-Participating Provider complies with Prior Authorization or the member must contact the Review Organization.

The member can be billed for non-compliance with precertification for services which the non-Participating Provider fails to receive Prior Authorization/Pre-Authorization for.

Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services, except for 48/96 hour maternity stays.
- inpatient services at any participating Other Health Care Facility.
- residential treatment.
- outpatient facility services.
- partial hospitalization.
- advanced radiological imaging.
- non-emergency Ambulance.
- certain Medical Pharmaceuticals.
- home health care services.
- radiation therapy.
- transplant services.

Covered Expenses Under the Medical Plan

The term Covered Expenses means expenses incurred by a person while covered under this plan for the charges listed below for:

- preventive care services; and
- services or supplies that are Medically Necessary for the care and treatment of an Injury or a Sickness, 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.

Any applicable Copayments, Deductibles or limits are shown in The Schedule.

Covered Expenses

Coverage includes all Medically Necessary basic health care services for complications of non-covered treatment.

- charges for inpatient Room and Board and other Necessary Services and Supplies made by a Hospital, subject to the limits as shown in The Schedule.
- 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 as shown in The Schedule.
- 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 received at a Free-Standing Surgical Facility.
- charges for Emergency Services.
- charges for Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse for professional nursing service.
- charges made 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 blood transfusions.
- charges for oxygen and other gases and their administration.
- charges made for Medically Necessary foot care for diabetes, peripheral neuropathies and peripheral vascular disease.
- charges made for or in connection with:
 - an annual cytologic screening (Pap smear) for detection of cervical cancer;
 - a single baseline mammogram for women ages 35 through 39. The total amount payable (including Deductibles and Copayments) for the mammogram cannot exceed 130% of the Medicare reimbursement amount. The provider may only bill for Deductibles and Copayments up to that amount and they may not Balance Bill for any charges over that. Screening mammographies must be performed in a health care facility or mobile mammography screening unit that is accredited under the American College of Radiology Accreditation Program or in a hospital;
 - a mammogram every two years for women ages 40 through 49, or an annual mammogram if a licensed Physician has determined the woman to be at risk; and
 - an annual mammogram for women ages 50 through 64. Your provider will indicate whether your mammogram is for preventive or diagnostic purposes.
- charges include screening mammography to detect the presence of breast cancer and charges for supplemental breast cancer screenings to detect the presence of breast cancer in adult women meeting the following:
 - the woman's/individual's screening mammography demonstrates, based on the breast imaging reporting and data system established by the American college of radiology, that the woman has dense breast tissue.
 - the woman/individual is at an increased risk of breast cancer due to family history, prior personal history of breast cancer, ancestry, genetic predisposition, or other reasons as determined by the woman's health care provider.
 - services include ultrasounds, MRI, digital breast tomosynthesis and molecular breast imaging.
- charges made for screening prostate-specific antigen (PSA) testing.
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges for any medical services necessary to administer prescribed off-label drugs. Coverage includes Medically

Necessary services associated with the administration of the drug.

Such coverage shall not be construed to do any of the following:

- Require coverage for any drug if the FDA has determined its use to be contraindicated for the treatment of the particular indication for which the drug has been prescribed;
- Require coverage for experimental drugs not approved for any indication by the FDA;
- Alter any law with regard to provisions limiting the coverage of drugs that have not been approved by the FDA;
- Require reimbursement or coverage for any drug not included in the drug formulary or list of covered drugs specified in the policy;
- Prohibit Cigna from limiting or excluding coverage of a drug, provided that the decision to limit or exclude coverage of the drug is not based primarily on the coverage of drugs described in this provision.
- charges for diagnostic and exploratory procedures to determine infertility, including surgical procedures to correct the medically diagnosed disease or condition of reproductive organs, including but not limited to endometriosis, collapsed/clogged fallopian tubes or testicular failure; in vitro fertilization, gamete intrafallopian transfer and zygote intrafallopian transfer are not covered.

The following details preventive services covered in accordance with the Federal PPACA mandate.

- charges made for 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;
 - for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
 - 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/coverage/preventive-care-benefits. For additional information on immunizations, visit the immunization schedule section of www.cdc.gov.

- charges for female sterilization in compliance with federal preventive care services.

- charges made for contraceptives, other than oral contraceptives. Refer to the Prescription Drug Benefits section for information regarding coverage on oral contraceptives.
- charges for men's family planning, counseling, testing and sterilization (e.g. vasectomies), excluding reversals.

Maternity

- charges for coverage for 48 hours of inpatient care following a vaginal delivery and 96 hours of inpatient care following a cesarean section for a mother and her newborn.
- any decision for early discharge (i.e. prior to the 48 or 96 hours) is to be made by the attending Physician or nurse mid-wife after conferring with the mother or person responsible for the mother or newborn.
- any length of stay beyond the 48 or 96 hours will be covered if determined Medically Necessary.

Inpatient care will include:

- medical services;
- educational services; and
- any other services that are consistent with protocols and guidelines developed by national pediatric, obstetric, and nursing professional organizations for these services (e.g. AAP/ACOG Guidelines).

Post-discharge Follow-up

- If a mother and newborn are discharged prior to the 48 or 96 hours, policies and contracts will also provide coverage for all Physician/advanced practice registered nurse-directed follow-up care provided during the first 72 hours after discharge. Coverage for follow-up care after that 72 hour period will be provided if the services are Medically Necessary.
- If a mother and newborn receive at least 48 or 96 hours of inpatient stay following a vaginal or cesarean section, respectively, then policies and contracts will provide coverage for follow-up care if it is determined Medically Necessary by the attending health care professionals.
- Coverage for follow-up care will apply to services provided in a medical setting (e.g. doctor's office or facility) or through home health care visits. Home health care visits must be conducted by a health care professional with knowledge and training in maternity and newborn care.

Follow-up services will include:

- physical assessment of the mother and newborn;
- parent education;
- assistance and training in breast and bottle feeding;
- assessment of the home support system;

- the performance of any Medically Necessary and appropriate clinical tests; and
 - any other services that are consistent with protocols and guidelines developed by national pediatric, obstetric, and nursing professional organizations for these services (e.g. AAP/ACOG Guidelines).
- Medically Necessary orthognathic surgery to repair or correct a severe facial deformity or disfigurement.

Convenience Care Clinic

Convenience Care Clinics provide for common ailments and routine services, including but not limited to, strep throat, ear infections or pink eye, immunizations and flu shots.

Virtual Care - Medical

Dedicated Virtual Providers/Telemedicine

Includes charges for the delivery of real-time medical and health-related services and consultations by dedicated virtual providers as medically appropriate through synchronous or asynchronous information and communication technology.

Includes charges for the delivery of mental health and substance use disorder-related services, consultations, and remote monitoring by dedicated virtual providers as appropriate through audio, video and secure internet-based technologies.

Virtual Physician Services/Telemedicine

Includes charges for the delivery of real-time medical and health-related services and consultations as medically appropriate through synchronous or asynchronous information and communication technology that are similar to office visit services provided in a face-to-face setting.

Includes charges for the delivery of real-time mental health and substance use disorder consultations and services, via secure telecommunications technologies that shall include video capability, telephone and internet, when such consultations and services are delivered by a behavioral provider and are similar to office visit services provided in a face-to-face setting.

- charges made for Medically Necessary Synchronous Teledentistry.
- charges for screening, diagnosis and treatment of autism spectrum disorder. Treatment for autism spectrum disorder include evidence-based, Medically Necessary care and related equipment prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed Physician who is a developmental pediatrician or a licensed Psychologist trained in autism who determines the care to be Medically Necessary, including any of the following: (a) Clinical therapeutic intervention; (b) Pharmacy care; (c) Psychiatric care; (d) Psychological care; (e) Therapeutic care.

Nutritional Counseling

Charges for counseling when diet is a part of the medical management of a medical or behavioral condition.

Enteral Nutrition

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

Coverage includes medically approved formulas prescribed by a Physician for treatment of inborn errors of metabolism (e.g., disorders of amino acid or organic acid metabolism).

Internal Prosthetic/Medical Appliances

Charges for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for non-functional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

HC-COV1399

01-24

Home Health Care Services

Charges for skilled care provided by certain health care providers during a visit to the home, when the home is determined to be a medically appropriate setting for the services. A visit is defined as a period of 2 hours or less. Home Health Care Services are subject to a maximum of 16 hours in total per day.

Home Health Care Services are covered when skilled care is required under any of the following conditions:

- the required skilled care cannot be obtained in an outpatient facility.
- confinement in a Hospital or Other Health Care Facility is not required.
- the patient's home is determined by Cigna to be the most medically appropriate place to receive specific services.

Covered services include:

- skilled nursing services provided by a Registered Nurse (RN); Licensed Practical Nurse (LPN); Licensed Vocational Nurse (LVN) and an Advanced Practice Registered Nurse (APRN).
- services provided by health care providers such as a physical therapist; occupational therapist or speech therapist.
- services of a home health aide when provided in direct support of those Nurses and health care providers.
- necessary consumable medical supplies and home infusion therapy administered or used by a health care provider.

Note: Physical, occupational, and other Outpatient Therapy Services provided in the home are covered under the Outpatient Therapy Services benefit shown in The Schedule.

The following are excluded from coverage:

- services provided by a person who is a member of the patient's family, even when that person is a health care provider.
- services provided by a person who normally resides in the patient's house, even when that person is a health care provider.
- non-skilled care, Custodial Services, and assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other services; self-care activities; homemaker services; and services primarily for rest, domiciliary or convalescent care.

Home Health Care Services, for a patient who is dependent upon others for non-skilled care and/or Custodial Services, is provided only when there is a family member or caregiver present in the home at the time of the health care visit to provide the non-skilled care and/or Custodial Services.

HC-COV1007

01-21

Hospice Care Services

Charges for services for a person diagnosed with advanced Illness (having a life expectancy of twelve or fewer months). Services provided by a Hospice Care Program are available to those who have ceased treatment and to those continuing to receive curative treatment and therapies.

A Hospice Care Program rendered by a Hospice Facility or Hospital includes services:

- by a Hospice Facility for Room and Board and Services and Supplies;
- by a Hospice Facility for services provided on an outpatient basis;
- by a Physician for professional services;
- by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
- for pain relief treatment, including drugs, medicines and medical supplies.

A Hospice Care Program rendered by an Other Health Care Facility or in the Home includes services:

- part-time or intermittent nursing care by or under the supervision of a Nurse;
- part-time or intermittent services of an Other Health Professional;
- physical, occupational and speech therapy;

- medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician;
- laboratory services;

but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses:

- services of 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;
- services for any period when you or your Dependent are not under the care of a Physician;
- services or supplies not listed in the Hospice Care Program;
- to the extent that any other benefits are payable for those expenses under the policy;
- services or supplies that are primarily to aid you or your Dependent in daily living.

HC-COV1243

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Mental Health and Substance Use Disorder Services

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

We have opioid education information and tools available to coordinate care of high-risk insureds with opioid-use disorders. Please call us at the number on the back of your ID card or visit www.cigna.com for more information.

Biologically Based Mental Illness

Mental Health Services include treatment of biologically based mental illness including schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American psychiatric association. The biologically based mental illness must be clinically diagnosed by a Physician authorized to practice medicine and surgery or osteopathic medicine and surgery; a licensed Psychologist; a professional clinical counselor, professional counselor, or licensed independent social worker; or, a licensed clinical nurse whose nursing specialty is Mental Health. The prescribed treatment must not be experimental or

investigational, having proven its clinical effectiveness in accordance with generally accepted medical standards.

Substance Use Disorder is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Use Disorder.

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Partial Hospitalization and Mental Health Residential Treatment Services.

Mental Health Residential Treatment Services are services provided by a Residential Treatment Center for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; 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 she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group or Mental Health Partial Hospitalization or Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

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.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are 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 nine or more hours in a week.

Inpatient Substance Use Disorder Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Use Disorder Services include Residential Treatment Services.

Substance Use Disorder Residential Treatment Services

are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Use Disorder conditions.

Substance Use Disorder Residential Treatment Center

means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Use Disorder; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; 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 Substance Use Disorder Residential Treatment Center when she/he is a registered bed patient in a Substance Use Disorder Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Use Disorder Rehabilitation Services

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Use Disorder or Intensive Outpatient Therapy Program.

A Substance Use Disorder Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Use Disorder 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 nine, or more hours in a week.

Substance Use Disorder Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Cigna will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Exclusions

The following are specifically excluded from Mental Health and Substance Use Disorder Services:

- counseling for activities of an educational nature.
- counseling for borderline intellectual functioning.
- counseling for occupational problems.
- counseling related to consciousness raising.
- vocational or religious counseling.
- I.Q. testing.
- custodial care, including but not limited to geriatric day care.
- psychological testing on children requested by or for a school system.
- occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

HC-COV1400

01-24

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Durable Medical Equipment

- charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by Cigna for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, ventilators, insulin pumps and wheel chairs.

Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:

- **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses,

including non-power mattresses, custom mattresses and posturepedic mattresses.

- **Bath Related Items:** bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas.
- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
- **Car/Van Modifications.**
- **Air Quality Items:** room humidifiers, vaporizers and air purifiers.
- **Other Equipment:** centrifuges, needleless injectors, heat lamps, heating pads, cryounits, cryotherapy machines, ultraviolet cabinets that emit Ultraviolet A (UVA) rays, sheepskin pads and boots, postural drainage board, AC/DC adaptors, scales (baby and adult), stair gliders, elevators, saunas, cervical and lumbar traction devices, exercise equipment and diathermy machines.

HC-COV1008

01-21

External Prosthetic Appliances and Devices

- charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect.

External prosthetic appliances and devices include prostheses/prosthetic appliances and devices; orthoses and orthotic devices; braces; and splints.

Prostheses/Prosthetic Appliances and Devices

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

- limb prostheses;
- terminal devices such as hands or hooks;
- speech prostheses; and
- facial prostheses.

Orthoses and Orthotic Devices

Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

- Non-foot orthoses – only the following non-foot orthoses are covered:
 - rigid and semi-rigid custom fabricated orthoses;

- semi-rigid prefabricated and flexible orthoses; and
- rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
 - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
 - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
 - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
 - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- non-foot orthoses primarily used for cosmetic rather than functional reasons; and
- non-foot orthoses primarily for improved athletic performance or sports participation.

Braces

A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

The following braces are specifically excluded: Copes scoliosis braces.

Splints

A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.

- replacement required because anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- replacement due to a surgical alteration or revision of the impacted site.

Coverage for replacement is limited as follows:

- no more than once every 24 months for persons 19 years of age and older.
- no more than once every 12 months for persons 18 years of age and under.

The following are specifically excluded external prosthetic appliances and devices:

- external and internal power enhancements for external prosthetic devices;
- microprocessor controlled prostheses and orthoses; and
- myoelectric prostheses and orthoses.

HC-COV1009

01-21

Infertility Services

- charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: infertility drugs which are administered or provided by a Physician; approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; artificial insemination; diagnostic evaluations; gamete intrafallopian transfer (GIFT); in vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT); and the services of an embryologist.

Infertility is defined as:

- the inability of opposite-sex partners to achieve conception after at least one year of unprotected intercourse;
- the inability of opposite-sex partners to achieve conception after six months of unprotected intercourse, when the female partner trying to conceive is age 35 or older;
- the inability of a woman, with or without an opposite-sex partner, to achieve conception after at least six trials of medically supervised artificial insemination over a one-year period; and
- the inability of a woman, with or without an opposite-sex partner, to achieve conception after at least three trials of medically supervised artificial insemination over a six-

month period of time, when the female partner trying to conceive is age 35 or older.

This benefit includes diagnosis and treatment of both male and female infertility.

However, the following are specifically excluded infertility services:

- reversal of male and female voluntary sterilization;
- infertility services when the infertility is caused by or related to voluntary sterilization;
- donor charges and services;
- cryopreservation of sperm and eggs; and
- any experimental, investigational or unproven infertility procedures or therapies.

HC-COV734

03-19

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Outpatient Therapy Services

Charges for the following therapy services:

Cognitive Therapy, Occupational Therapy, Osteopathic Manipulation, Physical Therapy, Pulmonary Rehabilitation, Speech Therapy

- charges for therapy services are covered when provided as part of a program of treatment.

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 Physician 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 Physicians. 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 Physicians.

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

Coverage 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 purposes of enabling individuals to perform the activities of daily living after an Injury or Sickness.

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 Copayment applies to the services provided by each provider for each therapy type per day.

HC-COV1012

01-21

Breast Reconstruction and Breast Prostheses

- charges made for reconstructive surgery following a mastectomy; benefits include: 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

- 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, non-cosmetic 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 utilization review Physician.

HC-COV631

12-17

Transplant Services and Related Specialty Care

Charges made for human organ and tissue Transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories. 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.

Implantation procedures for artificial heart, percutaneous ventricular assist device (PVAD), extracorporeal membrane oxygenation (ECMO), ventricular assist device (VAD), and intra-aortic balloon pump (IABP) are also covered.

- All transplant services and related specialty care services, other than cornea transplants, are covered when received at Cigna LifeSOURCE Transplant Network[®] facilities.
- Transplant services and related specialty care services received at Participating Provider facilities specifically contracted with Cigna for those transplant services and related specialty care services, other than Cigna LifeSOURCE Transplant Network[®] facilities, are payable at the In-Network level.
- Transplant services and related specialty care services received at any other facility, including non-Participating Provider facilities and Participating Provider facilities not specifically contracted with Cigna for transplant services and related specialty care services, are not covered.
- Cornea transplants received at a facility that is specifically contracted with Cigna for this type of transplant are payable at the In-Network level.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of hospitalization and surgery necessary for removal of an organ and transportation of a live donor (refer to Transplant and Related Specialty Care Travel Services). 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 and Related Specialty Care Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a pre-approved organ/tissue transplant or related specialty care are covered subject to the following conditions and limitations.

- Transplant and related specialty care related specialty care travel benefits are not available for cornea transplants.
- Benefits for transportation and lodging are available to the recipient of a pre-approved organ/tissue transplant and/or related specialty care from a designated Cigna LifeSOURCE Transplant Network[®] facility.
- The term recipient is defined to include a person receiving authorized transplant related services during any of the following: evaluation, candidacy, transplant event, or post-transplant care.

- Travel expenses for the person receiving the transplant will include charges for: transportation to and from the designated Cigna LifeSOURCE Transplant Network[®] facility (including charges for a rental car used during a period of care at the designated Cigna LifeSOURCE Transplant Network[®] facility transplant facility); and lodging while at, or traveling to and from the designated Cigna LifeSOURCE Transplant Network[®] facility transplant facility.
- 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.

These benefits for Transplant and Related Specialty Care Services and for Transplant and Related Specialty Care Travel Services are only available when the covered person is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above. Charges for the expenses of a donor companion are not covered. No transplant and related specialty care services or travel benefits are available when the covered person is a donor for an organ/tissue transplant; the transplant recipient's plan covers all donor costs.

*For additional Information please visit:

<https://cignalisource.com/transplant-network/index.html>

HC-COV1402

01-24

V1

Advanced Cellular Therapy

Charges for advanced cellular therapy products and services directly related to their administration are covered when Medically Necessary. Coverage includes the cost of the advanced cellular therapy product; medical, surgical, and facility services directly related to administration of the advanced cellular therapy product, and professional services.

Cigna determines which U.S. Food and Drug Administration (FDA) approved products are in the category of advanced cellular therapy, based on the nature of the treatment and how it is manufactured, distributed and administered. An example

of advanced cellular therapy is chimeric antigen receptor (CAR) T-cell therapy that redirects a person's T cells to recognize and kill a specific type of cancer cell.

Advanced cellular therapy products and their administration are covered at the in-network benefit level when prior authorized to be received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services. Advanced cellular therapy products and their administration received from a provider that is not contracted with Cigna for the specific advanced cellular therapy product and related services are not covered.

Advanced Cellular Therapy Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized advanced cellular therapy product 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 advanced cellular therapy product;
- the term recipient is defined to include a person receiving prior authorized advanced cellular therapy related services during any of the following: evaluation, candidacy, event, or post care;
- the advanced cellular therapy products and services directly related to their administration are received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services; and
- the provider is not available within a 60 mile radius of your primary home residence.

Travel expenses for the person receiving the advanced cellular therapy include charges for: transportation to and from the advanced cellular 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 mile radius of your primary home residence; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

HC-COV1326

01-24

Medical Pharmaceuticals

The plan covers charges made for Medical Pharmaceuticals that may be administered in an Inpatient setting, Outpatient setting, Physician's office, or in a covered person's home.

Benefits under this section are provided only for Medical Pharmaceuticals that, because of their characteristics as determined by Cigna, require a qualified licensed health care professional to administer or directly supervise administration.

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 coverage, the covered person may be required to try a specific Medical Pharmaceutical before trying others. Medical Pharmaceuticals administered in an Inpatient facility are reviewed per Inpatient review guidelines.

Cigna determines the utilization management requirements and other coverage conditions that apply to a Medical Pharmaceutical by considering a number of factors, including, but not limited to:

- Clinical factors, which may include but are not limited to Cigna's evaluations of the site of care and the relative safety or relative efficacy of Medical Pharmaceuticals.
- Economic factors, which may include but are not limited to the cost of the Medical Pharmaceutical and assessments of cost effectiveness after rebates.

The coverage criteria for 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 cost of a Medical Pharmaceutical.

Certain Medical Pharmaceuticals that are used for treatment of complex chronic conditions, are high cost, and are administered and handled in a specialized manner may be subject to additional coverage criteria or require administration by a participating provider in the network for the Cigna Pathwell Specialty Network. Cigna determines

which injections, infusions, and implantable drugs are subject to these criteria and requirements.

The Cigna Pathwell Specialty Network includes but is not limited to contracted physician offices, ambulatory infusion centers, home and outpatient hospital infusion centers, and contracted specialty pharmacies. When the Cigna Pathwell Specialty Network cannot meet the clinical needs of the customer as determined by Cigna, exceptions are considered and approved when appropriate.

A complete list of those Medical Pharmaceuticals subject to additional coverage criteria or that require administration by a participating provider in the Cigna Pathwell Specialty Network is available at www.cigna.com/PathwellSpecialty.

The following are not covered under the plan, including but not limited to:

- Medical Pharmaceutical regimens that have a Therapeutic Equivalent or Therapeutic Alternative to another covered Prescription Drug Product(s);
- Medical Pharmaceuticals newly approved by the Food & Drug Administration (FDA) up to the first 180 days following its market launch;
- Medical Pharmaceutical regimens for which there is an appropriate lower cost alternative for treatment.

In the event a covered Medical Pharmaceutical is not clinically appropriate, Cigna makes available an exception process to allow for access to non-covered drugs when Medically Necessary.

Cigna may consider certain Medical Pharmaceutical regimens as preferred when they are clinically effective treatments and the most cost effective. Preferred regimens are covered unless the covered person is not a candidate for the regimen and a Medical Necessity coverage exception is obtained.

HC-COV1186

01-23

Gene Therapy

Charges for gene therapy products and services directly related to their administration are covered 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 In-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 In-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.

HC-COV886

01-20

Clinical Trials

- charges made for Routine Patient Care administered to an insured person participating in any stage of an Eligible Cancer Clinical Trial if that care would be covered under the plan if the insured was not participating in the trial.
- Routine Patient Costs are generally defined as items and services that typically would be covered under the plan for an individual not enrolled in a clinical trial.
- "Approved Clinical Trial" is defined as 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. The clinical trial must be federally approved or funded by one of the designated entities in the statute (outlined below). Routine costs for Approved Clinical Trials are covered.

The clinical trial must meet the following requirements; the study or investigation must meet 1, 2 or 3 below:

1. Be approved or funded by:
 - A. the National Institutes of Health (NIH);
 - B. the Centers for Disease Control and Prevention (CDC);
 - C. the Agency for Health Care Research on Quality;
 - D. the Centers for Medicare & Medicaid Services;
 - E. cooperative group or center of any of the entities named in (A) through (D); or the Department of Defense or the Department of Veterans Affairs;
 - F. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - G. Any of the following if the "Conditions For Departments" are met:
 - (i) The Department of Veterans Affairs.
 - (ii) The Department of Defense.
 - (iii) The Department of Energy.
2. Be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
3. Involve a drug trial that is exempt from having such an investigational new drug application.

An "Eligible cancer clinical trial" means a cancer clinical trial that meets all of the following criteria:

- (a) A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.
- (b) The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.

- (c) The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.
- (d) The trial does one of the following:
 - (i) Tests how to administer a health care service, item, or drug for the treatment of cancer;
 - (ii) Tests responses to a health care service, item, or drug for the treatment of cancer;
 - (iii) Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer;
 - (iv) Studies new uses of a health care service, item, or drug for the treatment of cancer.
- (e) The trial is approved by one of the following entities:
 - (i) The National Institutes of Health or one of its cooperative groups or centers under the United States department of health and human services;
 - (ii) The United States Food and Drug Administration;
 - (iii) The United States Department of Defense;
 - (iv) The United States Department of Veterans' Affairs.
- (2) "Subject of a cancer clinical trial" means the health care service, item, or drug that is being evaluated in the clinical trial and that is not routine patient care.
- (3) "Health benefit plan" has the same meaning as in section 3924.01 of the Revised Code.
- (4) "Routine patient care" means all health care services consistent with the coverage provided in the health benefit plan or public employee benefit plan for the treatment of cancer, including the type and frequency of any diagnostic modality, that is typically covered for a cancer patient who is not enrolled in a cancer clinical trial, and that was not necessitated solely because of the trial.
- (5) For purposes of this section, a health benefit plan or public employee benefit plan may exclude coverage for any of the following:
 - (a) A health care service, item, or drug that is the subject of the cancer clinical trial;
 - (b) A health care service, item, or drug provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;
 - (c) An investigational or experimental drug or device that has not been approved for market by the United States Food and Drug Administration;
 - (d) Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the cancer clinical trial;

- (e) An item or drug provided by the cancer clinical trial sponsors free of charge for any patient;
- (f) A service, item, or drug that is eligible for reimbursement by a person other than the insurer, including the sponsor of the cancer clinical trial.
- Coverage for cancer clinical trials is subject to all terms, conditions, exclusions and limitations that apply to any other coverage under the plan for services performed by Participating and non-Participating providers.
- Routine Patient Care means all health care services consistent with the coverage provided in the health benefit plan for the treatment of cancer, including the type and frequency of any diagnostic modality that is typically covered for a cancer patient who is not enrolled in a cancer clinical trial and that was not necessitated solely because of the trial.

Routine Patient Care does not include, and reimbursement will not be provided for:

- A health care service, item or drug that is the subject of the cancer clinical trial (i.e. the service, item or drug that is being evaluated in the clinical trial and that is not Routine Patient Care);
- A health care service, item or drug provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;
- An investigational or experimental drug or device that has not been approved for market by the U.S. Food and Drug Administration;
- Transportation, lodging, food or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the cancer clinical trial;
- An item or drug provided by the cancer clinical trial sponsors free of charge for any patient; or
- A service, item or drug that is eligible for reimbursement by a person other than the carrier, including the sponsor of the cancer clinical trial.

For Ohio residents: Routine patient care for Eligible Cancer Clinical Trials are covered. The insured does not need a medical referral from a participating health care professional nor do they need to provide medical and scientific information establishing the appropriateness of participation.

HC-COV963

Prescription Drug Benefits The Schedule	
For You and Your Dependents	
<p>This plan provides Prescription Drug benefits for Prescription Drug Products provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a Deductible, Copayment or Coinsurance requirement for Covered Expenses for Prescription Drug Products.</p> <p>You and your Dependents will pay 100% of the cost of any Prescription Drug Product excluded from coverage under this plan. The amount you and your Dependent pays for any excluded Prescription Drug Product to the dispensing Pharmacy, will not count towards your Deductible, if any, or Out-of-Pocket Maximum.</p>	
Copayments (Copay)	
Copayments are amounts to be paid by you or your Dependent for covered Prescription Drug Products.	
Out-of-Pocket Expenses	
Out-of-Pocket Expenses are Covered Expenses incurred at a Pharmacy for Prescription Drug Products for which the Plan provides no payment because of the Coinsurance factor and any Copayments or Deductibles. When the Out-of-Pocket Maximum shown in The Schedule is reached, benefits are payable at 100%.	
Oral Chemotherapy Medication	
Prescription oral chemotherapy medication that is used to kill or slow the growth of cancerous cells is covered at Network Pharmacies at 100% with no deductible.	

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
<p>Patient Assurance Program</p> <p>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 Copayment or Coinsurance, if any. The Copayment or Coinsurance, if any, otherwise applicable to those certain covered Prescription Drug Products as set forth in The Schedule may be reduced in order for Patient Assurance Program discounts earned by Cigna to be applied or credited to the Copayment or Coinsurance, if any, as described above.</p> <p>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 Copayment or Coinsurance, if any, which, as noted, may be reduced from the amount set forth in The 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.</p> <p>Your Copayment or Coinsurance payment, if any, for covered Prescription Drug Products under the Patient Assurance Program counts toward your Out-of-Pocket Maximum.</p> <p>Any Patient Assurance Program discount that is used to satisfy your Copayment or Coinsurance, if any, for covered Prescription Drug Products under the Patient Assurance Program counts toward your Out-of-Pocket Maximum.</p> <p>Please note that the Patient Assurance Program discounts that Cigna may earn for Prescription Drug Products, and may apply or credit to your Copayment or Coinsurance, if any, in connection with the Patient Assurance Program are unrelated to any 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 Copayment 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.</p>		
<p>Out-of-Pocket Maximum</p> <p>Individual</p> <p>Family</p>	<p>\$1000 per person</p> <p>\$3000 per family</p>	<p>Not Applicable</p> <p>Not Applicable</p>
<p>Maintenance Drug Products</p> <p>Maintenance Drug Products may be filled in an amount up to a consecutive 90 day supply per Prescription Order or Refill at a retail Designated Pharmacy or home delivery Network Pharmacy.</p>		

BENEFIT HIGHLIGHTS		NETWORK PHARMACY	NON-NETWORK PHARMACY
<p>Certain Preventive Care Medications covered under this plan and required as part of preventive care services (detailed information is available at www.healthcare.gov) are payable at 100% with no Copayment or Deductible, when purchased from a Network Pharmacy. A written prescription is required.</p> <p>At least one Contraceptive drug or device for each contraceptive method will be covered at 100% with no Copayment or Deductible. For any additional drug or device within the same contraceptive method, you may be charged a Deductible, Copayment, or Coinsurance. If you reject a therapeutic equivalent of a drug or device, a higher Deductible, Copayment, or Coinsurance may apply.</p>			
Prescription Drug Products at Retail Pharmacies		The amount you pay for up to a consecutive 30-day supply at a Network Pharmacy	The amount you pay for up to a consecutive 30-day supply at a non-Network Pharmacy
Tier 1			
Generic Drugs on the Prescription Drug List		No charge after \$10 Copay	In-network coverage only
Tier 2			
Brand Drugs designated as preferred on the Prescription Drug List		No charge after \$35 Copay	In-network coverage only
Tier 3			
Brand Drugs designated as non-preferred on the Prescription Drug List		No charge after \$50 Copay	In-network coverage only
Tier 4			
Specialty Prescription Drug Products		No charge after \$150 Copay	In-network coverage only
Prescription Drug Products at Retail Designated Pharmacies		The amount you pay for up to a consecutive 90-day supply at a Designated Pharmacy	The amount you pay for up to a consecutive 90-day supply at a non-Designated Pharmacy
Specialty Prescription Drug Products are limited to up to a consecutive 30-day supply per Prescription Order or Refill.			
Note: In this context, a retail Designated Pharmacy is a retail Network Pharmacy that has contracted with Cigna for dispensing of 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		No charge after \$30 Copay	In-network coverage only
Tier 2			
Brand Drugs designated as preferred on the Prescription Drug List		No charge after \$105 Copay	In-network coverage only

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after \$150 Copay	In-network coverage only
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.	In-network coverage only
Prescription Drug Products at Home Delivery Pharmacies	The amount you pay for up to a consecutive 90-day supply at a Network Pharmacy	The amount you pay for up to a consecutive 90-day supply at a non-Network Pharmacy
Specialty Prescription Drug Products are limited to up to a consecutive 30-day supply per Prescription Order or Refill and are subject to the same Copayment or Coinsurance that applies to retail Pharmacies.		
Tier 1 Generic Drugs on the Prescription Drug List	No charge after \$30 Copay	In-network coverage only
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after \$105 Copay	In-network coverage only
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after \$150 Copay	In-network coverage only
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.	In-network coverage only

Prescription Drug Benefits

Covered Expenses

Your plan provides benefits for Prescription Drug Products on the Prescription Drug List that are dispensed by a Pharmacy. Details regarding your plan's Covered Expenses, which for the purposes of the Prescription Drug Benefit include Medically Necessary Prescription Drug Products ordered by a Physician, Limitations, and Exclusions are provided below and/or are shown in The Schedule.

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy for Medically Necessary Prescription Drug Products ordered by a Physician, your plan provides coverage for those expenses as shown in The 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.

Coverage under your plan's Prescription Drug Benefits also includes Medically Necessary Prescription Drug Products dispensed pursuant to a Prescription Order or Refill issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a Dependent 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 will be covered pursuant to the, as applicable, Copayment or Coinsurance for the Prescription Drug Product when dispensed by a Network Pharmacy.

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 or any of your

Dependents is a determination that is made by you or your Dependent and the prescribing Physician.

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 purposes 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). Please 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 the most up-to-date tier status, utilization management, or other coverage limitations for a Prescription Drug Product.

Coverage for "off-label" drug(s), provided: (a) it is recognized as safe and effective for the specific treatment prescribed according to any of the following: The AMA Drug Evaluations; The American Hospital Formulary Service; The US Pharmacopoeia Dispensing Information; or two articles from major peer-reviewed professional medical journals which meet the journalistic standards of the International Committee of Medical Journal Editors or the U.S. Department of Health and Human Services, if those articles are not contradicted by evidence presented in another article from such a journal; (b) it has been otherwise approved by the FDA; and (c) it has not been contraindicated by the FDA for the use prescribed.

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Limitations

For most Prescription Drug Products you and your Dependent pay only the cost sharing detailed in The Schedule of Prescription Drug Benefits. However, in the event you or your Dependent insist on a more expensive Brand Drug where a Therapeutic Equivalent Generic Drug is available, you will be financially responsible for an Ancillary Charge, in addition to any required Brand Drug Copayment and/or Coinsurance. In this case, the Ancillary Charge will not apply to your Deductible, if any, or Out-of-Pocket Maximum. However, in the event your Physician determines that the Generic Drug is not an acceptable alternative for you (and indicates Dispensed as Written on the Prescription Order or Refill), you will only

be responsible for payment of the appropriate Brand Drug Coinsurance and/or Copayment after satisfying your Deductible, if any.

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 participating 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 participating 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 Copayment and/or Coinsurance, after satisfying your Deductible, if any.

Prior Authorization Requirements

Coverage for certain Prescription Drug Products prescribed to you requires your Physician to obtain prior authorization from Cigna or its Review Organization. The reason for obtaining prior authorization from Cigna is to determine whether the Prescription Drug Product is Medically Necessary in accordance with Cigna's 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.

Opioid Analgesic

(1) If an insured person purchases an opioid analgesic covered product for the treatment of chronic pain, coverage herein shall be subject to prior authorization requirements or other utilization review measures as a condition of providing coverage.

(2) (a) If the course of treatment with the opioid analgesic continues for more than ninety days, insurer employs various strategies including but not limited to Retrospective Drug Utilization review and/or appropriate Drug Management Programs to prevent or address potential opioid or opioid potentiator overutilization; and/or

(b) insurer has established appropriate Utilization Management edits, triggering a care coordination alert at the dispensing Pharmacy, which include all of the following: (i) an active daily dose Morphine Milligram Equivalent (MME) maximum per drug in accordance with Medicare requirements; (ii) a cumulative daily MME (across all active opioid claims) exceeding 200 MME; and (iii) concurrent use of or treatment with a benzodiazepine at the time the opioid analgesic is prescribed.

(3) the restrictions in (1) and (2) shall not apply to an individual:

(a) who is a hospice patient in a Hospice Care Program;

(b) who has been diagnosed with a terminal condition but is not a hospice patient in a Hospice Care Program;

(c) who has cancer or another condition associated with the individual's cancer or history of cancer.

(4) insurer shall not penalize the prescriber, financially or otherwise, for deciding not to prescribe an opioid analgesic.

Opioid misuse and education can be found on our website, for more detailed information please visit www.cigna.com.

If Cigna or its Review Organization reviews the documentation provided and determines that the Prescription Drug Product is not Medically Necessary or otherwise excluded, your 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, your prescribing Physician is responsible for obtaining prior authorization from Cigna. If your prescribing Physician does not obtain prior authorization from us before the Prescription Drug Product is dispensed by the Pharmacy, you can ask us 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 Physician 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 Physician 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, your Physician and you 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 the provisions of the plan 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 at the website shown on your ID card or by calling member services at the telephone number on your ID card. Your Provider may request a Step Therapy exemption. An exemption request will be granted or denied within 48 hours for a request related to urgent care services and 10 calendar days for all other requests. See your Appeals section of this certificate for your Appeal rights.

These requirements do not apply to prescription drugs associated with the treatment of stage-four advanced, metastatic cancer or associated conditions.

Supply Limits

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

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.

Prescription drug coverage shall provide for medication synchronization for an insured if all of the following conditions are met: (1) the insured elects to participate in medication synchronization; (2) The insured, prescriber, and pharmacist at a Network Pharmacy agree that medication synchronization is in the best interest of the insured; (3) The prescription drug meets the requirements to be eligible for inclusion in medication synchronization.

To be eligible a drug must: (1) Be covered under the plan; (2) Be prescribed for the treatment and management of a chronic disease or condition and be subject to refills; (3) Satisfy all relevant prior authorization criteria; (4) Not have any quantity limits, dose optimization criteria, or other requirements that would be violated if synchronized; (5) Not have an special handling or sourcing needs, as determined by the plan that require a single designated Pharmacy to fill or refill the prescription; (6) Be formulated so that the quantity or amount dispensed can be effectively divided in order to achieve synchronization; (7) Not be a schedule II controlled substance, opiate, or benzodiazepine.

A policy or plan shall authorize coverage of a prescription drug subject to medication synchronization when the drug is dispensed in a quantity or amount that is less than a thirty one (31) day supply. Medication synchronization applies only once for each prescription drug subject to medication

synchronization for the same insured unless; a) the prescriber changes the dosage or frequency of administration of a prescription drug subject to medication synchronization or; b) the prescriber prescribes a different drug.

Shall permit and apply a prorated daily cost-sharing rate for a supply of a prescription drug subject to medication synchronization that is dispensed at a Network Pharmacy. Requirement does not waive any cost-sharing in its entirety.

"Medication synchronization" means a pharmacy service that synchronizes the filling or refilling of prescriptions in a manner that allows the dispensed drugs to be obtained on the same date each month.

"Cost-sharing" means the cost to an insured according to any coverage limit, Copayment, Coinsurance, Deductible, or other Out-of-Pocket expense requirements imposed by the policy or plan.

You may determine whether a Prescription Drug Product has been assigned a dispensing supply limit or similar limit or requirement at the website shown on your ID card or by calling member services at the telephone number on your ID card.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products. If you require Specialty Prescription Drug Products, you may be directed to a Designated Pharmacy with whom Cigna has an arrangement to provide those Specialty Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you may not receive coverage for the Specialty 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.

Your Payments

Covered Prescription Drug Products purchased at a Pharmacy are subject to any applicable Deductible, Copayments or Coinsurance shown in The Schedule, as well as any limitations or exclusions set forth in this plan. Please refer to The Schedule for any required Copayments, Coinsurance, Deductibles or Out-of-Pocket Maximums.

Copayment

Your plan requires that you pay a Copayment for covered Prescription Drug Products as set forth in The 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 Copayment requirement will be the lowest of the following amounts:

- the Copayment 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.

When a treatment regimen contains more than one type of Prescription Drug Products that are packaged together for your or your Dependent's convenience, any applicable Copayment or Coinsurance may apply to each Prescription Drug Product.

You will need to obtain prior approval from Cigna or its Review Organization for any Prescription Drug Product not listed on the Prescription Drug List that is not otherwise excluded. If Cigna or its Review Organization approves coverage for the 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 Schedule.

The amount you or your Dependent pays for any excluded Prescription Drug Product or other product or service will not be included in calculating any applicable plan Out-of-Pocket Maximum. You are responsible for paying 100% of the cost (the amount the Pharmacy charges you) for any excluded Prescription Drug Product or other product.

HC-PHR430

Exclusions

Coverage exclusions listed under the "Exclusions, Expenses Not Covered and General Limitations" section 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.

- coverage for Prescription Drug Products for the amount dispensed (days' supply) which exceeds the applicable supply limit, or is less than any applicable supply minimum 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 Physicians and dispensed by one or more Pharmacies.
- 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 you while you are 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 a 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.
- vitamins, except prenatal vitamins that require a Prescription Order or Refill, unless coverage for such product(s) is required by federal or state law.
- medications used for cosmetic or anti-aging 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.
- Medical Pharmaceuticals covered solely under the plan's medical benefits.
- Prescription Drug Products used for the treatment of male or female sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasm, 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 that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless state or federal law requires coverage of such medications or the over-the-counter 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 drug(s), or are available in over-the-counter 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 Sickness or Injury, unless coverage for such product(s) is required by federal or state law.
- medications used for travel prophylaxis unless specifically identified on the Prescription Drug List.
- 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.
- 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 under the “General Exclusion and Limitations” section of your plan’s certificate.

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Reimbursement/Filing a Claim

Retail Pharmacy

When you or your Dependents purchase your Prescription Drug Products through a Network Pharmacy, you pay any applicable Copayment, Coinsurance, or Deductible shown in The Schedule at the time of purchase. 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. 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.

HC-PHR432

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered Under the Medical Plan

Additional coverage limitations determined by plan or provider type are shown in The Schedule. Payment for the following is specifically excluded from this plan:

- care for health conditions that are 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 you are legally entitled to such treatment and facilities are reasonably available.
 - treatment of an Injury or Sickness (other than for Basic Health Care Services) which is due to war, declared, or undeclared.
 - charges which you are not obligated to pay and/or for which you are not billed. This exclusion includes, but is not limited to:
 - any instance where Cigna determines that a provider or Pharmacy did not bill you for, or has waived, reduced, or forgiven any portion of its charges and/or any portion of any Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for an otherwise Covered Expense (as shown on The Schedule) without Cigna's express consent.
 - charges of a non-Participating Provider who has agreed to charge you at an In-Network benefits level or some other benefits level not otherwise applicable to the services received.
- In the event that Cigna determines that this exclusion applies, then Cigna in its sole discretion shall have the right to:
- require you and/or any provider or Pharmacy submitting claims on your behalf to provide proof

sufficient to Cigna that you have made your required cost-share payment(s) prior to the payment of any benefits by Cigna;

- deny the payment of benefits in connection with the Covered Expense regardless of whether the provider or the Pharmacy represents that you remain responsible for any amounts that your plan does not cover; or
- reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover.
- charges or payment for healthcare-related services that violate state or federal law.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for 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, drug or Biologic therapies or devices that are determined by the utilization review Physician 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 or Sickness for which its use is proposed;
- the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the “Clinical Trials” sections of this plan; 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 the “Clinical Trials” sections of this plan.

In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician 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.

The plan or policy shall not limit or exclude coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy (a) it is recognized as safe and effective for the specific treatment prescribed according to any of the following: The AMA Drug Evaluations; The American Hospital Formulary Service; The U.S. Pharmacopoeia Dispensing Information; or two articles from major peer-reviewed professional medical journals which meet the journalistic standards of the International Committee of Medical Journal Editors or the U.S. Department of Health and Human Services, if those articles are not contradicted by evidence presented in another article from such a journal; (b) it has been otherwise approved by the FDA; and (c) it has not been contraindicated by the FDA for the use prescribed. The law does not prohibit health plans from using drug formularies. The law does require coverage for any medical services necessary to administer a drug.

- 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” section of Covered Expenses.
- the following services are excluded from coverage regardless of clinical indications: macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupuncture; 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, charges made for a continuous course of dental treatment for an Injury to teeth are covered. Also, facility charges and charges for general anesthesia or deep sedation which cannot be administered in a dental office are covered when Medically Necessary. Additionally, charges made by a Physician for any of the following surgical procedures are covered: excision of unerupted impacted wisdom tooth, including removal of alveolar bone and sectioning of tooth; removal of residual root (when performed by a dentist other than the one who extracted the tooth).
- for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity as shown in Covered Expenses, 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 Physician or under medical supervision.
- 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 unless Medically Necessary and or covered under the federal preventative care guidelines.
 - court-ordered treatment or hospitalization, unless treatment is prescribed by a Physician and is a covered service or supply under this plan.
 - 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), anorgasm, and premature ejaculation.
 - medical and Hospital care and costs for the child of your Dependent unless the child is otherwise eligible under this plan.
 - 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” sections of this plan.
 - 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 or devices 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.
 - corrective lenses eyeglass lenses and frames, contact lenses and associated services (exams and fittings), except the initial set after treatment of keratoconus or following cataract surgery.
 - routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
 - acupuncture.
 - all non-injectable prescription drugs unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
 - 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.
 - membership costs and fees associated with health clubs and weight loss programs.
 - membership costs and fees associated with smoking cessation programs, such as a hypnotist or inspirational speaker. Charges for smoking cessation counseling session(s) are covered.
 - 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.
 - dental implants for any condition.
 - fees associated with the collection, storage or donation of blood or blood products, except for autologous donation in anticipation of scheduled services when medical management review determines 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. Except for immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention.
 - health and beauty aids, cosmetics and dietary supplements.
 - all nutritional supplements, formulae, enteral feedings, supplies and specialty formulated medical foods, whether prescribed or not, except for infant formula needed for the treatment of inborn errors of metabolism.

- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- charges related to an Injury or Sickness payable under worker's compensation or similar laws.
- massage therapy.
- abortions, unless a Physician certifies in writing that the pregnancy would endanger the life of the mother, or the expenses are incurred to treat medical complications due to abortion.
- certain Medical Pharmaceuticals that are a Therapeutic Equivalent or Therapeutic Alternative to another covered Medical Pharmaceutical(s) and is administered in connection with a covered service rendered in an inpatient, outpatient, Physician's office or home health care setting. Such determinations may be made periodically, and benefits for a Medical Pharmaceutical that was previously excluded under this provision may be reinstated at any time.
- private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- 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 Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.

General Limitations

No payment will be made for expenses incurred for you or any one of your Dependents for the following:

- for 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 Sickness.
- for any charges related to care provided through a public program, other than Medicaid.
- for charges which would not have been made if the person did not have coverage.
- to the extent that they are more than Maximum Reimbursable Charges applicable to care, if any, received Out-of-Network.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- for expenses for services supplies, care, treatment, drugs, or surgery that are not Medically Necessary.
- for charges made by any Physician or Other Health Professional who is a member of your family or your Dependent's family.

- for expenses incurred outside the United States other than expenses for Medically Necessary emergency or urgent care while temporarily traveling abroad.

HC-EXC547

01-24

Coordination Of This Contract's Benefits With Other Benefits

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable Expense.

Definitions

Plan - A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

- (1) Plan includes: group and nongroup insurance contracts, health insuring corporation ("HIC") contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
- (2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56 ; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan - This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of

the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether This Plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.

Allowable Expense - Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

- The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.
- If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
- If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
- If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's

payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary plan to determine its benefits.

- The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

Closed Panel Plan - Closed Panel Plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent - Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order Of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

- A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
- B.
 - (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
 - (2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
- C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
 - (1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers

the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
- However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

- (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
- (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
- (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan covering the Custodial Parent;
- The Plan covering the spouse of the Custodial Parent;
- The Plan covering the non-custodial parent; and then
- The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

- (6) If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary plan.

Effect On The Benefits Of This Plan

- A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- B. If a covered person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right To Receive And Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. Cigna may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. Cigna need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Cigna any facts it needs to apply those rules and determine benefits payable.

Facility Of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, Cigna may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. Cigna will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means the reasonable cash value of the benefits provided in the form of services.

Right Of Recovery

If the amount of the payments made by Cigna is more than it should have paid under this COB provision, it may recover the

excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Coordination Disputes

If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting us at the Customer Service Toll-Free Number that appears on your Benefit Identification card, explanation of benefits or claim form or via our website at myCigna.com. If you are still not satisfied, you may call the Ohio Department of Insurance for instructions on filing a consumer complaint. Call 1-800-686-1526, or visit the Department’s website at <http://insurance.ohio.gov>.

Prohibited Coordination And Benefit Design

A contract shall not reduce benefits on the basis that:

- Another plan exists and the covered person did not enroll in that plan;
- A person is or could have been covered under another plan, except with respect to part B of Medicare; or
- A person has elected an option under another plan providing a lower level of benefits than another option which could have been elected.

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Expenses for Which a Third Party May Be Responsible

This plan does not cover 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, judgment 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 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:

- **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 subrogation right granted in the above paragraph, 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.

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.
- 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 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 pursuing any subrogation or recovery rights by providing requested information.

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10-16

Payment of Benefits

You may not assign to any party, including, but not limited to, a provider of healthcare 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, 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. Any attempt to assign such rights shall be void and unenforceable under all circumstances.

You may, however, authorize Cigna to pay any healthcare benefits under this policy to a Participating or non-Participating Provider. When you authorize the payment of your healthcare benefits to a Participating or non-Participating Provider, you authorize the 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 healthcare 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 healthcare benefits to a Participating or non-Participating Provider as the authority to assign any other rights under this policy to any party, including, but not limited to, a provider of healthcare services/items.

Even if the payment of healthcare benefits to a non-Participating Provider has been authorized by you, Cigna may, at its option, make payment of benefits to you. When benefits are paid to you, you or your Dependents are responsible for reimbursing the non-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 will 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 or institution appearing to have assumed his custody and support.

When one of our participants passes away, Cigna may receive notice that an executor of the estate has been established. The executor has the same rights as our insured 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 to whom the overpayment was made.

Recovery of Overpayment on a Provider Claim

A payment made by Cigna to a provider is considered final two years after payment is made. After that date, the amount of the payment is not subject to adjustment, except in the case of fraud by the provider.

Cigna may recover the amount of any part of a payment that we determine to be an overpayment to the provider if the recovery process is initiated not later than two years after the payment was made. Cigna must provide notice in writing and specify covered person's name, date of service, amount of overpayment, claim number, detailed explanation of basis for overpayment, method in which payment was made including the date of payment and check number.

Cigna must give the provider opportunity to appeal an overpayment determination. If the provider fails to respond within 30 days of receipt of notice, elects not to appeal, or appeals the determination but decision is upheld, Cigna may initiate overpayment recovery. Cigna can permit the provider to repay the overpaid amount or have the amount recouped.

This section does not apply in cases of fraud by the provider, the insured or member, or Cigna with respect to the claim on which the overpayment or underpayment 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.

Financial Obligation for Non-Covered Services or Supplies

You or your Dependents will be financially obligated to pay for any non-covered services or supplies.

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Termination of Insurance

Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the date your Active Service ends except as described below.

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

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, the insurance will not continue past the date your Employer stops paying premium for you or otherwise cancels the insurance.

Dependents

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

- the date your insurance ceases, except when you die.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

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

Special Continuation of Medical and/or Dental Insurance For Military Reservists and Their Dependents

If you are a Reservist, and if your Medical Insurance would otherwise cease because you are called or ordered to active military duty, you may continue Medical Insurance for yourself and your Dependents, upon payment of the required premium to your Employer, until the earliest of the following dates:

- 18 months from the date your insurance would otherwise cease, except that coverage for a Dependent may be extended to 36 months as provided in the section below entitled "Extension of Continuation to 36 months";
- the last day for which the required premium has been paid;
- the date you or your Dependent becomes eligible for insurance under another group policy;
- the date the group policy is canceled.

The continuation of Medical Insurance will provide the same benefits as those provided to any similarly situated person insured under the policy who has not been called to active duty.

"Reservist" means a member of a reserve component of the armed forces of the United States. "Reservist" includes a member of the Ohio National Guard and the Ohio Air National Guard.

Extension of Continuation to 36 Months

If your Dependent's insurance is being continued as outlined above, such Dependent may extend the 18-month continuation to a total of 36 months if any of the following occur during the original 18-month period:

- you die;
- you are divorced or legally separated from your spouse; or
- your Dependent ceases to qualify as an eligible Dependent under the policy.

Provisions Regarding Notification and Election of Special Continuation

Your Employer will notify you of your right to elect continuation of Medical Insurance. To elect the continuation,

you or your Dependent must notify the Employer and pay the required premium within 31 days after the date your insurance would otherwise cease, or within 31 days after the date you are notified of your right to continue, if later.

Special Continuation of Medical Insurance

If your Active Service ends because of involuntary termination of employment, and if:

- you have been insured under the policy (or under the policy and any similar group coverage replaced by the policy) during the entire 3 months prior to the date your Active Service ends; and
 - you are eligible for unemployment compensation benefits; and
 - you pay the Employer the required premium;
- your Medical Insurance will be continued until:
- you become eligible for similar group medical benefits or for Medicare;
 - the last day for which you have made the required payment;
 - 12 months from the date your Active Service ends; or
 - the date the policy cancels;

whichever occurs first.

At the time you are given notice of termination of employment, your Employer will give you written notice of your right to continue the insurance. To elect this option, you must apply in writing and make the required monthly payment to the Employer within 31 days after the date your Active Service ends.

If your insurance is being continued under this section, the Medical Insurance for Dependents insured on the date your insurance would otherwise cease may be continued, subject to the provisions of this section. The insurance for your Dependents will be continued until the earlier of:

- the date your insurance for yourself ceases; or
- with respect to any one Dependent, the date that Dependent no longer qualifies as a Dependent.

This option will not reduce any continuation of insurance otherwise provided.

Dependent Medical Insurance After Divorce

In the case of divorce, annulment, dissolution of marriage or legal separation you may be required to continue the insurance for any one of your Dependents.

Medical Benefits Extension

Coverage will continue to be provided while you are confined to a Hospital following termination of coverage. Coverage will be provided for the specific medical condition causing the confinement and any other Medically Necessary treatment during that period of confinement.

This extension of coverage will end on the earliest of the following:

- the date the insured is discharged from the Hospital;
- the date the insured's attending Physician determines that the Hospital Confinement is no longer Medically Necessary;
- the date the insured exhausts the coverage available for the confinement and/or medical condition; or
- the effective date of coverage for the insured under another policy, plan or contract.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when a person's benefits cease.

HC-BEX31

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OHIO CLAIM DETERMINATION PROCEDURES

Procedures Regarding 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, as described below:

Certain services require prior authorization in order to be covered. This prior authorization is called a "preservice Medical Necessity determination." The certificate describes who is responsible for obtaining this review. Your authorized representative (typically, your health care provider) must request Medical Necessity determinations according to the procedures described below, in the certificate, and in your provider's network participation documents as applicable.

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

Preservice Medical Necessity Determinations

When you or your representative request a required Medical Necessity determination prior to care, Cigna will make the determination within 48 hours for all Urgent Care services after obtaining all necessary information regarding the proposed admission, procedure, or health care service requiring a Medical Necessity determination. Non-Urgent Care services will be responded to within 10 calendar days. In the case of a determination to authorize an admission, procedure, or health care service, Cigna will notify the provider or health care facility rendering the health care service by telephone or facsimile within 3 business days after making the initial certification. In the case of an adverse determination, Cigna will notify the provider or health care facility rendering the health care service by telephone within 3 business days after receiving the request, and shall provide written or electronic confirmation of the telephone notification to you or your representative and the provider or health care facility within 1 business day after making the telephone notification.

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 to Cigna 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 fails to follow Cigna's procedures for requesting a required preservice Medical Necessity determination, Cigna will notify you or your representative of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request.

If the determination periods above (a) could seriously jeopardize your life, health, or safety, or the safety of others due to your psychological state, or (b) in the opinion of a practitioner with knowledge of your medical or behavioral condition, would subject you to the adverse health consequences without the care or treatment that is the subject of the request, Cigna will make the preservice determination on an expedited basis. Cigna's Physician will defer to the determination of the treating Physician, regarding whether an expedited determination is necessary. Cigna will notify you or your representative of an expedited determination within 48 hours after receiving the Urgent Care services request.

Once a prior authorization is approved, Cigna will not retroactively deny a prior authorization except in cases of fraudulent or materially incorrect information. On the date the

prior authorized service is provided you must still be eligible under the plan and the provider must submit an accurate claim that matches the information submitted for your prior authorization approval.

Appeals of adverse prior authorization determinations from the provider

- For Urgent Care services, the appeal shall be approved or denied within 48 hours after receipt.
- For all other matters, the appeal shall be approved or denied within 10 calendar days after receipt.
- The appeal shall be between the health care practitioner requesting the service in question and a clinical peer.
- If the appeal does not resolve the disagreement, either the covered person or an authorized representative may request an external review.

Concurrent Medical Necessity 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 Medical Necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, Cigna will make the determination within 24 hours after obtaining all necessary information. In the case of a determination to certify an extended stay or additional health care services, Cigna will notify the provider or health care facility rendering the health care service by telephone or facsimile within 24 hours after making the certification. In the case of an adverse determination, Cigna will notify the provider or health care facility rendering the health care service by telephone within 24 hours after making the adverse determination, and shall provide written or electronic confirmation to you or your representative and the provider or health care facility within 1 business day after the telephone notification. The health care service to you shall be continued, with standard Coinsurance, Copayments and Deductibles, if applicable, until you or your representative has been notified of the determination.

Postservice Medical Necessity Determinations

When you or your representative requests a Medical Necessity determination after services have been rendered, Cigna will make the determination within 30 business days after receiving all necessary information. In the case of a certification, Cigna may notify you or your representative and the provider or health care facility rendering the health care service in writing. In the case of an adverse determination, Cigna will notify you or your representative and the provider or health care facility rendering the health care service, in writing, within 5 business days after making the adverse determination. This includes claims submitted for a service where prior authorization was required but not obtained if: the

service is directly related to another service for which prior approval was obtained, the service was not known to be needed prior to the time the prior authorized service was performed, and the need for the service was revealed at the time the authorized service was performed.

Upon written request, a retrospective review will be conducted of a claim where prior authorization was required but not obtained if the service in question meets all of the following:

- The service is directly related to another service for which prior approval was obtained and already performed.
- The new service was not known to be needed at the time the original prior authorized service was performed.
- The need for the new service was revealed at the time the original authorized service was performed.

Postservice Claim Determinations Not Involving Utilization Review

When you or your representative requests payment for services which have been rendered, and the determination does not involve utilization review, Cigna will notify you of the claim payment determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters requiring additional documentation, Cigna will notify you or your representative 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 within a time period of not more than 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and 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 in accordance with state and federal law, and will include all of the following that pertain to the determination: information sufficient to identify the claim; the specific reason or reasons for the adverse determination; 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 time limits applicable, including a statement of a claimant's rights to bring a civil action following an adverse benefit determination on appeal; 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 a 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; and in the case of a claim involving Urgent Care, a description of the expedited review process applicable to such claim.

Additional Ohio prior authorization requirements related to medications for chronic conditions

Preservice approvals related to chronic conditions for an approved drug will be approved for the lesser of 12 months or the last day you are eligible under the plan. Cigna may require your health care provider to submit information on a quarterly basis indicating that your chronic condition has not changed.

A 12 month approval does not apply to medications prescribed for a non-maintenance condition; medications that have a typical treatment of less than a year; medications that require an initial trial period to determine effectiveness and tolerability, beyond which a one-year or greater prior authorization period will be given; medications where there is medical or scientific evidence that does not support a 12 month prior approval; medications that are a schedule I or II controlled substance or any opioid analgesic or benzodiazepine; and medications that are not prescribed by an in-network provider as part of the care management program.

HC-APL303

Federal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

HC-FED1

10-10

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

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

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the QMCSO being issued.

HC-OAPIN2023

Qualified Medical Child Support Order Defined

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

- the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
- the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
- the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
- the order states the period to which it applies; and
- if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

HC-FED4

10-10

Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)

If you or your eligible Dependent(s) experience a special enrollment event as described below, you or your eligible Dependent(s) may be entitled to enroll in the Plan outside of a designated enrollment period upon the occurrence of one of the special enrollment events listed below. If you are already

enrolled in the Plan, you may request enrollment for you and your eligible Dependent(s) under a different option offered by the Employer for which you are currently eligible. If you are not already enrolled in the Plan, you must request special enrollment for yourself in addition to your eligible Dependent(s). You and all of your eligible Dependent(s) must be covered under the same option. The special enrollment events include:

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; spouse only; Employee and spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, spouse and Dependent child(ren). Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage. Dependent children who were already Dependents of the Employee but not currently enrolled in the Plan are not entitled to special enrollment.
- **Loss of eligibility for State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.
- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
 - divorce or legal separation;
 - cessation of Dependent status (such as reaching the limiting age);
 - death of the Employee;
 - termination of employment;
 - reduction in work hours to below the minimum required for eligibility;
 - you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
 - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
 - the other plan no longer offers any benefits to a class of similarly situated individuals.
- **Termination of Employer contributions (excluding continuation coverage).** If a current or former Employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and all of your eligible Dependent(s).
- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: due to failure of the Employer or other responsible entity to remit premiums on a timely basis; when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an Employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.
- **Eligibility for employment assistance under State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other special enrollment event will be effective no later than the first day of the first calendar month following receipt of the request for special enrollment.

Domestic Partners and their children (if not legal children of the Employee) are not eligible for special enrollment.

HC-FED96

04-17

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).

A. 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:

- if you meet Special Enrollment criteria and enroll as described in the Special Enrollment section; or
- if your Employer agrees, and you meet the criteria shown in the following Sections B through H and enroll for or change coverage within the time period established by your Employer.

B. Change of status

A change in status is defined as:

- change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
- change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
- change in employment status of Employee, spouse or Dependent 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;
- changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
- change in residence of Employee, spouse or Dependent to a location outside of the Employer's network service area; and
- changes which cause a Dependent to become eligible or ineligible for coverage.

C. Court order

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

D. Medicare or Medicaid eligibility/entitlement

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

E. 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.

F. Changes in coverage of spouse or Dependent under another employer's plan

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

G. Reduction in work hours

If an Employee's work hours are reduced below 30 hours/week (even if it does not result in the Employee losing eligibility for the Employer's coverage); and the Employee (and family) intend to enroll in another plan that provides Minimum Essential Coverage (MEC). The new coverage must be effective no later than the 1st day of the 2nd month following the month that includes the date the original coverage is revoked.

H. Enrollment in a Qualified Health Plan (QHP)

The Employee must be eligible for a Special Enrollment Period to enroll in a QHP through a Marketplace or the Employee wants to enroll in a QHP through a Marketplace during the Marketplace's annual open enrollment period; and the disenrollment from the group plan corresponds to the intended enrollment of the Employee (and family) in a QHP through a Marketplace for new coverage effective beginning no later than the day immediately following the last day of the original coverage.

HC-FED95

04-17

Eligibility for Coverage for Adopted Children

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

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

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

HC-FED67

09-14

Coverage for Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under a federal law known as the "Newborns' and Mothers' Health Protection Act": 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; or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

HC-FED11

10-10

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.

HC-FED12

10-10

Group Plan Coverage Instead of Medicaid

If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

HC-FED13

10-10

Requirements of Family and Medical Leave Act of 1993 (as amended) (FMLA)

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

Continuation of Health Insurance During Leave

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

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

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

Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, as amended, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

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

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

HC-FED93

10-17

Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage you may have.

Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependents as follows:

You may continue benefits by paying the required premium to your Employer, until the earliest of the following:

- 24 months from the last day of employment with the Employer;
- the day after you fail to return to work; and
- the date the policy cancels.

Your Employer may charge you and your Dependents up to 102% of the total premium.

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your certificate.

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA or an available conversion plan at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if you gave your Employer advance written or verbal notice of your military service leave, and the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a waiting period that was not yet satisfied before the leave

began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

If your coverage under this plan terminates as a result of your eligibility for military medical and dental coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

HC-FED18

10-10

Claim Determination Procedures under ERISA

The following complies with federal law. Provisions of applicable laws of your state may supersede.

Procedures Regarding 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 a preservice, concurrent, or postservice basis, as described below:

Certain services require prior authorization in order to be covered. The Certificate describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care professional) must request prior authorization according to the procedures described below, in the Certificate, and in your 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 the Certificate, in your 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 effect as of the date services were rendered to you.

Preservice Determinations

When you or your representative requests 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 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 responds to the notice.

If the determination periods above would seriously jeopardize your life or health, your ability to regain maximum function, or in the opinion of a health care professional with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, Cigna will make the preservice determination on an expedited basis. Cigna will defer to the determination of the treating health care professional 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 to Cigna 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 preservice determination, but fails to follow Cigna's procedures for requesting a required preservice determination, Cigna will notify you or your representative of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless you or your representative requests written notification.

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 to 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 after receiving the request.

Postservice Determinations

When you or your representative requests a coverage determination or a claim payment determination after services have been rendered, 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 or your representative 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 pertain to the determination: information sufficient to identify the claim including, if applicable, the date of service, provider and claim amount; diagnosis and treatment codes, and their meanings; 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 time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA 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 a 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; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a “qualifying event” that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred, unless you move out of that plan’s coverage area or the plan is no longer available. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

For you and your Dependents, COBRA continuation is available 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; or
- 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 a loss of coverage under the Plan:

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

Who is Entitled to COBRA Continuation?

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

The following individuals are not qualified beneficiaries for purposes of COBRA continuation: domestic partners, grandchildren (unless adopted by you), stepchildren (unless 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 sections titled “Secondary Qualifying Events” and “Medicare Extension For Your 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) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their 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 discussed below. Under no circumstances will 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 coverage 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, all 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
- 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 covered persons 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” listed below will also apply to the period of disability extension.

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA Continuation

COBRA continuation coverage will be terminated upon the occurrence of any of the following:

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with Cigna;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in 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 under a pre-existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition provision is no longer applicable; or the occurrence of an event described in one of the first three bullets above;
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

Moving Out of Employer's Service Area or Elimination of a Service Area

If you and/or your Dependents move out of the Employer's service area or the Employer eliminates a service area in your location, your COBRA continuation coverage under the plan will be limited to out-of-network coverage only. In-network coverage is not available outside of the Employer's service area. If the Employer offers another benefit option through Cigna or another carrier which can provide coverage in your location, you may elect COBRA continuation coverage under that option.

Employer's Notification Requirements

Your Employer is required to provide you and/or your Dependents with the following notices:

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan 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 continuation coverage election notice as explained below.

- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
 - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
 - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
 - in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

The COBRA coverage election notice will list the individuals who are eligible for COBRA continuation coverage and inform you of the applicable premium. The notice will also include instructions for electing COBRA continuation coverage. You must notify the Plan Administrator of your election no later than the due date stated on the COBRA election notice. If a written election notice is required, it must be post-marked no later than the due date stated on the COBRA election notice. If you do not make proper notification by the due date shown on the 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. 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 continuation coverage 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.

How Much Does COBRA Continuation Coverage Cost?

Each qualified beneficiary may be required to pay the entire cost of 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

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

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within that 45 days, you will lose all COBRA continuation rights under the Plan.

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation 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 your payment is received after the due date, your 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 payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

You Must Give Notice of Certain Qualifying Events

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

- Your divorce or legal separation; or
- Your child ceases to qualify as a Dependent under the Plan.
- The occurrence of a secondary qualifying event as discussed under “Secondary Qualifying Events” above (this notice must be received prior to the end of the initial 18- or 29-month COBRA period).

(Also refer to the section titled “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. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer’s Bankruptcy

If you are covered as a retiree, and a proceeding in bankruptcy is filed with respect to the Employer under Title 11 of the United States Code, you may be entitled to COBRA continuation coverage. If the bankruptcy results in a loss of coverage for you, your Dependents or your surviving spouse within one year before or after such proceeding, you and your covered Dependents will become COBRA qualified beneficiaries with respect to the bankruptcy. You will be entitled to COBRA continuation coverage until your death. Your surviving spouse and covered Dependent children will be entitled to COBRA continuation coverage for up to 36 months following your death. However, COBRA continuation

coverage will cease upon the occurrence of any of the events listed under “Termination of COBRA Continuation” above.

Trade Act of 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TYY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

In addition, if you initially declined COBRA continuation coverage and, within 60 days after your loss of coverage under the Plan, you are deemed eligible by the U.S. Department of Labor or a state labor agency for trade adjustment assistance (TAA) benefits and the tax credit, you may be eligible for a special 60 day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and will continue for 18 months, unless you experience one of the events discussed under “Termination of COBRA Continuation” above. Coverage will not be retroactive to the initial loss of coverage. If you receive a determination that you are TAA-eligible, you must notify the Plan Administrator immediately.

Interaction With Other Continuation Benefits

You may be eligible for other continuation benefits under state law. Refer to the Termination section for any other continuation benefits.

HC-FED94

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ERISA Required Information

The name of the Plan is:

G&A OUTSOURCING, INC. DBA G&A PARTNERS
HEALTH & WELFARE BENEFIT PLAN

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

G&A OUTSOURCING, INC. DBA G&A PARTNERS
17220 KATY FREEWAY, SUITE 350
Houston, TX 77094
713-784-1181

Employer Identification
Number (EIN):

760461926

Plan Number:

515

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

G&A OUTSOURCING, INC. DBA G&A PARTNERS

The name, address and ZIP code of the person designated as agent for service of legal process is:

G&A OUTSOURCING, INC. DBA G&A PARTNERS

The office designated to consider the appeal of denied claims is:

The Cigna Claim Office responsible for this Plan

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

The Plan’s fiscal year ends on 06/30.

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

Plan Trustees

A list of any Trustees of the Plan, which includes name, title and address, is available upon request to the Plan Administrator.

Plan Type

The plan is a healthcare benefit plan.

Collective Bargaining Agreements

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.

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 not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to 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 his duly authorized representative.

Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it.

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 participant is required to terminate, modify, amend or change the Plan.

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

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

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

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

Statement of Rights

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

Receive Information About Your Plan and Benefits

- 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.
- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

Continue Group Health Plan Coverage

- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review the documents governing the Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Enforce Your Rights

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

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this

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

HC-FED72

05-15

Notice of an Appeal or a Grievance

The appeal or grievance provision in this certificate may be superseded by the law of your state. Please see your explanation of benefits for the applicable appeal or grievance procedure.

HC-SPP4

04-10

V1

Appointment of Authorized Representative

You may appoint an authorized representative to assist you in submitting a claim or appealing a claim denial. However, Cigna 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 medical services may have jeopardized your coverage through the waiver of the cost-sharing amounts that you are required to pay under your 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.

HC-AARI

01-17

When You Have A Complaint Or An Appeal

Definitions

“Adverse benefit determination” means a decision by a health plan issuer:

- To deny, reduce, or terminate a requested health care service or payment in whole or in part, including all of the following:
 - A determination that the health care service does not meet the health plan issuer’s requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, including experimental or investigational treatments;
 - A determination of an individual’s eligibility for individual health insurance coverage, including coverage offered to individuals through a non-employer group, to participate in a plan or health insurance coverage;
 - A determination that a health care service is not a covered benefit;
- The imposition of an exclusion, including exclusions for source of Injury, network, or any other limitation on benefits that would otherwise be covered.
- Not to issue individual health insurance coverage to an applicant, including coverage offered to individuals through a non-employer group;
- To rescind coverage on a health benefit plan.

“Authorized representative” means an individual who represents a covered person in an internal appeal or external review process of an adverse benefit determination who is any of the following:

- A person to whom a covered individual has given express, written consent to represent that individual in an internal appeals process or external review process of an adverse benefit determination;
- A person authorized by law to provide substituted consent for a covered individual;
- A family member or a treating health care professional, but only when the covered person is unable to provide consent.

“Covered person” means a policyholder, subscriber, enrollee, member, or individual covered by a health benefit plan.

“Covered person” does include the covered person’s authorized representative with regard to an internal appeal or external review.

“Covered benefits” or “benefits” means those health care services to which a covered person is entitled under the terms of a health benefit plan.

“Final adverse benefit determination” means an adverse benefit determination that is upheld at the completion of a health plan issuer’s internal appeals process.

“Health benefit plan” means a policy, contract, certificate, or agreement offered by a health plan issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

“Health care services” means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, Injury, or disease.

“Health plan issuer” means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the superintendent of insurance, that contracts, or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services under a health benefit plan, including a Sickness and accident insurance company, a health insuring corporation, a fraternal benefit society, a self-funded multiple employer welfare arrangement, or a nonfederal, government health plan. “Health plan issuer” includes a third party administrator to the extent that the benefits that such an entity is contracted to administer under a health benefit plan are subject to the insurance laws and rules of this state or subject to the jurisdiction of the superintendent.

“Independent review organization” means an entity that is accredited to conduct independent external reviews of adverse benefit determinations.

“Rescission” or **“to rescind”** means a cancellation or discontinuance of coverage that has a retroactive effect.

“Rescission” does not include a cancellation or discontinuance of coverage that has only a prospective effect or a cancellation or discontinuance of coverage that is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

“Stabilize” means the provision of such medical treatment as may be necessary to assure, within reasonable medical probability that no material deterioration of a covered person’s medical condition is likely to result from or occur during a transfer, if the medical condition could result in any of the following:

- Placing the health of the covered person or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part.

In the case of a woman having contractions, “stabilize” means such medical treatment as may be necessary to deliver, including the placenta.

“Step Therapy Exemption” means an overriding of a step therapy protocol in favor of immediate coverage of the health care provider’s selected prescription drug.

“Superintendent” means the superintendent of insurance.

When You Have a Complaint

For the purposes of this section, any reference to “you,” “your” or “Member” also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start With Customer Service

We are here to listen and to help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you may call our toll-free number and explain your concern to one of our Customer Service representatives. Please call us at the Customer Service Toll-Free Number that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back 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 can start the appeals procedure.

Internal Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing, within 365 days of receipt of a denial notice, to the following address:

Cigna HealthCare, Inc.
National Appeals Organization (NAO)
P.O. Box 188011
Chattanooga, TN 37422

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 to register your appeal by telephone. Call us at 800.Cigna.24/800.244.6224 or the toll-free number on your Benefit Identification card, explanation of benefits or claim form.

Level One Appeal

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.

We will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision).

We will respond within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we 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.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay.

If you request that your appeal be expedited based on (a) above, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level-one appeal would be detrimental to your medical condition.

Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours.

Step Therapy Exemption Appeals

We will respond with an approval or denial within 48 hours for a request related to urgent care services and 10 calendar days for all other requests.

Understanding the External Review Process

Under Chapter 3922 of the Ohio Revised Code all health plan issuers must provide a process that allows a person covered under a health benefit plan or a person applying for health benefit plan coverage to request an independent external review of an adverse benefit determination. This is a summary of that external review process. An adverse benefit determination is a decision by Cigna to deny benefits because services are not covered, are excluded, or limited under the plan, or the covered person is not eligible to receive the benefit.

The adverse benefit determination may involve an issue of Medical Necessity, appropriateness, health care setting, or level of care or effectiveness. An adverse benefit determination can also be a decision to deny health benefit plan coverage or to rescind coverage.

Opportunity for External Review

An external review may be conducted by an Independent Review Organization (IRO) or by the Ohio Department of Insurance. The covered person does not pay for the external review. There is no minimum cost of health care services denied in order to qualify for an external review. However, the covered person must generally exhaust the health plan issuer's internal appeal process before seeking an external review. Exceptions to this requirement will be included in the notice of the adverse benefit determination.

External Review by an IRO - A covered person is entitled to an external review by an IRO in the following instances:

- The adverse benefit determination involves a medical judgment or is based on any medical information.
- The adverse benefit determination indicates the requested service is experimental or investigational, the requested health care service is not explicitly excluded in the covered person's health benefit plan, and the treating Physician certifies at least one of the following:
 - Standard health care services have not been effective in improving the condition of the covered person.
 - Standard health care services are not medically appropriate for the covered person.
 - No available standard health care service covered by Cigna is more beneficial than the requested health care service.

There are two types of IRO reviews, standard and expedited. A standard review is normally completed within 30 days. An expedited review for urgent medical situations is normally completed within 7 days and can be requested if any of the following applies:

- The covered person's treating Physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal.
- The covered person's treating Physician certifies that the final adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function if treatment is delayed until after the time frame of a standard external review.
- The final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not yet been discharged from a facility.

- An expedited internal appeal is already in progress for an adverse benefit determination of experimental or investigational treatment and the covered person's treating Physician certifies in writing that the recommended health care service or treatment would be significantly less effective if not promptly initiated.

NOTE: An expedited external review is not available for retrospective final adverse benefit determinations (meaning the health care service has already been provided to the covered person).

External Review by the Ohio Department of Insurance - A covered person is entitled to an external review by the Department in the either of the following instances:

- The adverse benefit determination is based on a contractual issue that does not involve a medical judgment or medical information.
- The adverse benefit determination for an emergency medical condition indicates that medical condition did not meet the definition of emergency AND Cigna's decision has already been upheld through an external review by an IRO.

Request for External Review

Regardless of whether the external review case is to be reviewed by an IRO or the Department of Insurance, the covered person, or an authorized representative, must request an external review through Cigna within 180 days of the date of the notice of final adverse benefit determination issued by Cigna.

All requests must be in writing, except for a request for an expedited external review. Expedited external reviews may be requested electronically or orally. The covered person will be required to consent to the release of applicable medical records and sign a medical records release authorization.

If the request is complete Cigna will initiate the external review and notify the covered person in writing, or immediately in the case of an expedited review, that the request is complete and eligible for external review. The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information. When a standard review is requested, the notice will inform the covered person that, within 10 business days after receipt of the notice, they may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review. Cigna will also forward all documents and information used to make the adverse benefit determination to the assigned IRO or the Ohio Department of Insurance (as applicable).

If the request is not complete Cigna will inform the covered person in writing and specify what information is needed to make the request complete. If Cigna determines that the adverse benefit determination is not eligible for external

review, Cigna must notify the covered person in writing and provide the covered person with the reason for the denial and inform the covered person that the denial may be appealed to the Ohio Department of Insurance.

The Ohio Department of Insurance may determine the request is eligible for external review regardless of the decision by Cigna and require that the request be referred for external review. The Department's decision will be made in accordance with the terms of the health benefit plan and all applicable provisions of the law.

IRO Assignment

When Cigna initiates an external review by an IRO, the Ohio Department of Insurance web based system randomly assigns the review to an accredited IRO that is qualified to conduct the review based on the type of health care service. An IRO that has a conflict of interest with Cigna, the covered person, the health care provider or the health care facility will not be selected to conduct the review.

IRO Review and Decision

The IRO must consider all documents and information considered by Cigna in making the adverse benefit determination, any information submitted by the covered person and other information such as; the covered person's medical records, the attending health care professional's recommendation, consulting reports from appropriate health care professionals, the terms of coverage under the health benefit plan, the most appropriate practice guidelines, clinical review criteria used by the health plan issuer or its utilization review organization, and the opinions of the IRO's clinical reviewers.

The IRO will provide a written notice of its decision within 30 days of receipt by Cigna of a request for a standard review or within 72 hours of receipt by Cigna of a request for an expedited review. This notice will be sent to the covered person, Cigna and the Ohio Department of Insurance and must include the following information:

- A general description of the reason for the request for external review.
- The date the independent review organization was assigned by the Ohio Department of Insurance to conduct the external review.
- The dates over which the external review was conducted.
- The date on which the independent review organization's decision was made.
- The rationale for its decision.
- References to the evidence or documentation, including any evidence-based standards, that was used or considered in reaching its decision.

NOTE: Written decisions of an IRO concerning an adverse benefit determination that involves a health care treatment or service that is stated to be experimental or investigational also includes the principle reason(s) for the IRO's decision and the written opinion of each clinical reviewer including their recommendation and their rationale for the recommendation.

Binding Nature of External Review Decision

An external review decision is binding on Cigna except to the extent Cigna has other remedies available under state law. The decision is also binding on the covered person except to the extent the covered person has other remedies available under applicable state or federal law.

A covered person may not file a subsequent request for an external review involving the same adverse benefit determination that was previously reviewed unless new medical or scientific evidence is submitted to Cigna.

If You Have Questions About Your Rights or Need Assistance

You may contact Cigna:

Cigna HealthCare Inc.
National Appeals Organization (NAO)
PO Box 188011
Chattanooga, TN 37422
1-800-Cigna24
www.Cigna.com

You may also contact the Ohio Department of Insurance:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300
Columbus, OH 43215
800-686-1526 / 614-644-2673
614-644-3744 (fax)
614-644-3745 (TDD)

Contact ODI Consumer Affairs:

<https://secured.insurance.ohio.gov/ConsumServ/ConServComments.asp>

File a Consumer Complaint:

<http://insurance.ohio.gov/Consumer/OCS/Pages/ConsComp1.aspx>

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse benefit determination, will include: information sufficient to identify the claim; the specific reason or reasons for the adverse benefit determination; 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; a statement describing

any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); and 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 benefit determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of adverse benefit determination will include a discussion of the decision.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative 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 and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which 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; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or 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 section 502(a) of ERISA 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 Level One Appeal process.

HC-APL357

01-24

V1

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time

basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.

- on any of your Employer's scheduled work days if you are excused from the regular duties of your work by your Employer on that day due to Sickness, health status or Injury.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

HC-DFS1110

12-18

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.

HC-DFS1406

01-20

Ancillary Charge

An additional cost, outside of plan cost sharing detailed in The Schedule of Prescription Drug Benefits, which may apply to some Prescription Drug Products when you request a more expensive Brand Drug when a lower cost, Therapeutic Equivalent, Generic Drug is available. The Ancillary Charge is the amount by which the cost of the requested Brand Drug exceeds the cost of the Generic Drug.

HC-DFS1562

01-21

Balance Bill

The portion an out-of-network provider may bill you, equaling the difference between their charge and the Maximum Reimbursable Charge in addition to applicable deductibles, copayments and coinsurance.

HC-DFS1010

10-16

Basic Health Care Services

The term Basic Health Care Services means the following services which are Medically Necessary:

- Physician's services, except when such services are supplemental services;
- Inpatient hospital services;

- Outpatient medical services;
- Emergency health services;
- Urgent Care services;
- Diagnostic laboratory services and diagnostic and therapeutic radiologic services;
- Diagnostic and treatment services, other than prescription drug services for biologically-based mental illness;
- Preventive health care services, including but not limited to voluntary family planning services, infertility services, periodic Physician examinations, prenatal obstetrical care and well-child care; and
- Routine patient care for patients enrolled in an eligible cancer clinical trial pursuant to Ohio Rev. Code 3923.80.

The term "supplemental and specialty medical services" means services that are Medically Necessary, but are not "Basic Health Care Services". The terms "Basic Health Care Services" and "supplemental and specialty medical services" shall be interpreted in accordance with Ohio law.

HC-DFS617

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, § 7002 (2010), and as may be amended thereafter).

HC-DFS840

10-16

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, § 7002 (2010), and as may be amended thereafter).

HC-DFS841

10-16

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 your Physician may be classified as a Brand Drug under the plan.

HC-DFS842

10-16

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.

HC-DFS1563

10-21

Charges

The term charges means 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.

HC-DFS1193

01-19

Chiropractic Care

The term Chiropractic Care means 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.

HC-DFS1657

01-22

Convenience Care Clinic

Convenience Care Clinics are staffed by nurse practitioners and physician assistants and offer customers convenient, professional walk-in care for common ailments and routine services. Convenience Care Clinics have extended hours and are located in or near easy-to-access, popular locations (pharmacies, grocery and free-standing locations) with or without appointment.

HC-DFS1643

01-22

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, and

- Services not required to be performed by trained or skilled medical or paramedical personnel.

HC-DFS4

04-10
V1**Dependent**

Dependents are:

- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is:
 - less than 26 years old.
 - your natural child, stepchild, or adopted child;
 - after having reached the limiting age, has been continuously covered under any health plan, and not eligible for coverage under the Medicaid or Medicare program.
 - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

Proof of the child's condition and dependence may be required to be submitted to the plan within 31 days after the date the child ceases to qualify above. From time to time, but not more frequently than once a year, the plan may require proof of the continuation of such condition and dependence.

A child includes an adopted child including that child from the first day of placement in your home regardless of whether the adoption has become final.

It also includes a stepchild, a grandchild who lives with you, a foster child, or a child for whom you are the legal guardian. If your Domestic Partner has a child who lives with you, that child will also be included as a Dependent.

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

Anyone who is eligible as an Employee will not be considered as a Dependent or Dependent spouse unless the Dependent or Dependent spouse declines Employee coverage. A child under age 26 may be covered as either an Employee or as a Dependent child. You cannot be covered as an Employee while also covered as a Dependent of an Employee.

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

HC-DFS1690

01-23

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. A Pharmacy that is a Network Pharmacy is not necessarily a Designated Pharmacy.

HC-DFS1564

01-21

Domestic Partner

A Domestic Partner is defined as a person of the same or opposite sex who:

- shares your permanent residence;
- has resided with you for no less than one year;
- is no less than 18 years of age;
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is considered by Cigna to be sufficient to establish financial interdependency under the circumstances of your particular case;
- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit attesting to the above which can be made available to Cigna upon request.

In addition, you and your Domestic Partner will be considered to have met the terms of this definition as long as neither you nor your Domestic Partner:

- has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
- is currently legally married to another person; or
- has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

You and your Domestic Partner must have registered as Domestic Partners, if you reside in a state that provides for such registration.

The section of this certificate entitled "COBRA Continuation Rights Under Federal Law" will not apply to your Domestic Partner and his or her Dependents.

HC-DFS47

01-24
V3

Emergency Medical Condition

Emergency Medical Condition means a medical condition, including a mental health condition or substance use disorder, manifesting 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; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

HC-DFS1765

01-23

Emergency Services

Emergency Services means, with respect to an Emergency Medical Condition, a medical screening examination that is within the capability of the emergency department of a Hospital or of an independent freestanding emergency facility, including ancillary services routinely available to the emergency department to evaluate such 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 or emergency department, as are required to Stabilize the patient.

HC-DFS1763

01-23

Employee

The term Employee means a full-time Employee of the Employer who is currently in Active Service. Those on health status who are not Active Service are also included. The term does not include Employees who are part-time or temporary or who normally work less than 30 hours a week for the Employer.

HC-DFS1109

12-18

Employer

The term Employer means the policyholder and those affiliated Employers whose Employees are covered under this Policy.

HC-DFS1566

01-21

Essential Health Benefits

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

HC-DFS411

01-11

Expense Incurred

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

HC-DFS10

04-10
V1

Federally Eligible Individual

An individual:

- for whom as of the date on which the individual seeks to convert to Non-Group (Individual) Coverage, the period of Creditable Coverage (at least 18 months) was under a group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with any such plan);

- who is not eligible for coverage under:
 - a group health plan;
 - part A or part B of title XVIII of the Social Security Act; or
 - a State plan under title XIX of such Act (or any successor program), and does not have other health insurance coverage;
- with respect to the most recent group coverage within the coverage period (at least 18 months), who was not terminated due to nonpayment of premiums or fraud;
- who elected continuation coverage under a COBRA continuation provision or similar state program, if offered such option; and
- who has exhausted continuation coverage under such provision or program, if the individual elected such coverage.

HC-DFS559

04-10
V1**Free-Standing Surgical Facility**

The term Free-Standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it 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.

HC-DFS1407

01-20

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 your Physician 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 your Physician.

HC-DFS846

10-16

Health Insuring Corporation

A Health Insuring Corporation means a corporation that, pursuant to a policy, contract or certificate, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, Basic Health Care Services, Supplemental Medical Benefits or Specialty Medical Benefits, or a combination of Basic Health Care Services and either Supplemental Medical Benefits or Specialty Medical Benefits, through either an open panel plan or a Closed Panel Plan. Throughout this Certificate, the Health Insuring Corporation will be referred to as “Cigna Health and Life Insurance Company” or “Cigna”.

HC-DFS578

04-10
V1**Hospice Care Program**

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

HC-DFS51

04-10
V1

Hospice Care Services

The term Hospice Care Services means any services provided by: a Hospital, a Skilled Nursing Facility or a similar institution, a Home Health Care Agency, a Hospice Facility, or any other licensed facility or agency under a Hospice Care Program.

HC-DFS52

04-10
V1

Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by Cigna; and
- fulfills any licensing requirements of the state or locality in which it operates.

HC-DFS53

04-10
V1

Hospital

The term Hospital means:

- 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 Physicians; and provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: specializes in treatment of Mental Health and Substance Use Disorder 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.

HC-DFS1415

01-20
V2

Hospital Confinement or Confined in a Hospital

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

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Use Disorder Services in a Mental Health or Substance Use Disorder Residential Treatment Center.

HC-DFS807

12-15

In-Network

The term In-Network refers to healthcare services or items provided by your Primary Care Physician or services/items provided by another Participating Provider and authorized by your Primary Care Physician or the Review Organization. Authorization by your Primary Care Physician or the Review Organization is not required in the case of Mental Health and Substance Abuse treatment, other than Hospital Confinement solely for detoxification.

Emergency Care which meets the definition of Emergency Services is considered In-Network. For details, refer to the Emergency Services and Urgent Care coverage section.

HC-DFS37

HC-DFS579

04-10
V1

Injury

The term Injury means an accidental bodily injury.

HC-DFS12

04-10
V1

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

determine whether a drug is a Maintenance Medication by calling member services at the telephone number on your ID card.

HC-DFS847

10-16

Maintenance Treatment

The term Maintenance Treatment means:

- treatment rendered to keep or maintain the patient's current status.

HC-DFS56

04-10

V1

Maximum Reimbursable Charge - Medical

The Maximum Reimbursable Charge does not apply to Emergency Services.

The Maximum Reimbursable Charge for covered services for Open Access Plus In-Network is determined based on the lesser of:

- the provider's normal charge for a similar service or supply;
- the amount agreed to by the Out-of-Network provider and Cigna; or

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;
- the amount agreed to by the Out-of-Network provider and Cigna; 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.

HC-DFS1642

01-22

V2

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

HC-DFS16

04-10

V1

Medical Pharmaceutical

Medical Pharmaceuticals are used for treatment of complex chronic conditions, are administered and handled in a specialized manner, and may be high cost. Because of their characteristics, they require a qualified Physician to administer or directly supervise administration. Some Medical Pharmaceuticals may initially or typically require Physician oversight but subsequently may be self-administered under certain conditions specified in the product's FDA labeling.

HC-DFS1751

01-24

Medically Necessary/Medical Necessity

Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, 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;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or Other Health Professional;
- 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 your Sickness, 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 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.

HC-DFS1411

01-20

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

HC-DFS17

04-10

V1

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 will not include any charges for special nursing fees, dental fees or medical fees.

HC-DFS1409

01-20

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.
- been designated as a Network Pharmacy for the purposes of coverage under your Employer's 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.

HC-DFS1198

01-19

New Prescription Drug Product

A Prescription Drug Product, or new use or dosage form of a previously 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 U.S. Food and Drug Administration (FDA) and ending on the date Cigna makes a Prescription Drug List coverage status decision.

HC-DFS1568

01-21

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

HC-DFS22

04-10

V1

Other Health Care Facility

The term Other Health Care Facility means a facility other than a Hospital or Hospice Facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities.

HC-DFS1412

01-20

Other Health Professional

The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses. Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.

HC-DFS1413

01-20

Participating Provider

The term Participating Provider means 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.

HC-DFS1194

01-19

Patient Protection and Affordable Care Act of 2010 (“PPACA”)

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

HC-DFS412

01-11

Pharmacy

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

HC-DFS851

10-16

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 or 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-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.

HC-DFS1570

01-21

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical

practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

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

HC-DFS25

04-10

V1

Prescription Drug Charge

The Prescription Drug Charge is the amount that, prior to application of the plan’s cost-share requirement(s), is payable by Cigna to its Pharmacy Benefit Manager for a specific covered Prescription Drug Product dispensed at a Network Pharmacy, including any applicable dispensing fee and tax. The “Pharmacy Benefit Manager” is the business unit, affiliate, or other entity that manages the Prescription Drug Benefit for Cigna.

HC-DFS1191

01-19

Prescription Drug List

A list that categorizes Prescription Drug Products covered under the plan’s Prescription Drug Benefits into coverage tiers. This list is developed by Cigna based on clinical factors communicated by the P&T Committee and 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 ID card.

HC-DFS1752

01-24

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. For the purpose of benefits under the plan, this definition may also include products in the following categories if specifically identified on the Prescription Drug List:

- Certain durable products and supplies that support drug therapy;

- Certain diagnostic testing and screening services that support drug therapy;
- Certain medication consultation and other medication administration services that support drug therapy;
- Certain digital products, applications, electronic devices, software and cloud-based service solutions used to predict, detect and monitor health conditions in support of drug therapy.

HC-DFS1645

01-22

Prescription Order or Refill

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

HC-DFS856

10-16

Preventive Care Medications

The Prescription Drug Products or other medications (including over-the-counter medications) designated as payable by the plan at 100% of the cost (without application of any Deductible, Copayment or Coinsurance) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

A written prescription is required to process a claim for a Preventive Care Medication. You may determine whether a drug is a Preventive Care Medication through the internet website shown on your ID card or by calling member services at the telephone number on your ID card.

HC-DFS857

10-16

Preventive Treatment

The term Preventive Treatment means treatment rendered to prevent disease or its recurrence.

HC-DFS57

04-10

V1

Primary Care Physician

The term Primary Care Physician means a Physician who qualifies as a Participating Provider in general practice, internal medicine, family practice OB/GYN or pediatrics; and who has been voluntarily selected by you and is contracted as a Primary Care Physician with, as authorized by Cigna, to provide or arrange for medical care for you or any of your insured Dependents.

HC-DFS40

04-10

V1

Psychologist

The term Psychologist means a person who is licensed under Chapter 4732 of the Ohio Revised Code. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is operating within the scope of his license and performing a service for which benefits are provided under this plan when performed by a Psychologist; and any psychotherapist while he is providing care authorized by the Provider Organization if he is state licensed or nationally certified by his professional discipline and performing a service for which benefits are provided under this plan when performed by a Psychologist.

HC-DFS268

04-10

V1

Room and Board

The term Room and Board includes 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.

HC-DFS1408

01-20

Service Area

The geographic area, as described in the Provider Directory applicable to your plan, where Cigna is authorized to provide services.

HC-DFS961

10-16

Sickness – For Medical Insurance

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

HC-DFS50

04-10

V1

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: maintains on the premises all facilities necessary for medical treatment; provides such treatment, for compensation, under the supervision of Physicians; and provides Nurses' services.

HC-DFS31

04-10

V1

Specialist

The term Specialist means a Physician who provides specialized services, and is not engaged in general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics.

HC-DFS33

04-10

V1

Specialty Medication - for Prescription Drug Benefits

The term Specialty Medication means high cost medications which are used to treat rare and chronic conditions which include, but are not limited to, multiple sclerosis, hepatitis C or rheumatoid arthritis.

HC-DFS69

04-10

V6

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 determine whether a medication is a Specialty Prescription Drug Product through the website shown on your ID card or by calling member services at the telephone number on your ID card.

HC-DFS858

10-16

Stabilize

Stabilize means, with respect to an Emergency Medical Condition, to provide medical treatment as necessary to assure that no material deterioration of the condition is likely if the individual is transferred from a facility, or, with respect to a pregnant woman who is having contractions, to deliver.

HC-DFS1767

01-23

Synchronous, Real Time Communication

A live, two-way interaction between a patient and a dentist conducted through audiovisual technology.

HC-DFS1335

03-19

Teledentistry

The delivery of dental services through the use of synchronous, real-time communication and the delivery of services of a dental hygienist or expanded function dental auxiliary pursuant to a dentist's authorization.

HC-DFS1336

03-19

Telemedicine/Virtual Care

Telemedicine services means a mode of providing health care services through synchronous or asynchronous information and communication technology by a health care professional, within the professional's scope of practice, who is located at a site other than the site where the recipient is located.

HC-DFS1526

Terminal Illness

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

HC-DFS54

04-10

V1

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 medication.

HC-DFS859

10-16

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 medication.

HC-DFS860

10-16

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 Cigna, 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 Physician's recommendation that the insured should not travel due to any medical condition.

HC-DFS34

04-10

V1

Usual and Customary (U&C) Charge

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.

HC-DFS861

10-16