

Lemonade, Inc.

OPEN ACCESS PLUS IN-NETWORK

EFFECTIVE DATE: January 1, 2026

CN037
3345201

This document printed in January, 2026 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: Lemonade, Inc.

GROUP POLICY(S) — COVERAGE
3345201 - OAIN OPEN ACCESS PLUS IN-NETWORK

EFFECTIVE DATE: January 1, 2026

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.



Alicia M. Morrow, ESQ, 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 (see the PAC/CSR section of your certificate) 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.

HC-SPP2

04-10

V1



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
V1

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

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

Mental Health Parity and Addiction Equity Act

The Certificate is amended as stated below:

In the event of a conflict between the provisions of your plan documents and the provisions of this notice, the provisions that provide the better benefit shall apply.

Visit Limits:

Any health care service billed with a Mental Health or Substance Use Disorder diagnosis, will not incur a visit limit, including but not limited to genetic counseling.

HC-NOT93 08-17

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 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, then Cigna 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. 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 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.

HC-IMP356

01-23

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 연락해주시고요. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주시고요.

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 ناشنویان: 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 as described in the Continuity of Care provision

located in the Important Information About Your Medical Plan section of this plan.

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.



Special Plan Provisions

The Cigna 24-Hour Health Information Line

The 24-Hour **Health Information Line (HIL)** assists you in understanding the right level of treatment at the right time. Trained Nurses provide health and medical information and assist you to choose the most appropriate care resource. Our Health Information Line Nurses identify level of care resources in the individual's area (emergency, urgent, Physician, home/self-care), provide general health information (preventive care, illness condition definitions, diagnostic and surgical procedures, etc.), and can help you find network providers. You can call the Health Information Line and get live support 24 hours a day, 7 days a week. Dial the number on the back of your Cigna ID card and you'll be connected directly to a Specialist trained as a Nurse who is ready to help answer your health questions.

Appointment Scheduling

You should have access to timely appointments and scheduling. The following guidelines represent both the plan's and the state of California's requirements for appointment accessibility with Participating Providers:

- Emergent or high risk cases should have access to immediate appointments, appropriate emergency room authorization or direction to dial 911.
- Urgent cases not requiring prior-authorization should have access to appointments within 24 hours of the appointment request.
- If services must be prior authorized, appointments should be offered concurrent with the prior authorization request and the appointment should be provided within 96 hours of the appointment request.
- Non-urgent, symptomatic or routine appointments with a PCP should be scheduled within 10 days of the appointment request.
- Non-urgent, symptomatic or routine appointments with a Specialist should be scheduled within 15 days of the appointment request.
- Preventive screenings and physicals should be scheduled within 30 days of the appointment request.
- Non-urgent appointments for ancillary services for the diagnosis or treatment of Injury or Sickness, or other health condition should be scheduled within 15 days of the appointment request.

- Non-urgent appointments with a non-Physician mental health care provider should be scheduled within 10 business days of the appointment request.
- Average waiting time in the office should not exceed 30 minutes.
- When it is necessary for you or a health care professional to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for your health care needs, and ensures continuity of care consistent with good professional practice.
- The applicable waiting time for a particular appointment may be extended if the referring or treating provider, or the health professional providing triage or screening services, has determined and noted in the relevant record that a longer wait time will not have a detrimental impact on your health.

Accessing Health Care

To contact the Department of Insurance, for complaints regarding your ability to access health care in a timely manner, write or call:

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

Calling within California: 1-800-927-4357

Los Angeles Area and Outside California: 1-213-897-8921

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

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED

Participating Providers

Copayment, Deductible, and Coinsurance options reflect the amount the covered person will pay for In-Network and Out-of-Network benefits. In-Network benefits require use of Participating Providers or facilities in the Service Area. Cigna recommends use of Participating Providers and facilities, as member out-of-pocket costs could be lower than when using non-Participating Providers.



Service Area

The term Service Area means the area in which Cigna has a Participating Provider network. Cigna's national network of Participating Providers is within the United States. Cigna's toll-free care line personnel can provide you with the names of Participating Providers. If you or your Dependents need medical care, you may obtain a listing of Participating Providers by calling the number on your ID card. A listing of Participating Providers can also be found at www.cigna.com.

Away From Home Care

If you or your Dependents need medical care while away from home, you may have access to a national network of Participating Providers through Cigna's Away-From-Home Care feature. Call the number on your ID card for the names of Participating Providers in other network areas.

Emergency Services

Benefits for services and supplies received outside the Service Area are covered only for medical emergencies and other urgent situations where treatment could not have been reasonably delayed until the insured person was able to return to the United States.

To contact the Department of Insurance, write or call:

Consumer Affairs Division
California Department of Insurance
Ronald Reagan Building
300 South Spring Street
Los Angeles, CA 90013
Calling within California: 1-800-927-4357
Los Angeles Area and Outside California: 1-213-897-8921

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

Your Rights Under HIPAA If You Lose Group Coverage

Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health insurance coverage for workers and their families when they change or lose their jobs. California law provides similar and additional protections. If you lose group health insurance coverage and meet certain criteria, you are entitled to purchase individual health coverage (non-group) from any health plan that sells individual coverage for hospital, medical or surgical benefits. Every health plan that sells individual health coverage for these benefits must offer individual coverage to an eligible person under HIPAA. The health plan cannot reject your application if: you are an eligible person under HIPAA; you agree to pay the required premiums; and you live or work

inside the plan's service area. To be considered an eligible person under HIPAA you must meet the following requirements:

- you have 18 or more months of creditable coverage without a break of 63 days or more between any of the periods of creditable coverage or since your most recent coverage was terminated;
- your most recent creditable coverage was a group, government or church plan that provided hospital, medical or surgical benefits. (COBRA and Cal-COBRA are considered group coverage);
- you were not terminated from your most recent creditable coverage due to nonpayment of premiums or fraud;
- you are not eligible for coverage under a group health plan, Medicare, or Medicaid (Medi-Cal);
- you have no other health insurance coverage; and
- you have elected and exhausted any continuation coverage you were offered under COBRA or Cal-COBRA.

There are important choices you need to make in a very short time frame regarding the options available to you following termination of your group health care coverage. You should read carefully all available information regarding HIPAA coverage so you can understand fully the special protections of HIPAA coverage and make an informed comparison and choice regarding available coverage. For more information, please call the number on your ID card.

If you believe your HIPAA rights have been violated, you should contact the CA Department of Insurance or visit the Department's web site.

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 also does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation age or disability.

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 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, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation age or disability, you can file a grievance by sending an email to the Nondiscrimination Complaint Coordinator at ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422
You may also call the number on the back of your ID card or 1-800-244-6224
Fax: 866-254-9406

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, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD)

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

the claim submission instructions for those claims. Claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim forms from the website listed on your identification card or by using the toll-free number on your identification card.

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE CIGNA'S CLAIM FORMS, OR WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.
YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

Timely Filing of Out-of-Network Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within 180 days for Out-of-Network benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within 180 days for Out-of-Network benefits, the claim will not be considered valid and will be denied.

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.

How To File Your Claim

If your plan provides coverage when care is received only from In-Network providers, you may still have Out-of-Network claims (for example, when Emergency Services are received from an Out-of-Network provider) and should follow

Eligibility - Effective Date

Employee Insurance

This plan is offered to you as an Employee.



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 as determined by Your Employer; and
- you are an eligible Employee as determined by your Employer; 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

A period of time as determined by your Employer, not to exceed 90 calendar 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.

Late Entrant - Employee

You are a Late Entrant if:

- you elect the insurance more than 30 days after you become eligible; or
- you are eligible for coverage through a guarantee association and you elect the insurance more than 60 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 are a Dependent who has lost or will lose coverage under Medi-Cal, the Healthy Families Program (HFP), or the Access for Infants and Mothers Program (AIM) and you elect the insurance more than 60 days after you become eligible and you declined coverage during your initial enrollment period by signing a Declination of Medical Coverage form, provided by your Employer; or
- you again elect it after you cancel your payroll deduction (if required).

Exception for Newborns and Adopted Children

Any Dependent child born or placed for adoption, while you are insured will become insured on the date of his birth or placement for adoption, if you elect Dependent Insurance no later than 31 days after his birth or placement for adoption. If you do not elect to insure your newborn child or child placed for adoption within 31 days, coverage for that child will end on the 31st day. No benefits for expenses incurred beyond the 31st day will be payable.

HC-ELG383

01-23

Continuity of Care

In certain circumstances, if you are receiving continued care from a Participating Provider at the time of the provider's network contract termination, you may be eligible to continue to receive care from the provider at the Network cost-share



amount for up to 90 days or as specified below from the date you are notified of your provider's termination.

A continuing care patient is an individual who is:

- undergoing a course of treatment for a serious and complex condition from the provider or facility.

For an acute medical condition that involves a sudden onset of symptoms due to an illness, Injury, or other medical problem that requires prompt medical attention and that has a limited duration, for the duration of the condition.

For a serious medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure, worsens over an extended period, or requires ongoing treatment to maintain remission or prevent deterioration, for a time period necessary to complete a course of treatment and to arrange for a safe transfer of care to another Participating Provider, not to exceed 12 months from the provider's contract termination date.

- pregnant and undergoing treatment for the pregnancy from the provider or facility, for the duration of the pregnancy and the immediate postpartum period.
- undergoing a course of institutional or inpatient care from the provider or facility.
- scheduled to undergo non-elective surgery, including receipt of post-operative care with respect to such surgery.
- determined to be terminally ill and is receiving treatment for such illness from the provider or facility.
- For a terminal illness that is an incurable or irreversible condition that has a high probability of causing death within one year or less, for the duration of the terminal illness.
- scheduled for a surgery or other procedure that is authorized by Cigna as part of a documented course of treatment and has been recommended and documented by the provider in occur within 180 days of the provider's contract termination date.
- a newborn child between birth and age 36 months for a time period not to exceed 12 months from the provider's contract termination date.

Provider's Responsibility – In order for a terminated Participating Provider to continue caring for you under this continuity of care provision, the provider must comply with Cigna's contractual and credentialing requirements and must meet Cigna's standards for utilization review and quality assurance. The terminated Participating Provider must accept payment from Cigna (and applicable cost sharing from you) as

payment in full for the continued care provided, as required under §2799B-8 of the federal PHS Act. The terminated non-Participating Provider must also agree to a mutually acceptable rate of payment. If these conditions are not met, Cigna is not required to arrange for continuity of care.

Cigna is not obligated to arrange for continuity of care with a terminated Participating Provider who has been terminated for medical disciplinary reasons or who has committed fraud or other criminal activities.

Arranging for Continuity of Care – To make a request for continuity of care, you will need to contact Customer Service at the phone number on your ID card to make a formal request for continuity of care under this provision. Contact Customer Service as early as possible, so that the review process can begin and your treatment can continue under this provision.

Cigna will review the formal request to determine if the condition and terminated Participating Provider's status qualifies for continuity of care under this provision.

You will be notified if continuity of care arrangements can be made with the current terminated Participating Provider, and will receive information relating to the extent and length of care that can be provided under this provision. Cigna will make every effort to expedite the review and inform you of the continuity of care decision as soon as possible.

If the condition, or the terminated provider refuses to render care or has been determined unacceptable for quality or contractual reasons, Cigna will work with you to accomplish a timely transition to a qualified Participating Provider.

HC-IMP393

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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 Services.

Direct Access For Treatment of Certain Reproductive and Sexual Health Care Services

You are allowed direct access to a licensed/certified Participating Provider for covered reproductive and sexual health care services. There is no requirement to obtain an authorization from your Primary Care Physician for visits to the Participating Provider of your choice for:

- care related to the prevention or treatment of pregnancy, including sterilization and abortion.

- diagnosis or treatment related to an infectious, contagious, or communicable disease, including public health conditions and sexually transmitted diseases.
- diagnosis and treatment related to rape, including the collection of medical evidence.
- diagnosis and treatment for sexual assault, including the collection of medical evidence with regard to the alleged sexual assault.
- diagnosis and treatment for HIV and other tests.

HC-IMP348

01-23



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.

If you are unable to locate, or you do not have timely access to, an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you may use an Out-of-Network Provider. If you call the number on the back of your I.D. card to obtain assistance with your Out-of-Network Provider coverage, Cigna may negotiate Out-of-Network billed charges on your behalf with the Out-of-Network Provider. If you contact Cigna and do obtain authorization for services provided by an Out-of-Network Provider, Cigna will arrange for those services and benefits for those services will be covered at the In-Network benefit level. Otherwise, they may be covered at an Out-of-Network cost share.

Covered medical services received to diagnose or treat a Mental Health or Substance Use Disorder condition will be payable according to the Mental Health and Substance Use Disorder sections of The Schedule.

Coinsurance

The term Coinsurance means the percentage of Covered Expenses that an insured person is required to pay under the plan 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. Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical deductible for the rest of that year.

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%.

Multiple Surgical Reduction

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



Open Access Plus In-Network Medical Benefits

The Schedule

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 a percentage of the surgeon's allowable charge as specified in Cigna Reimbursement Policies. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

Co-Surgeon

The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna Reimbursement Policies.

Out-of-Network Charges for Certain Services

Charges for services furnished by an Out-of-Network provider in an In-Network facility while you are receiving In-Network services at that In-Network facility: (i) are payable at the In-Network cost-sharing level; and (ii) the allowable amount used to determine the Plan's benefit payment 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.

If services are rendered in California by a California-licensed non-Participating Provider as part of covered non-Emergency Services in an In-Network facility any In-Network cost-sharing will be apply to any In-Network Deductible and Out-of-Pocket Maximum.

In certain situations when services are rendered in California, you may voluntarily choose to pay the Out-of-Network cost share to a California-licensed non-Participating Provider who provides services as part of covered non-Emergency Services in an In-Network facility. If you and the non-Participating Provider agree to this arrangement, the non-Participating Provider must receive your written authorization at least 24 hours in advance of providing service. The non-Participating Provider must also provide you with a written estimate of your total out-of-pocket cost for the care prior to obtaining your consent. When submitting the claim, the non-Participating provide must include a copy of such authorization with the request for reimbursement. You may always seek care from a Participating Provider and you may call the number on the back of your ID card for assistance in finding a Participating Provider and arranging for services from a Participating Provider.



Open Access Plus In-Network Medical Benefits

The Schedule

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.

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.



BENEFIT HIGHLIGHTS	IN-NETWORK
Lifetime Maximum	Unlimited
The Percentage of Covered Expenses the Plan Pays	90%
Calendar Year Deductible Individual Family Maximum Family Maximum Calculation Individual Calculation: Family members meet only their individual deductible and then their claims will be covered under the plan coinsurance; if the family deductible has been met prior to their individual deductible being met, their claims will be paid at the plan coinsurance.	\$250 per person \$500 per family
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%.	\$4,000 per person \$8,000 per family
Combined Medical/Pharmacy Out-of-Pocket Maximum Combined Medical/Pharmacy Out-of-Pocket: includes retail and home delivery drugs Home Delivery Pharmacy Costs Contribute to the Combined Medical/Pharmacy Out-of-Pocket Maximum	Yes Yes



BENEFIT HIGHLIGHTS	IN-NETWORK
<p>Physician's Services</p> <p>Primary Care Physician's Office Visit</p> <p>Specialty Care Physician's Office Visit</p> <p>Consultant and Referral Physician's Services</p> <p>Note: OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with Cigna on an In-Network basis.</p> <p>Surgery Performed in the Physician's Office</p> <p> Primary Care Physician</p> <p> Specialty Care Physician</p> <p>Second Opinion Consultations (provided on a voluntary basis)</p> <p> Primary Care Physician's Office Visit</p> <p> Specialty Care Physician's Office Visit</p> <p>Allergy Treatment/Injections</p> <p> Primary Care Physician's Office Visit</p> <p> Specialty Care Physician's Office Visit</p> <p>Allergy Serum (dispensed by the Physician in the office)</p> <p> Primary Care Physician</p> <p> Specialty Care Physician</p>	<p>\$35 per visit copay, then 100%</p> <p>\$45 per visit copay, then 100%</p> <p></p> <p>\$35 per visit copay, then 100%</p> <p>\$45 per visit copay, then 100%</p> <p></p> <p>\$35 per visit copay, then 100%</p> <p>\$45 per visit copay, then 100%</p> <p></p> <p>100%</p> <p>100%</p> <p></p> <p>100%</p> <p>100%</p>
<p>Convenience Care Clinic (includes any related lab and x-ray services and surgery)</p>	<p>\$35 per visit copay, then 100%</p>



BENEFIT HIGHLIGHTS	IN-NETWORK
<p>COVID-19 Diagnostic Screening and Testing (Physician’s Office or other Place of Service)</p> <p>Note: COVID immunizations are covered under Preventive Care</p>	100%
<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: Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services).</p>	<p>100%</p> <p>\$35 per visit copay, then 100%</p> <p>\$45 per visit copay, then 100%</p>



BENEFIT HIGHLIGHTS	IN-NETWORK
Primary Care Physician Virtual Office Visit	\$35 per visit copay, then 100%
Specialty Care Physician Virtual Office Visit	\$45 per visit copay, then 100%
Preventive Care Routine Preventive Care - all ages Immunizations - all ages	100% 100%
Mammograms, PSA, PAP Smear, Colorectal Cancer Screening Preventive Care Related Services (i.e. "routine" services) Diagnostic Related Services (i.e. "non-routine" services) Colorectal cancer screening tests as defined by the U.S. Preventive Services Task Force A and B recommendations, including a follow-up colonoscopy required for a positive result on a test or procedure	100% Subject to the plan's x-ray benefit & lab benefit; based on place of service 100%
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%
Inpatient Hospital - Facility Services	\$600 per admission copay, then plan deductible, then 90%
Bed and Board Limit Semi-Private Room Private Room Special Care Units (ICU/CCU)	Limited to the semi-private negotiated rate Limited to the semi-private negotiated rate Limited to the negotiated rate



BENEFIT HIGHLIGHTS	IN-NETWORK
<p>Outpatient Facility Services</p> <p>Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room</p> <p>Note: Non-surgical treatment procedures are not subject to the facility copay.</p>	<p>\$350 per visit copay, then plan deductible, then 90%</p>
<p>Inpatient Hospital Physician's Visits/Consultations</p>	<p>Plan deductible, then 90%</p>
<p>Inpatient Professional Services</p> <p>Surgeon</p> <p>Radiologist, Pathologist, Anesthesiologist</p>	<p>Plan deductible, then 90%</p>
<p>Outpatient Professional Services</p> <p>Surgeon</p> <p>Radiologist, Pathologist, Anesthesiologist</p>	<p>Plan deductible, then 90%</p>
<p>Urgent Care Services</p> <p>Urgent Care Facility or Outpatient Facility</p> <p>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.</p> <p>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) billed by the facility as part of the UC visit</p> <p>The scan copay applies per type of scan per day</p>	<p>\$50 per visit copay, then 100%</p> <p>\$100 per scan copay, then \$50 per visit copay, then 100%</p>



BENEFIT HIGHLIGHTS	IN-NETWORK
<p>Emergency Services</p> <p>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.</p> <p>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) billed by the facility as part of the ER visit The scan copay applies per type of scan per day</p>	<p>\$250 per visit copay (waived if admitted), then 100%</p> <p>\$100 per scan copay, then \$250 per visit copay (waived if admitted), then 100%</p>
<p>Air Ambulance</p>	<p>Plan deductible, then 90%</p>
<p>Ambulance</p>	<p>Plan deductible, then 90%</p>
<p>Inpatient Services at Other Health Care Facilities</p> <p>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</p> <p>Calendar Year Maximum: 90 days combined</p>	<p>Plan deductible, then 90%</p>
<p>Laboratory Services</p> <p>Primary Care Physician’s Office Visit</p> <p>Specialty Care Physician’s Office Visit</p> <p>Outpatient Hospital Facility</p> <p>Independent Lab Facility</p>	<p>\$35 per visit copay, then 100%</p> <p>\$45 per visit copay, then 100%</p> <p>Plan deductible, then 90%</p> <p>Plan deductible, then 90%</p>
<p>Radiology Services</p> <p>Primary Care Physician’s Office Visit</p> <p>Specialty Care Physician’s Office Visit</p> <p>Outpatient Hospital Facility</p>	<p>100%</p> <p>100%</p> <p>Plan deductible, then 90%</p>



BENEFIT HIGHLIGHTS	IN-NETWORK
<p>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)</p> <p>The scan copay applies per type of scan per day</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>\$100 per scan copay, then \$35 per visit copay, then 100%</p> <p>\$100 per scan copay, then \$45 per visit copay, then 100%</p> <p>\$600 per admission copay, then plan deductible, then 90%</p> <p>\$100 per scan copay, then plan deductible, then 90%</p>
<p>Outpatient Therapy Services</p> <p>Calendar Year Maximum: 90 days for all therapies combined</p> <p>The limit does not apply to Mental Health and Substance Use Disorder conditions, Pervasive Developmental Disorders and Autism.</p> <p>Note: The Outpatient Therapy Services maximum does not apply to the treatment of autism.</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>\$45 per visit copay*, then 100%</p> <p>*Note: Outpatient Therapy Services copay applies, regardless of place of service, including the home.</p>



BENEFIT HIGHLIGHTS	IN-NETWORK
<p>Outpatient Cardiac Rehabilitation</p> <p>Calendar Year Maximum: Unlimited</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>\$45 per visit copay, then 100%</p>
<p>Chiropractic Care</p> <p>Calendar Year Maximum: 20 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>\$45 per visit copay, then 100%</p>
<p>Acupuncture</p> <p>Calendar Year Maximum: UNLIMITED</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>\$45 per visit copay, then 100%</p>
<p>Home Health Care Services</p> <p>Calendar Year Maximum: 100 days (includes outpatient private nursing when approved as Medically Necessary)</p> <p>The limit does not apply to Mental Health and Substance Use Disorder conditions.</p> <p>Dialysis services in the home setting do not accumulate to the Home Health Care maximum</p>	<p>Plan deductible, then 90%</p>



BENEFIT HIGHLIGHTS	IN-NETWORK
<p>Hospice</p> <p>Inpatient Services</p> <p>Outpatient Services (same coinsurance level as Home Health Care Services)</p>	<p>Plan deductible, then 90%</p> <p>Plan deductible, then 90%</p>
<p>Bereavement Counseling</p> <p>Services provided as part of Hospice Care</p> <p>Inpatient</p> <p>Outpatient</p> <p>Services provided by Mental Health Professional</p>	<p>Plan deductible, then 90%</p> <p>Plan deductible, then 90%</p> <p>Covered under Mental Health benefit</p>



BENEFIT HIGHLIGHTS	IN-NETWORK
<p>Medical Pharmaceuticals</p> <p>Physician's Office</p> <p>Home Setting</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p>	<p>100%</p> <p>Plan deductible, then 90%</p> <p>Plan deductible, then 90%</p> <p>Plan deductible, then 90%</p>
<p>Gene Therapy</p> <p>Includes prior authorized gene therapy products and services directly related to their administration, when Medically Necessary.</p> <p>Gene therapy must be received at an In-Network facility specifically contracted with Cigna to provide the specific gene therapy. Gene therapy at other In-Network facilities is not covered.</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>\$600 per admission copay, then plan deductible, then 90%</p> <p>\$350 per visit copay, then plan deductible, then 90%</p> <p>Plan deductible, then 90%</p> <p>Plan deductible, then 90%</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>



BENEFIT HIGHLIGHTS	IN-NETWORK
<p>Advanced Cellular Therapy</p>	
<p>Includes prior authorized advanced cellular therapy products and related services when Medically Necessary.</p>	
<p>Advanced Cellular Therapy Product</p>	<p>Covered Same as Medical Pharmaceuticals</p>
<p>Inpatient Facility</p>	<p>\$600 per admission copay, then plan deductible, then 90%</p>
<p>Outpatient Facility</p>	<p>\$350 per visit copay, then plan deductible, then 90%</p>
<p>Inpatient Professional Services</p>	<p>Plan deductible, then 90%</p>
<p>Outpatient Professional Services</p>	<p>Plan deductible, then 90%</p>
<p>Advanced Cellular Therapy Travel Maximum:</p>	<p>100%</p>
<p>\$10,000 per episode of advanced cellular therapy</p>	
<p>(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>	



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 on an In-Network basis.</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>\$35 per visit copay, then 100%</p> <p>\$45 per visit copay, then 100%</p> <p>Plan deductible, then 90%</p> <p>\$35 per visit copay, then 100%</p> <p>\$45 per visit copay, then 100%</p> <p>\$600 per admission copay, then plan deductible, then 90%</p>
<p>Abortion</p> <p>Includes abortion procedures, abortion related services, pre-abortion and follow-up services.</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>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p>



BENEFIT HIGHLIGHTS	IN-NETWORK
<p>Men’s Family Planning Services</p> <p>Office Visits, Lab and Radiology Tests and Counseling</p> <p> Primary Care Physician</p> <p> Specialty Care Physician</p> <p>Surgical Sterilization Procedures for Vasectomy (excludes reversals)</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>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p>
<p>Infertility Services</p> <p>Coverage will be provided for the following services:</p> <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. 	



BENEFIT HIGHLIGHTS	IN-NETWORK
<p>Physician's Office Visit (Lab and Radiology Tests, Counseling)</p> <p>Primary Care Physician</p> <p>Specialty Care Physician</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Inpatient Professional Services</p> <p>Outpatient Professional Services</p> <p>Lifetime Maximum: Unlimited</p> <p>Includes all related services billed with an infertility diagnosis (i.e. x-ray or lab services billed by an independent facility).</p>	<p>\$35 per visit copay, then 100%</p> <p>\$45 per visit copay, then 100%</p> <p>\$600 per admission copay, then plan deductible, then 90%</p> <p>\$350 per visit copay, then plan deductible, then 90%</p> <p>Plan deductible, then 90%</p> <p>Plan deductible, then 90%</p>
<p>Transplant Services and Related Specialty Care</p> <p>Includes all medically appropriate, non-experimental transplants</p> <p>Primary Care Physician's Office Visit</p> <p>Specialty Care Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Inpatient Professional Services</p> <p>Lifetime Travel Maximum: \$10,000 per transplant</p>	<p>\$35 per visit copay, then 100%</p> <p>\$45 per visit copay, then 100%</p> <p>\$600 per admission copay, then 100% at LifeSOURCE center, otherwise \$600 per admission copay, then plan deductible, then 90%</p> <p>100% at LifeSOURCE center, otherwise plan deductible, then 90%</p> <p>100% (only available when using LifeSOURCE facility)</p>
<p>Durable Medical Equipment</p> <p>Calendar Year Maximum: Unlimited</p>	<p>Plan deductible, then 90%</p>



BENEFIT HIGHLIGHTS	IN-NETWORK
<p>Outpatient Dialysis Services</p> <p>Primary Care Physician’s Office Visit</p> <p>Specialty Care Physician’s Office Visit</p> <p>Outpatient Facility Services</p> <p>Note: Non-surgical treatment procedures are not subject to the facility copay.</p> <p>Home Setting</p>	<p>\$35 per visit copay, then 100%</p> <p>\$45 per visit copay, then 100%</p> <p>\$350 per visit copay, then plan deductible, then 90%</p> <p>Plan deductible, then 90%</p>
<p>External Prosthetic Appliances</p> <p>Calendar Year Maximum: Unlimited</p>	<p>Plan deductible, then 90%</p>
<p>Diabetic Equipment</p> <p>Calendar Year Maximum: Unlimited</p>	<p>Plan deductible, then 90%</p>
<p>Nutritional Counseling</p> <p>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.</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>\$35 per visit copay, then 100%</p> <p>\$45 per visit copay, then 100%</p> <p>\$600 per admission copay, then plan deductible, then 90%</p> <p>\$350 per visit copay, then plan deductible, then 90%</p> <p>Plan deductible, then 90%</p> <p>Plan deductible, then 90%</p>



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>\$35 per visit copay, then 100%</p> <p>\$45 per visit copay, then 100%</p> <p>\$600 per admission copay, then plan deductible, then 90%</p> <p>\$350 per visit copay, then plan deductible, then 90%</p> <p>Plan deductible, then 90%</p> <p>Plan deductible, then 90%</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>\$35 per visit copay, then 100%</p> <p>\$45 per visit copay, then 100%</p> <p>\$600 per admission copay, then plan deductible, then 90%</p> <p>\$350 per visit copay, then plan deductible, then 90%</p> <p>Plan deductible, then 90%</p> <p>Plan deductible, then 90%</p>
<p>Routine Foot Disorders</p>	<p>Not covered except for services associated with foot care for diabetes, peripheral neuropathies and peripheral vascular disease when Medically Necessary.</p>



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</p> <p>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>\$600 per admission copay, then plan deductible, then 90%</p> <p>100%</p> <p>100%</p> <p>100%</p>

Open Access Plus In-Network Medical Benefits

Prior Authorization/Pre-Authorized

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 plan.

Prior Authorization is not required for preventative care services.

Services that require Prior Authorization are covered services in the following categories:

- inpatient Hospital services, except for 48/96 hour maternity stays.
- inpatient services at any participating Other Health Care Facility.
- residential treatment.
- outpatient facility services.
- advanced radiological imaging.
- non-emergency Ambulance.
- certain Medical Pharmaceuticals.
- transplant services.
- speech, occupational and physical therapy.
- infertility services.
- durable medical equipment.
- Home Health Care Services.
- home infusion services.
- back/spine procedures.
- ear devices.
- oral pharynx procedures.
- orthotics and prosthetics.
- radiation therapy.
- sleep management.
- genetic testing.
- musculoskeletal pain management services.

Pre-determinations

Prior Authorization is not required for all services. Post-service claims may also be reviewed and denied for lack of Medical Necessity. For services rendered by a Participating Provider, it is your provider's responsibility to understand

whether services are considered Medically Necessary. You or your provider may submit a request for a "pre-determination" if the provider is uncertain whether the service will meet Medical Necessity guidelines. If a Participating Provider provides non-Medically Necessary services, the provider is prohibited from billing you for these services unless you have agreed in advance to be financially responsible for such services.

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Covered Expenses

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.

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

- 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 chemotherapy.
- 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 for the treatment of nicotine use.
- charges made for services related to the diagnosis, treatment, and management of osteoporosis. Covered services include, but are not limited to, all FDA approved technologies, including bone mass measurement technologies as deemed Medically Necessary.
- charges, not subject to any applicable member Deductible, Coinsurance or Copay, for prenatal testing resulting from participation in the Expanded Alpha Feto Protein program administered by the State Department of Health Services.
- charges for at least 48 hours of inpatient care following a vaginal delivery and at least 96 hours of inpatient care following a cesarean section for both mother and newborn. The mother and/or newborn may be discharged earlier if the Physician consults with the mother. If discharged early, there will be at least one follow-up visit within 48 hours of discharge. Follow-up care may be in the mother's home, in the Physician's office, or in a licensed facility. An additional length of stay beyond the 48/96 hours will be covered if Medically Necessary.
- charges for a Hospital stay resulting from a mastectomy and/or lymph node dissection for a period of time determined by a Physician in consultation with the patient.
- charges for cancer screening tests that are based on generally accepted medical guidelines or scientific evidence. Prior authorization is not required for biomarker testing: for a person with advanced or metastatic stage 3 or 4 cancer; or for cancer progression or recurrence in a person with advanced or metastatic state 3 or 4 cancer.
- charges for colorectal cancer screening tests as defined by the U.S. Preventive Services Task Force A and B recommendations, including a follow-up colonoscopy required for a positive result on a test or procedure.
- charges for screening prostate-specific antigen (PSA) testing, screening and diagnosis of prostate cancer PSA testing and digital rectal examinations.
- charges made for or in connection with mammograms for breast cancer screenings or diagnostic purposes including, but not limited to: a baseline mammogram for women age 35, but less than 40; a mammogram for women age 40, but less than 50, every two years or more, if Medically Necessary and if recommended by a Physician, nurse practitioner or a nurse midwife; and a mammogram every year for women age 50 and over.
- charges made for an annual Papanicolaou laboratory screening test.
- HIV testing regardless of whether testing is related to the patient's primary diagnosis.
- charges for Medically Necessary home test kits for sexually transmitted diseases (STDs), including any laboratory costs of processing the kit, when the test kit is ordered directly by a clinician or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs.
- charges for adverse childhood experiences (ACE) screenings.
- charges for abortion procedures, abortion related services, pre-abortion and follow-up services; prior authorization is not required for outpatient services.
- charges for female contraceptives, including information and counseling on 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.
- charges 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;

- The American Academy of Pediatrics' Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care;
- The Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; 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. For additional information on immunizations, visit the immunization schedule section of www.cdc.gov.

- charges for standard fertility preservation services when a covered treatment may directly or indirectly cause iatrogenic infertility. Iatrogenic is infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment. As used here, 'directly or indirectly' means medical treatment with a possible side effect of infertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine. As used here, 'standard' means fertility preservation services consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.
- charges made for surgical, including orthognathic surgery, and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ).
- Medically Necessary orthognathic surgery to repair or correct a severe facial deformity or disfigurement.

The following describes coverage provided for the treatment of diabetes:

- charges for the following Medically Necessary equipment for the management and treatment of insulin-using diabetes, noninsulin-using diabetes, and gestational diabetes: blood glucose monitors; blood glucose monitors designed to assist the visually impaired; insulin pumps and all related necessary supplies; podiatric devices to prevent or treat diabetes-related complications; and visual aids (not including eyewear) to assist the visually impaired with proper dosing of insulin.
- charges for diabetes outpatient self-management training, education, and medical nutrition therapy necessary to allow a covered person to properly use the equipment, supplies, and medications listed previously, and any additional diabetes outpatient self-management training, education,

and medical nutrition therapy prescribed by or directed by a Physician.

- charges for general anesthesia and associated facility charges for dental procedures rendered in a Hospital or Ambulatory Surgical Facility for: a Dependent child under the age of 7; covered person who is developmentally disabled; or a covered person whose health is compromised and general anesthesia is Medically Necessary.
- charges made for a drug that has been prescribed for purposes other than those approved by the FDA will be covered if:
 - the drug is otherwise approved by the FDA;
 - the drug is used to treat a life-threatening condition or, a chronic and seriously debilitating condition and the drug is Medically Necessary to treat that condition;
 - the drug has been recognized for the treatment prescribed by any of the following: the American Hospital Formulary Service Drug Information, one of the following compendia if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: The Elsevier Gold Standard's Clinical Pharmacology; The National Comprehensive Cancer Network Drug and Biologics compendium; The Thomson Micromedex Drug Dex; or two articles from major peer reviewed medical journals that present data supporting the proposed use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.
- charges made for acupuncture services involving the stimulation of specific anatomical locations on the skin through the penetration of fine needles, for the purpose of relieving pain or treating disease as Medically Necessary.

Preventive Care

The plan covers charges for preventive care services that are covered as required by the Affordable Care Act (ACA). The ACA-designated resources that identify the preventive services required for coverage are:

- United States Preventive Services Task Force (USPSTF) grade A or B recommendations.
- Advisory Committee on Immunization Practices (ACIP) recommendations adopted by the Director of the Center for Disease Control and Prevention (CDC).
- Health Resources and Services Administration (HRSA) supported comprehensive guidelines which appear in any of

the following sources: periodicity schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care; Uniform Panel of the Secretary’s Advisory Committee on Heritable Disorders in Newborns and Children; guidelines specifically issued for women and adopted by HRSA preventive care services, including wellness examinations and routine immunizations.

Preventive care services include screening exams performed for a covered person who is symptom and disease free. Diagnostic tests performed to evaluate abnormalities (e.g., lab results, physical findings, or symptoms), monitoring, and surveillance testing for a covered person with a known condition or history that increases the risk of disease are not considered preventive care services. A positive result on a preventive screening exam does not alter its classification as a preventive service, but does influence how that service is classified when rendered in the future.

In addition to the designated services identified by ACA sources, adult wellness examinations, prostate cancer screening, digital breast tomosynthesis for breast cancer screening are covered under the preventive care services benefit.

Preventive services include, but may not be limited to, the following:

- Preventive medicine comprehensive evaluation and management services (i.e., wellness examinations) for well-baby, well-child and well-adult (including well-woman) include: an age-and gender-appropriate history; physical examination; counseling/anticipatory guidance; risk factor reduction interventions; the ordering of appropriate immunization(s) and laboratory/screening procedures. Wellness exam frequency:
 - for a covered person under age 5, according to the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule.
 - for a covered person age 5 and above: annual wellness examination; annual well-woman exam; and additional visits for women’s services related to conception management.
- Preventive care services that may be provided during a wellness examination include:
 - administration/interpretation of Health Risk Assessment Instrument.
 - autism screening.
 - anxiety screening.

- behavioral/social/emotional assessment.
- blood pressure measurement for high blood pressure screening/preeclampsia screening.
- breast-feeding promotion/counseling/support.
- counseling/education to minimize exposure to ultraviolet radiation.
- counseling/education regarding FDA-approved contraception methods for women including counseling for continued adherence and follow-up, management of side effects, and instruction in fertility awareness-based methods including the lactation amenorrhea method.
- counseling to prevent initiation of tobacco use.
- counseling related to sexual behavior/sexually transmitted infection (STI) prevention including HIV Preexposure Prophylaxis (PrEP) related adherence counseling and pre- and post-prescription follow up counseling.
- critical congenital heart disease screening.
- depression screening, maternal depression screening, suicide risk assessment.
- discussion of aspirin prophylaxis.
- discussion of chemoprevention with women at risk for breast cancer.
- discussion/referral for genetic counseling/evaluation for BRCA testing.
- hearing and vision screening.
- hepatitis B risk assessment.
- intimate partner/interpersonal and domestic violence screening/referral to support services.
- obesity screening/counseling regarding weight loss, healthy diet and exercise.
- oral health assessment/discussion of water fluoridation/referral to dental home.
- sudden cardiac arrest/sudden cardiac death risk assessment.
- tobacco use screening/counseling.
- unhealthy Alcohol use and substance abuse screening/counseling.
- urinary incontinence screening.
- Preventive care screenings and interventions that may be provided as part of a wellness examination or at a separate encounter:
 - abdominal aortic aneurysm screening for men, age 65-75 who have ever smoked.

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- administration/interpretation of Health Risk Assessment Instrument (e.g., suicide risk assessment; sudden cardiac arrest/death risk assessment).
 - anemia, Iron Deficiency Anemia Screening for children age 12 months.
 - anxiety screening: adolescent and adult women including pregnant and postpartum women.
 - bacteriuria screening: Pregnant women at 12- 16 weeks gestation or at the first prenatal visit, if later.
 - bilirubin screening for newborns.
 - breast cancer/ovarian cancer risk assessment and genetic counseling for women at risk.
 - BRCA1/BRCA2 genetic testing for susceptibility to breast or ovarian cancer, if indicated, for women.
 - breast cancer screening for women age 40 and older, with or without clinical breast exam, every 1-2 years.
 - breast-feeding support/counseling during pregnancy and after birth.
 - breast-feeding equipment/supplies.
 - cervical cancer screening: Pap smear for women age 21-65, every three years; HPV/DNA test alone or in combination with Pap smear for women age 30-65, every five years.
 - chlamydia screening: all sexually active women age 24 and younger, and older women at increased risk.
 - cholesterol screening: children/adolescents ages 9-11 years and 17-21 years; ages 2-8 years and 12-16 years with risk factors.
 - cholesterol screening: adults age 40-75.
 - colorectal cancer screening: consultation prior to colonoscopy.
 - colorectal cancer screening: beginning at age 45 by any of the following methods: high-sensitivity guaiac fecal occult blood testing (HSgFOBT) or fecal immunochemical test (FIT) annually; or stool DNA-FIT every one to three years; or flexible sigmoidoscopy every five years; or flexible sigmoidoscopy every ten years with an annual FIT; or colonoscopy screening every ten years; or computed tomographic colonography (virtual colonoscopy) every five years; or double contrast barium enema (DCBE) every five years.
 - colonoscopy screening following positive results on stool-based screening tests and abnormal findings identified by flexible sigmoidoscopy or CT colonography.
 - congenital hypothyroidism screening: newborns.
 - critical congenital heart disease screening: newborns before discharge from hospital.
 - depression screening/maternal depression screening: adolescents and adults including pregnant and postpartum women.
 - depression and suicide risk assessment.
 - developmental/behavioral/social/emotional screening.
 - fall prevention: community-dwelling adults age 65 years and older with risk factors.
 - fluoride application: infants and children birth to age 6 years (in primary care setting).
 - gestational diabetes: pregnant women at first prenatal visit for those at risk; all pregnant women at 24 to 28 weeks gestation.
 - gonorrhea screening: all sexually active women age 24 and younger and older women at increased risk.
 - gonorrhea prophylactic ocular medication to prevent blindness for newborns.
 - health promotion/prevention of Illness or Injury counseling.
 - hearing screening: infants, children through age 10 years, adolescents age 11 years through age 21 years (not a complete hearing examination).
 - hepatitis B screening: pregnant women, first prenatal visit; adolescents and adults at high risk for infection.
 - hepatitis C screening: adults aged 18-79.
 - high blood pressure screening (outside the clinical setting): adults age 18 and older.
 - human immunodeficiency virus (HIV) infection screening: pregnant women, adolescents and adults 15 to 65 years; younger adolescents or adults with risk factors; annually for sexually active women (adolescent and adult).
 - lead screening: children at risk for lead exposure.
 - lung cancer counseling to discuss need for screening.
 - lung cancer screening: annually for adults age 50 to 80 with 20 pack-year smoking history, and currently smoke, or have quit within the past 15 years.
 - metabolic screening: newborns.
 - nutrition/physical activity counseling, behavioral interventions: adults who have risk factors for cardiovascular disease; obese adults and children age six years and older.

- nutrition/physical activity counseling, behavioral interventions: pregnant adolescent and adults.
- obesity prevention in midlife women (age 40-60 with normal or overweight body mass index (BMI); nutrition/physical activity counseling.
- osteoporosis screening: women age 65 or older (or younger women with fracture risk as determined by a formal Clinical Risk Assessment Tool).
- perinatal depression prevention, interventions: pregnant and postpartum women.
- phenylketonuria (PKU) screening: newborns.
- prediabetes and type 2 diabetes screening and counseling: adults, age 35-70 who are overweight or obese; women with a history of gestational diabetes.
- prevention of Human Immunodeficiency Virus (HIV) infection: preexposure Prophylaxis (PrEP) related services: includes: HIV screening; kidney function testing; hepatitis B and C screening; pregnancy testing as appropriate; sexually transmitted infection screening and behavioral counseling; adherence counseling.
- prostate cancer screening: men age 45 and older or age 40 with risk factors.
- Rh incompatibility screening: pregnant women at first visit and repeat for unsensitized Rh negative women at 24-28 weeks.
- routine immunizations: COVID-19, diphtheria, tetanus toxoids and acellular pertussis (DTaP, Tdap, Td), dengue (recommended for certain populations only), haemophilus influenza type b conjugate (Hib), Hepatitis A (Hep A), hepatitis B (Hep B), human papillomavirus (HPV), influenza, measles, mumps and rubella (MMR), meningococcal (MCV), pneumococcal, poliovirus (IPV), rotavirus (RV), varicella, zoster.
- sexually transmitted infection (STI) prevention counseling: sexually active adolescents and adults at increased risk.
- sickle cell disease screening: newborns.
- smoking and tobacco use cessation counseling/interventions: adults and pregnant women who smoke.
- syphilis screening: pregnant women and persons at increased risk of infection.
- tuberculosis screening: children, adolescents and adults at increased risk.
- unhealthy alcohol use/substance abuse screening and counseling: all adults, and adolescents age 11-21.
- unhealthy drug use screening: all adults, age 18 and older.
- venipuncture for preventive laboratory screenings.
- vision screening: age 3 through age 15 (not a complete vision examination) Instrument based screening recommended for risk assessment at ages 12 and 24 months in addition to the well visits at 3-5 years of age.
- women's contraceptive services: services for insertion/removal of intrauterine devices, implants; fitting diaphragm or cervical cap; contraceptive devices (ParaGard®, Skyla®, Kyleena™, Liletta™ Mirena®); injection (depot medroxyprogesterone acetate); implants; surgical sterilization procedures; pathology services related to surgical sterilization procedures.

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

Dedicated Virtual Providers

Includes charges for the delivery of real-time medical and health-related services, consultations, and remote monitoring by dedicated virtual providers as medically appropriate through audio, video and secure internet-based technologies.

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

Includes charges for the delivery of real-time medical and health-related services, consultations, and remote monitoring as medically appropriate through audio, video, and secure internet-based technologies that are similar to office visit services provided in a face-to-face setting.

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.



Pervasive Developmental Disorders and Autism

Covered expenses are professional services and treatment programs, including applied behavior analysis (ABA), and evidence-based behavior intervention programs that develop or restore to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism provided that:

- The treatment is prescribed by a licensed Physician or is developed by a licensed psychologist.
- The treatment is provided under a treatment plan prescribed by a qualified autism service provider.
- The treatment plan has measurable goals over a specific time-line that is developed and approved by the qualified autism service provider for the specific patient being treated.
- The treatment plan is not used for purposes of providing/reimbursing respite care, day care or educational services and is not used to reimburse a parent for participating in the treatment program.

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), such as phenylketonuria (PKU).

Second Opinions

You or your Physician may request a second opinion relating to a medical treatment or surgical procedure. Reasons for a second opinion to be provided or authorized shall include, but are not limited to, the following:

- if you question the reasonableness or necessity of recommended surgical procedures.
- if you question a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.
- if the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to

diagnose the condition, and you request an additional diagnosis.

- if the treatment plan in progress is not improving your medical condition within an appropriate period of time given the diagnosis and plan of care, and you request a second opinion regarding the diagnosis or continuance of the treatment.
- if you have attempted to follow the plan of care or consulted with your initial provider concerning serious concerns about the diagnosis or plan of care.

If you or the Physician who is treating you requests a second opinion pursuant to this section, an authorization or denial shall be provided in an expeditious manner. When your condition is such that you face an imminent and serious threat to your health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness that would be detrimental to your ability to regain maximum function, the second opinion shall be authorized or denied in a timely fashion appropriate for the nature of your condition, not to exceed seventy-two (72) hours after Cigna's receipt of the request, whenever possible.

Appropriately Qualified Health Care Professional

An Appropriately Qualified Health Care Professional is a Primary Care Physician or Specialist who is acting within his/her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion. You may obtain a second opinion in one of the following ways:

- if you request a second opinion about care from your Primary Care Physician, the second opinion shall be provided by an Appropriately Qualified Health Care Professional, of your choice within the primary care Physician's medical group.
- if you are requesting a second opinion about care from a Specialist, you may obtain the second opinion from any Qualified Health Care Professional of the same or equivalent specialty of your choice. If not authorized by Cigna or the Primary Care Physician's medical group, additional medical opinions not within the Primary Care Physician's medical group shall be your responsibility.

In approving a second opinion the Physician and/or Cigna shall take into account your ability to travel to the provider. Cigna shall require the second opinion health professional to provide you and the initial health professional with a consultation report, including any recommended procedures or



tests that the second opinion health professional believes appropriate.

You are limited to one (1) second medical opinion per medical treatment or surgical procedure, unless Cigna based on its independent determination, authorizes additional medical opinions concerning your medical condition.

Internal Prosthetic/Medical Appliances

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

HC-COV1019

01-23

Home Health Care Services

Charges for skilled care 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-COV1413

01-23

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 Care 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 is 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-COV1414

01-23

Mental Health and Substance Use Disorder Services

Mental Health and Substance Use Disorder Services are services that are required to treat a mental health condition or Substance Use Disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases*, or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

If a covered person receives specialty telehealth (virtual care) services for a mental or behavioral health condition through a third party telehealth provider, the covered person has the option of continuing to receive that telehealth (virtual care) service with an in-person Participating Provider.

Coverage includes Medically Necessary Mental Health and Substance Use Disorder treatment, including but not limited to services provided by a 988 center or mobile crisis team.

Covered behavioral health crisis services received from a 988 center or mobile crisis team are not subject to any prior authorization or other utilization management requirements, and you will be responsible for no more than the same cost share that would apply if the covered services are rendered by a Participating Provider who is not a 988 center or mobile crisis team.

As used in this provision:

- “988” means the three-digit telephone number designated by the Federal Communications Commission (FCC) for the purpose of connecting individuals experiencing a behavioral health crisis and with the capacity to connect callers to behavioral health crisis services through the National Suicide Prevention Lifeline network.
- “988 center” means a center operating on a county or regional basis in California and participating in the National Suicide Prevention Lifeline network to respond to statewide or regional 988 calls.
- “Behavioral health crisis services” means the continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs of those with a Mental Health or Substance Use Disorder crisis that are wellness, resiliency, and recovery oriented. These include, but are not limited to, crisis intervention, including counseling provided by 988 centers, mobile crisis teams, and crisis receiving and stabilization services.

The plan covers, not subject to any member Coinsurance or Copay cost share, the cost of developing an evaluation, and health care services (other than prescription drugs), required or recommended by a Community Assistance, Recovery and Empowerment Court Program’s court-approved CARE agreement or CARE plan. Prior authorization is not required.

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 Mental Health Residential Treatment Services.

Mental Health 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 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 Partial Hospitalization or Intensive Outpatient Therapy Program.

Substance Use Disorder Partial Hospitalization services are rendered not less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency.

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.

HC-COV1054

01-23

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; and devices to restore a method of speaking following a laryngectomy, other than electronic voice producing machines.

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 prosthesis and orthoses; and
- myoelectric prostheses and orthoses.

HC-COV1625

01-23

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 donor sperm and eggs; and
- any experimental, investigational or unproven infertility procedures or therapies.

HC-COV734

01-19

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 nondiseased 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 correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: 1) to improve function; or 2) to create normal appearance, to the extent possible. Reconstructive Surgery also includes Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate means a condition that may include cleft palate, cleft lip or other craniofacial anomalies associated with cleft palate. 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-COV728

08-18

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 are covered subject to the following conditions and limitations:

- Transplant and 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 Cigna designated LifeSOURCE Transplant Network® facility); and lodging while at, or traveling to and from the Cigna LifeSOURCE Transplant Network® 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 Services and Related Specialty Care, 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 the donor for an organ/tissue transplant; the transplant recipient's plan would cover all donor costs.

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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.

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Medical Pharmaceuticals

The plan covers charges made for Medical Pharmaceuticals that are 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 which, due to their characteristics (as determined by Cigna), are required to be administered, or the administration of which must be directly supervised, by a qualified Physician or Other Health Professional. Benefits payable under this section include Medical Pharmaceuticals whose administration may initially, or typically, require Physician or Other Health Professional oversight but may be self-administered under certain conditions specified in the product's FDA labeling.

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

Utilization management requirements or other coverage conditions are based on a number of factors which may include clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of Medical Pharmaceuticals as well as whether certain supply limits or other utilization management

requirements should apply. Economic factors may include, but are not limited to, the Medical Pharmaceutical's cost including, but not limited to, assessments on the cost effectiveness of the Medical Pharmaceuticals and available rebates. Regardless of its eligibility for coverage under your 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 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.

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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.

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Clinical Trials

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

- the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate; or

- the individual provides medical and scientific information establishing that the individual's participation in the qualified trial would be appropriate.

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

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

- it is a federally funded trial. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - National Institutes of Health (NIH).
 - Centers for Disease Control and Prevention (CDC).
 - Agency for Health Care Research and Quality (AHRQ).
 - Centers for Medicare and Medicaid Services (CMS).
 - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA).
 - a qualified non-governmental research entity identified in NIH guidelines for center support grants.
- any of the following: Department of Energy, Department of Defense, Department of Veterans Affairs, if **both** of the following conditions are met:
 - the study or investigation has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and
 - the study or investigation assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA).
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application.



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

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

Examples of routine patient care costs and services include:

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

HC-COV884

01-20

Clinical Trials

This plan covers routine patient care costs and services related to an approved clinical trial for a qualified individual. The

individual must be eligible to participate according to the trial protocol and **either** of the following conditions must be met:

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

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

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

- it is a federally funded trial. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - National Institutes of Health (NIH);
 - Centers for Disease Control and Prevention (CDC);
 - Agency for Health Care Research and Quality (AHRQ);
 - Centers for Medicare and Medicaid Services (CMS);
 - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs (VA);
 - a qualified non-governmental research entity identified in NIH guidelines for center support grants.
- any of the following: Department of Energy, Department of Defense, Department of Veterans Affairs, if **both** of the following conditions are met:
 - the study or investigation has been reviewed and approved through a system of peer review comparable to the system of peer review of studies and investigations used by the National Institutes of Health (NIH); and
 - the study or investigation assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA);
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application.



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

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

Examples of routine patient care costs and services include:

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



Prescription Drug Benefits The Schedule

For You and Your Dependents

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.

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.

Copayments (Copay)

Copayments are amounts to be paid by you or your Dependent for covered Prescription Drug Products.

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 and if applicable at non-Network Pharmacies, the same as the out of network medical cost share for injectable/IV chemotherapy.

BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
Lifetime Maximum	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Out-of-Pocket Maximum		
Individual	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Family	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Maintenance Drug Products		
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.		
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.		



BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
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 \$25 Copay	In-network coverage only
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after \$45 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 \$20 Copay	In-network coverage only
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after \$50 Copay	In-network coverage only
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after \$90 Copay	In-network coverage only



BENEFIT HIGHLIGHTS	NETWORK PHARMACY	NON-NETWORK PHARMACY
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 \$20 Copay	In-network coverage only
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after \$50 Copay	In-network coverage only
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after \$90 Copay	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.

For combination anti-retroviral drug treatments that are Medically Necessary for the treatment of AIDS/HIV, this plan covers a single-tablet drug regimen that is as effective as a multi-tablet regimen unless, consistent with clinical guidelines and peer-reviewed scientific and medical literature, the multi-tablet regimen is clinically equal or more effective and more likely to result in adherence to a drug regimen.

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. Determinations 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.

A Prescription Drug Product that is not on the Prescription Drug List may be covered if the Prescription Drug Product is determined to be Medically Necessary and your Physician obtains authorization for coverage of the non-Prescription Drug List Prescription Drug Product.

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Limitations

For most Prescription Drug Products you or 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 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.

Contraceptives

In the event your Physician determines that a prescription contraceptive that would be payable at 100% is not a medically acceptable alternative for you, the applicable cost-share for a covered alternative contraceptive will be waived. Contact Cigna at the website or phone number on your ID card.

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.

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, you or your prescribing Physician are responsible for obtaining prior authorization from Cigna. If you do 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, you and your Physician will receive confirmation within 72 hours for non-urgent requests and within 24 hours for exigent requests. 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 within 72 hours for non-urgent requests and within 24 hours for exigent requests. 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. The appeal provisions, including the address for submitting an appeal, are outlined in the "When You Have A Complaint Or An Adverse Determination Appeal" section of your certificate. You may also call Customer Service at the toll-free number on your Identification Card if you have questions about the appeal process.

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.

Step Therapy Exceptions

The plan's exception criteria must include, but is not limited to, any of the following criteria:

- The required Prescription Drug Product is contraindicated or is likely, or expected, to cause an adverse reaction, or physical or mental harm, in comparison to the requested Prescription Drug Product.
- The required Prescription Drug Product is expected to be ineffective based on your known clinical characteristics and prescription drug regimen.
- You have tried the required Prescription Drug Product while covered under this plan or under previous health coverage or Medicaid, and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse reaction. You may be required to submit documentation demonstrating that you tried the required Prescription Drug Product before it was discontinued.
- The required Prescription Drug Product is not clinically appropriate for you because it is expected to do any of the following, as determined by your prescribing Physician: worsen a comorbid condition; decrease the capacity to maintain a reasonable functional ability in performing daily activities; or pose a significant barrier to adherence to, or compliance with, your prescription drug regimen or care plan.
- You are stable on a Prescription Drug Product selected by your prescribing Physician for the medical condition under consideration while covered by this plan or previous health coverage.

In circumstances where you or your Dependent are changing plans:

- The new plan cannot require a repeat of step therapy when you are already being treated for a medical condition by a Prescription Drug Product that is appropriately prescribed and is considered safe and effective.
- The new plan may impose a prior authorization requirement for the continued coverage of a Prescription Drug Product prescribed pursuant to step therapy imposed by the former plan.
- The new plan must allow a prescribing provider to prescribe another medically appropriate Prescription Drug Product.

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.

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.

A pharmacist who is subject to California law is permitted under certain circumstances to dispense a partial fill of a prescription for certain controlled substances, and applicable cost-share must be prorated accordingly.

FDA-approved, self-administered hormonal contraceptives will be covered for up to a 12-month supply when dispensed at one time.

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.

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you may receive reduced or no coverage for the Prescription Drug Product. Refer to The Schedule for further information.

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.

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.

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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.

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.
- 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.
- 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 such as for treatment of phenylketonuria (PKU).
- 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.

HC-PHR664

01-23

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.

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01-19

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Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

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 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 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 this exclusion applies, then Cigna 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.

Provided further, if you use a coupon provided by a pharmaceutical manufacturer or other third party that discounts the cost of a prescription medication or other product, Cigna may, in its sole discretion, reduce the benefits provided under the plan in proportion to the amount of 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.

- 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 deny coverage for a drug or Biologic therapy as experimental, investigational and unproven if the drug or Biologic therapy is otherwise approved by the FDA to be lawfully marketed, has not been contraindicated by the FDA for the use for which the drug or Biologic has been prescribed, and is recognized as safe and effective for the

- treatment of cancer in any of the standard reference compendia: (A) The American Hospital Formulary Service's Drug Information, (B) One of the following compendia if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (i). The Elsevier Gold Standard's Clinical Pharmacology; (ii) The National Comprehensive Cancer Network Drug and Biologics compendium; (iii) The Thomson Micromedex DrugDex, (C) two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem. Cosmetic surgery and therapy does not include gender reassignment services.
 - the following services are excluded from coverage regardless of clinical indications: macromastia or gynecomastia surgeries; surgical treatment of varicose veins; abdominoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
 - dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition unless services are an integral part of reconstructive surgery for cleft palate. However, facility charges and charges for general anesthesia or deep sedation which cannot be administered in a dental office are covered when Medically Necessary.
 - for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a 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 otherwise covered under this plan. This exclusion does not apply to health care services required or recommended by a Community Assistance, Recovery and Empowerment Court Program's court-approved CARE agreement or CARE plan.

- court-ordered treatment or hospitalization, unless treatment is prescribed by a Physician and is a covered service or supply under this plan. This exclusion does not apply to health care services required or recommended by a Community Assistance, Recovery and Empowerment Court Program's court-approved CARE agreement or CARE plan.
- medical and Hospital care and costs for the child of your Dependent child, 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 (other than behavioral training services for pervasive developmental disorder or autism), biofeedback, neurofeedback, hypnosis, 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.
- private Hospital rooms and/or private duty nursing except as provided under the Home Health Care 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.

- 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.
- 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.
- 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.
- products and supplies associated with the administration of medications that are available to be covered under the Prescription Drug Benefit. Such products and supplies include but are not limited to therapeutic Continuous Glucose Monitor (CGM) sensors and transmitters and insulin pods.
- routine foot care, including the paring and removing of corns and calluses and toenail maintenance. However, foot care services for diabetes, peripheral neuropathies and peripheral vascular disease are covered when Medically Necessary.
- membership costs and fees associated with health clubs, weight loss programs or smoking cessation programs.
- genetic screening or pre-implantations genetic screening, except as described in Covered Expenses. 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 unless services are an integral part of reconstructive surgery for cleft palate.
- 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.
- health and beauty aids, cosmetics, and dietary supplements.
- all nutritional supplements, formulae, enteral feedings, supplies and specially formulated medical foods, whether prescribed or not, except for infant formula needed for the treatment of inborn errors of metabolism such as for treatment of phenylketonuria (PKU).
- charges related to an Injury or Sickness paid under worker's compensation or similar laws.
- massage therapy.

General Limitations

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

- 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-EXC553

01-23

Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for medical care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the

Primary Plan the Reasonable Cash Value of any services it provided to you.

Allowable Expense

The amount of charges considered for payment under the Plan for a Covered Service prior to any reductions due to coinsurance, copayment or deductible amounts. If Cigna contracts with an entity to arrange for the provision of Covered Services through that entity's contracted network of health care providers, the amount that Cigna has agreed to pay that entity is the allowable amount used to determine your coinsurance or deductible payments. If the Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

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

- An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this Policy or any date before this section or any similar provision takes effect.



Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

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

be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

- If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

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

Effect on the Benefits of This Plan

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

The difference between the amount that this Plan would have paid if this Plan had been the Primary Plan, and the benefit payments that this Plan had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. Cigna will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

As each claim is submitted, Cigna will determine the following:

- Cigna's obligation to provide services and supplies under this Policy;
- whether a benefit reserve has been recorded for you; and
- whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, Cigna will use the benefit reserve recorded for you to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.



Recovery of Excess Benefits

If Cigna pays charges for benefits that should have been paid by the Primary Plan, or if Cigna pays charges in excess of those for which we are obligated to provide under the Policy, Cigna will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare Plan or other organization. If we request, you must execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 55 days of the request, the claim will be closed. If the requested information is subsequently received, the claim will be processed.

Coordination of Benefits with Medicare

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

When Medicare is the Primary Payer

Medicare will be the primary payer and this Plan will be the secondary payer, even if you don't elect to enroll in Medicare or you receive services from a provider who does not accept Medicare payments, in the following situations:

- **COBRA or State Continuation**: You, your spouse, or your covered Dependent qualify for Medicare for any reason and are covered under this Plan due to COBRA or state continuation of coverage.
- **Retirement or Termination of Employment**: You, your spouse, or your covered Dependent qualify for Medicare for

any reason and are covered under this Plan due to your retirement or termination of employment.

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

When This Plan is the Primary Payer

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

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

Domestic Partners

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

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



eligible for Medicare on the earliest date any coverage under Medicare could become effective.

Failure to Enroll in Medicare

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

Assistance with Medicare Questions

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

HC-COB366

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Expenses For Which A Third Party May Be Responsible

This plan does not cover:

- Expenses incurred by you or your Dependent; (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- 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 as described above:

- Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.
- Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, 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.

HC-SUB161

01-23

Payment of Benefits

Assignment and 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.

Ambulance benefits will be paid directly to the provider of the ambulance service.

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.

HC-POB143

01-19

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 cancelled.
- the last day of the calendar month in which 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, your insurance will not continue past the date your Employer stops paying premium for you or otherwise cancels your insurance.

Dependents

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

- the date your insurance ceases.

- 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 cancelled.

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

HC-TRM220 M

01-23

Continuation of Coverage under Cal-COBRA

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

Employer groups with 20 or more Employees

You and your Dependents may elect to continue health coverage after you have exhausted continuation coverage under COBRA. Domestic Partners and stepchildren will not be eligible for Cal-COBRA independent from the Employee. This continuation coverage (Cal-COBRA) will be provided for up to 36 months from the date your COBRA continuation coverage began, if you are entitled to less than 36 months of continuation coverage under COBRA.

Employer groups with less than 20 Employees

This Continuation applies to you and your Dependents if your Employer is subject to Cal-COBRA law. Domestic Partners and stepchildren will not be eligible for Cal-COBRA independent from the Employee. Cal-COBRA law applies to any small Employer that employed 2 to 19 eligible Employees on at least 50 percent of its working days during the preceding calendar year, or, if the Employer was not in business during any part of the preceding calendar year, employed 2 to 19 eligible Employees on at least 50 percent of its working days during the preceding calendar quarter. This continuation coverage will be provided for up to 36 months from the date of the Qualifying Event.

Notice Requirements

Under the requirements of Cal-COBRA, an Employer must give notice to its Employees and Dependents of the right to continue their group health care benefits. A person who would otherwise lose coverage as a result of a Qualifying Event is generally entitled to continue the same benefits that were in



effect the day before the date of the qualifying event. Coverage may be continued under Cal-COBRA only if the required premiums are paid when due and will be subject to future plan changes.

Qualifying Events for Continuation of Cal-COBRA Coverage

A **Qualifying Event** is any of the following:

- termination of the Employee's employment (other than for gross misconduct) or reduction of hours worked so as to render the Employee ineligible for coverage.
- death of the Employee.
- divorce or legal separation of the Employee from his or her spouse.
- with respect to Dependents only, the loss of coverage due to the Employee becoming entitled to Medicare.
- a Dependent child ceasing to qualify as an eligible Dependent under the plan.

Notification Requirements

The Employer will notify Cigna (or an administrator acting on Cigna's behalf) in writing, of termination or reduction of hours with respect to any Employee who is employed by the Employer, within 30 days of the date of the qualifying event. You may be disqualified from receiving Cal-COBRA continuation coverage if your Employer does not provide the required written notification to Cigna (or an administrator acting on Cigna's behalf).

The Employer shall also notify Cigna (or an administrator acting on Cigna's behalf) in writing, within 30 days of the date, when the Employer becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Sec. 1161 et seq., or when the Employer becomes subject to federal COBRA requirements.

To be eligible for continuation coverage, for one of the Qualifying Event(s) you or your Dependent must notify Cigna (or an administrator acting on Cigna's behalf) in writing of such Qualifying Event within 60 days after the event occurs.

If you or your Dependent do not notify Cigna (or an administrator acting on Cigna's behalf) in writing within 60 days of the Qualifying Event(s), you will be disqualified from receiving Cal-COBRA continuation coverage.

Once notified of the Qualifying Event, Cigna (or an administrator acting on Cigna's behalf) will send you or your Dependent the necessary benefit information, premium information, enrollment form and notice requirements within

14 days after receiving notification of the Qualifying Event from the Employer, you or your Dependent. The information shall be sent to the qualified beneficiary's last known address. Notice of the right to continue coverage to your spouse will be deemed notice to any Dependent child residing with your spouse.

Formal Election

To continue group coverage under Cal-COBRA you must make a formal election by submitting a written request to Cigna (or an administrator acting on Cigna's behalf) at: Cigna, Attn: State Continuation Unit, P.O. Box 2010, Concord, NH 03302. For questions, call 1-800-315-6011.

The written request must be delivered by first-class mail, certified mail or other reliable means of delivery within 60 days of the later of the following dates:

- the date of the Qualifying Event.
- the date the qualified beneficiary receives notice of the ability to continue group coverage as provided above.
- the date coverage under the Employer's health plan terminates or will terminate by reason of the Qualifying Event.

If a formal election is not received by Cigna (or an administrator acting on Cigna's behalf) within this time period, you or your Dependent will not receive Cal-COBRA benefits.

Cal-COBRA Premium Payments

To complete the election process, you must make the first required premium payment no more than 45 days after submitting your completed application to Cigna (or an administrator acting on Cigna's behalf). All subsequent premiums will be due on a monthly basis. Your first premium payment should be delivered to Cigna (or an administrator acting on Cigna's behalf) at Cigna, Attn: State Continuation Unit, P.O. Box 2010, Concord, NH 03302 by first-class mail, certified mail, or other reliable means of delivery. The first premium payment must satisfy any required premiums and all premiums due. Failure to submit the correct premium amount within the 45 day period will disqualify the qualified beneficiary from receiving Cal-COBRA coverage. There is a 30 day grace period to pay subsequent premiums. If the premium is not paid before the expiration of the grace period, Cal-COBRA continuation benefits will terminate at midnight at the end of the period for which premium payments were made.

If elected, the maximum period of continuation coverage for a Qualifying Event is 36 months from the date the qualified



beneficiary's benefits under the policy would have otherwise terminated because of the Qualifying Event.

Other events will cause Cal-COBRA benefits to end sooner and this will occur on the earliest of any of the following:

- the date the Employer ceases to provide any group health plan to any Employee.
- the end of the period for which premium payments were made, if the qualified beneficiary ceases to make payments or fails to make timely payments of a required premium, in accordance with the terms and conditions of the policy.
- the first day after the date of election on which the qualified beneficiary first becomes covered under any other group health plan which does not contain any exclusions or limitations with respect to any pre-existing condition for such person; or the date such exclusion or limitation no longer applies to the Employee or Dependent.
- the first day after the date of election on which the qualified beneficiary first becomes entitled to Medicare.
- the coverage for a qualified beneficiary that is determined to be disabled under the Social Security Act will terminate as described below.
- the qualified beneficiary moves out of the service area or the qualified beneficiary commits fraud or deception in the use of services.

Continuation of Coverage for Totally Disabled Individuals

A qualified beneficiary who is eligible for continuation coverage due to termination of the Employee's employment (other than for gross misconduct) or reduction of hours worked so as to render the Employee ineligible for coverage and who is totally disabled under the Social Security Act during the first 60 days of continuation coverage is entitled to a maximum period of 36 months after the date the qualified beneficiary's benefits under the contract would otherwise have terminated because of a Qualifying Event. The Employee or Dependent must provide Cigna (or an administrator acting on Cigna's behalf) with a copy of the Social Security Administration's determination of total disability within 60 days of the date of the determination letter and prior to the end of the original 36 month continuation coverage period in order to be eligible for coverage pursuant to this paragraph. If the qualified beneficiary is no longer disabled under the Social Security Act, the benefits provided in this paragraph shall terminate on the later of 36 months after the date the qualified beneficiary's benefits under the policy would otherwise have terminated because of a Qualifying Event, or the month that begins more than 31 days after the date of the final

determination under Social Security Act that the qualified beneficiary is no longer disabled. The qualified beneficiary eligible for 36 months of continuation coverage as a result of a disability shall notify Cigna (or an administrator acting on Cigna's behalf) within 30 days of a determination that the qualified beneficiary is no longer disabled.

Continuation of Coverage Upon Termination of Prior Group Health Plan

The Employer shall notify qualified beneficiaries currently receiving continuation coverage, whose continuation coverage will terminate under one group benefit plan prior to the end of the period the qualified beneficiary would have remained covered as specified above, of the qualified beneficiary's ability to continue coverage under a new group benefit plan for the balance of the period the qualified beneficiary would have remained covered under the prior group benefit plan. This notice shall be provided either 30 days prior to the termination or when all enrolled Employees are notified, whichever is later.

Cigna (or an administrator acting on Cigna's behalf) shall provide to the Employer replacing a health plan contract issued by Cigna, or to the Employer's agent or broker representative, within 15 days of any written request, information in possession of Cigna reasonably required to administer the notification requirements of this Notification section.

The Employer shall notify the successor plan in writing of the qualified beneficiaries currently receiving continuation coverage so that the successor plan, or contracting Employer or administrator, may provide those qualified beneficiaries with the necessary premium information, enrollment forms, and instructions consistent with the disclosure required by this Notification section to allow the qualified beneficiary to continue coverage. This information shall be sent to all qualified beneficiaries who are enrolled in the plan and those qualified beneficiaries who have been notified as specified in this Cal-COBRA section of their ability to continue their coverage and may still elect coverage within the specified 60 day period. This information shall be sent to the qualified beneficiary's last known address, as provided to the Employer by Cigna (or an administrator acting on Cigna's behalf), currently providing continuation coverage to the qualified beneficiary. The successor plan shall not be obligated to provide this information to qualified beneficiaries if the Employer or prior plan fails to comply with this section.

If the plan provides for a conversion privilege, the plan must offer this option within the 180 days of the end of the



maximum period. However, no conversion will be provided if the qualified beneficiary does not actually maintain Cal-COBRA coverage to the expiration date.

IMPORTANT NOTICE – CAL-COBRA BENEFITS WILL ONLY BE ADMINISTERED ACCORDING TO THE TERMS OF THE CONTRACT. CIGNA WILL NOT BE OBLIGATED TO ADMINISTER, OR FURNISH, ANY CAL-COBRA BENEFITS AFTER THE CONTRACT HAS TERMINATED.

HC-TRM221

01-23

Rescissions

Your coverage may not be rescinded (retroactively terminated) by Cigna or the plan sponsor unless the plan sponsor or an individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud; or the plan sponsor or individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

HC-TRM80

01-11

Medical Benefits Extension

Upon Policy Cancellation

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy, and you or your Dependent is Totally Disabled on that date due to an Injury or Sickness, Medical Benefits will be paid without requirement of premium for Covered Expenses incurred in connection with that Injury or Sickness. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in the Schedule;
- the date you are covered for medical benefits under another group policy;
- the date you are no longer Totally Disabled;
- 12 months from the date your Medical Benefits cease;
- 12 months from the date the policy is canceled.

Totally Disabled

You will be considered Totally Disabled if, because of an Injury or a Sickness:

- you are unable to perform the basic duties of your occupation; and
- you are not performing any other work or engaging in any other occupation for wage or profit.

Your Dependent will be considered Totally Disabled if, because of an Injury or a Sickness:

- he is unable to engage in the normal activities of a person of the same age, sex and ability; or
- in the case of a Dependent who normally works for wage or profit, he is not performing such work.

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

HC-BEX7

04-10

VI

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.



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.
- **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)

Employee: The Employee must be eligible for a Special Enrollment Period to enroll in a QHP through an Exchange (Marketplace) or the Employee seeks to enroll in a QHP through an Exchange 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 an Exchange for new coverage effective beginning no later than the day immediately following the last day of the original coverage.

Family: A plan may allow an Employee to revoke family coverage midyear in order for family members (“related individuals”) to enroll in a QHP through an Exchange (Marketplace). The related individual(s) must be eligible for a Special Enrollment Period to enroll in a QHP or seek to enroll in a QHP during the Marketplace’s annual open enrollment period, and the disenrollment from the group plan corresponds to the intended enrollment of the individual(s) in a QHP for new coverage effective beginning no later than the day immediately following the last day of the original coverage. If the Employee does not enroll in a QHP, the Employee must select self-only coverage or family coverage including one or more already-covered individuals.

HC-FED111

01-23

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.

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA 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.

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.

HC-FED104

01-19

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 emergency services only. Because the Plan does not provide out-of-network coverage, nonemergency services will not be covered under the plan 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.

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.

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ERISA Required Information

The name of the Plan is:

Lemonade, Inc. Employee Health and Welfare Benefits Plan

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

Lemonade, Inc
5 Crosby St, 3rd Floor
New York, NY 10013
844-733-8666

Employer Identification
Number (EIN):

320469673

Plan Number:

501

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

Employer named above

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

Employer named above

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 12/31.

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.

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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.

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Confidential Medical Information – Confidential Communication Requests

California law prohibits Cigna from disclosing to anyone, without express written authorization, a covered person (Protected Individual)'s Medical Information or information that indicates a covered person received a Sensitive Service.

Cigna permits the person to request, and will accommodate requests for, confidential communication in the form and format requested by the person, if it is readily producible in the requested form and format, or at alternative locations.

Cigna permits a person to submit a Confidential Communication Request designating a specific mailing address, email address, and/or telephone number for receiving communications containing the person's Medical Information or any information that indicates the person received a Sensitive Service.

To make a Confidential Communication Request, contact Cigna at the phone number or website on the back of your ID card.

Cigna must implement a Confidential Communication Request within 7 calendar days of receiving a request that is submitted by electronic transmission or telephone; or within 14 calendar days of receiving a request by first class mail. Cigna will, upon request from the person, acknowledge receipt of the Confidential Communication Request and advise the person of implementation status.

A Confidential Communication Request applies to all communications that disclose medical information or provider name and address related to receipt of medical services by the person requesting the confidential communication.

An implemented Confidential Communication Request will be valid until a revocation of the request is submitted, or until a new Confidential Communication request is submitted.

As used here:

- Medical Information is any Individually Identifiable Information, in electronic or physical form, in possession of or derived from a provider of health care, health insurer, pharmaceutical company, or contractor regarding a patient's medical history, mental or physical condition, or treatment.
- Individually Identifiable Information is medical information that includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number,



or other information that, alone or in combination with other publicly available information, reveals the individual's identity.

- A Sensitive Service is a health care service related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence obtained by a patient of any age or at the minimum age specified for consenting to the service.

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.

If for any reason, you are not capable of appointing a new authorized representative, a duly authorized representative may do so on your behalf. If Cigna does not honor your designation of an authorized representative, you may request reconsideration of Cigna's determination by, as applicable, confirming that the signature on the authorization is yours, or that the authorized representative fully disclosed to you all relevant facts regarding its billing practices.

HC-AAR5

01-23

When You Have A Complaint Or An Adverse Determination Appeal

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 and service 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 help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, or a rescission of coverage, you can 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 Appeal Procedure

Cigna has a one-step appeal procedure for appeals decisions. To initiate an appeal for most claims, you must submit a request for an appeal within 365 days of receipt of a denial notice. If you appeal a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal. Appeals may be submitted to the following address:

Cigna
National Appeals Organization (NAO)
PO 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 the toll-free number on your Benefit Identification card, explanation of benefits or claim form.

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals



involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

We will respond in writing with a decision within 30 calendar days after we receive an appeal for a required pre-service or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a post-service 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 30 calendar days and to specify any additional information needed to complete the review. Please note that the California Department of Insurance (CDI) does not require you to participate in Cigna's appeals review for more than 30 days although you may choose to do so. At the completion of this 30-day-review period, when the disputed decision is upheld or your case remains unresolved, you may apply to the CDI for a review of your case.

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

You may request that the appeal process be expedited if, your treating Physician certifies in writing that an imminent and serious threat to your health may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health.

If you request that your appeal be expedited, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited internal appeal would be detrimental to your medical condition.

When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing. The CDI allows you to apply for an Independent Medical Review after this expedited decision if you are unsatisfied with our determination.

Independent Medical Review Procedures

When the disputed decision is upheld or your case remains unresolved after 30 days and when your case meets the criteria outlined below, you are eligible to apply to the CDI for an Independent Medical Review (IMR). The CDI has final authority to accept or deny cases for the IMR process. If your

case is not accepted for IMR, the CDI will treat your application as a request for the CDI itself to review your issues and concerns. Prior to application for an IMR, you are free to seek other avenues of appeal with Cigna. If you choose to do so, you will not forfeit your eligibility to apply for the IMR.

The Independent Medical Review Organization is composed of persons who are not employed by Cigna or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the policy.

There is no charge for you to apply for or participate in this IMR process. Cigna will abide by the decision of the Independent Medical Review Organization.

In order to qualify for an IMR, certain conditions must be met: your Physician has recommended a health care service as Medically Necessary and Cigna has disagreed with this determination, or you have received urgent care or emergency services that a Physician has deemed Medically Necessary and Cigna has disagreed with this determination, or you have been seen by a Physician for the diagnosis or treatment of the medical condition for which you are seeking an Independent Medical Review and Cigna has determined these services as not Medically Necessary or clinically appropriate. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for an independent medical appeal under this process. You remain entitled to send such issues to the CDI for a Department review.

Independent Review Process for Experimental and Investigational Therapies

Special provisions apply to the IMR process for coverage decisions related to experimental or investigational therapies. If Cigna denies your appeal because the requested service or treatment is experimental or investigational, Cigna will send you a letter within 5 business days of making the denial decision. The letter will include:

- a notice explaining your right to an IMR;
- an IMR application;
- a Physician Certification Form for your Physician to complete which certifies that you have a life-threatening or seriously debilitating condition; your Physician's certification must also indicate that standard therapies have not been effective in treating your condition or the requested therapy is likely to be more beneficial than any standard therapy as documented in two separate sources of medical or scientific evidence;
- an envelope for you to return the completed forms to us.



A “life-threatening” condition means either or both of the following:

- diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.
- a “seriously debilitating” condition means diseases or conditions that cause major irreversible morbidity.

“Medical and scientific evidence” means any of the following:

- peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.
- peer-reviewed literature, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS database Health Services Technology Assessment Research (HSTAR).
- medical journals recognized by the Secretary of Health and Human Services, under section 1861(t)(2) of the Social Security Act.
- either of the following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American Dental Association Accepted Dental Therapeutics and The United States Pharmacopoeia-Drug Information.
- any of the following reference compendia if recognized by the Federal Center for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: The Elsevier Gold Standard's Clinical Pharmacology, The National Comprehensive Cancer Network Drug and Biologics Compendium, The Thomson Micromedex DrugDex.
- findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

- peer-reviewed abstracts accepted for presentation at major medical association meetings.

The IMR will be conducted by an Independent Medical Review Organization which is qualified to review issues related to experimental and investigational therapies as selected by the CDI. The IMR must be completed within 30 calendar days. If your Physician determines that the proposed therapy which is the subject of the IMR would be significantly less effective if not initiated promptly, an expedited IMR is available. An expedited IMR will be completed within 7 calendar days from the date an expedited IMR was requested. This timeframe may be extended by up to 3 calendar days if there is a delay in providing any documents which the Independent Medical Review Organization requests for review. The IMR’s decision must state the reason that the therapy should or should not be covered, citing your specific medical condition, the relevant documents, and the relevant medical and scientific evidence. Cigna will cover the services subject to the terms and conditions generally applicable to other benefits under your policy.

Assistance from the State of California

We will provide you with an application and instructions on how to apply to the CDI for an IMR. You must submit the application to the CDI within 180 days of your receipt of our appeal review denial. In compelling circumstances, the Commissioner of Insurance may grant an extension.

The Independent Medical Review Organization will render an opinion within 30 days. If a delay would be detrimental to your medical condition, you may apply to the Department for an expedited review of your case. If accepted, the Independent Medical Review Organization will render a decision in three days.

You have the right to contact the California Department of Insurance for assistance at any time. The Commissioner may be contacted at the following address and fax number:

California Department of Insurance
Claims Service Bureau, Attn: IMR
300 South Spring Street
Los Angeles, CA 90013
or fax to 213-897-5891

Notice of Benefit Determination on Appeal

Every notice of an appeal decision will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim; the specific reason or reasons for the denial decision; reference to the specific policy provisions on which the decision 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); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that 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 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; demonstrate 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 policy 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 appeal processes. However, no action will be brought at all unless brought within three years after a claim is submitted for In-Network services.

HC-APL415

01-20

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 as determined by your Employer 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 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-DFS1186

HC-DFS1095V4

08-18

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

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-DFS1130

HC-DFS840V2
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-DFS1130

HC-DFS841V2
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-DFS1130

HC-DFS842V3
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. The P&T Committee is responsible for ensuring that the plan offers a clinically appropriate Prescription Drug List to enrollees consistent with the requirements of CIC 10123.201(b)(6).

A decision by the P&T Committee is paramount to a decision by the Business Decision Team.

HC-DFS1845

01-23

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.
 - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability. Proof of the child's condition and dependence may be required to be submitted to the plan. Such proof must be provided within 60 days after the request is received. After initial proof is submitted, the plan may require, from time to time but not more frequently than annually, proof of the continuation of such condition and dependence.

The term child means a child born to you, a child legally adopted by you from the date the child is placed in your physical custody prior to the finalization of the child's adoption, or a child supported by you pursuant to a court order (including a qualified medical child support order). It also

includes a stepchild or a child for whom you are the legal guardian. If your Domestic Partner has a child, 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.

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

HC-DFS1833

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 your Domestic Partner who has registered the domestic partnership by filing a Declaration of Domestic Partnership with the California Secretary of state pursuant to Section 298 of the Family Code or an equivalent document issued by a local agency of California, another state, or a local agency of another state under which the partnership was created.



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

HC-DFS1024

10-16

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 an Employee as determined by your Employer who is currently in Active Service.

HC-DFS1846

01-23

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

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-DFS1131

HC-DFS846V3
10-16

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

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-DFS1306

HC-DFS847V2
01-19

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-DFS1305

HC-DFS1198V1
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-DFS1178

HC-DFS851V2

Pharmacy & Therapeutics (P&T) Committee

A committee comprised of Physicians voting and an independent pharmacist that represent a range of clinical specialties, and the composition of which satisfies the membership requirements of CIC 10123.201. 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.

A decision by the P&T Committee is paramount to a decision by the Business Decision Team.

HC-DFS1847

01-23

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-DFS1178

HC-DFS1179

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-DFS1178

HC-DFS856V2



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-DFS1178

HC-DFS857V2

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, obstetrics/gynecology or pediatrics; and who has been selected by you, as authorized by Cigna, to provide or arrange for medical care for you or any of your insured Dependents.

HC-DFS167

04-10
V2

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include 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.

HC-DFS26

04-10
V1

Review Organization

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

HC-DFS808

12-15

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

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 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-DFS1135

HC-DFS858V2
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

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-DFS1135

HC-DFS859V2
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-DFS1135

HC-DFS860V2

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-DFS1135

HC-DFS861V2

10-16