

International Medical, Prescription Drug, Dental and Vision and EAP Plan

Summary Plan Description

January 1, 2025

This document is the Summary Plan Description ("SPD") for this benefit. This SPD is required by federal law called the Employee Retirement Income Security Act of 1974 ("ERISA"). This SPD reflects the terms of the benefit in effect as of January 1, 2025. Ecolab has the right to amend or terminate all or part of the Plan at any time.

ADMINISTRATIVE INFORMATION
TABLE OF CONTENTS

Plan Name and Description 1

Benefit Options Chart 1

Eligible Employees 3

Eligible Dependents 4

Enrollment Periods and Coverage Effective Dates 5

Mid-Year Election Change Events 6

Coverage and Benefits Information in Benefits Description 7

Benefit Payments 8

Impact of Leaves of Absence on Benefits 8

Benefit Claims and Appeals 10

Participation Claims and Appeals 11

Qualified Medical Child Support Orders 12

Post Retirement Benefits 12

COBRA Continuation Coverage 12

USERRA Continuation Coverage 17

Other Notices 18

Subrogation and Reimbursement 20

ERISA Plan Information 23

Statement of ERISA Rights 24

ECOLAB HEALTH AND WELFARE BENEFITS PLAN: MEDICAL, PRESCRIPTION DRUG, DENTAL, VISION, EAP AND FLEXIBLE BENEFIT OPTIONS

ADMINISTRATIVE INFORMATION SUMMARY PLAN DESCRIPTION

EFFECTIVE JANUARY 1, 2025

Plan Name and Description

The name of the Plan is the Ecolab Health and Welfare Benefits Plan ("Plan"). The Plan provides health and other welfare benefits to Eligible Employees of Ecolab Inc. and subsidiaries of Ecolab Inc. that have adopted the Plan ("Participating Employers" or "Employers") and their Eligible Dependents.

This Administrative Information Summary Plan Description ("Administrative Information SPD") describes the medical, prescription drug, dental, vision and EAP options under the Plan.

This Administrative Information SPD and the attached Vendor Benefit Description together make up the ERISA-required Summary Plan Description. The list of options covered under this Administrative Information SPD and the title of the Vendor Benefit Description for each option is below in the *Benefit Options Chart.* The SPD is part of the Plan Document.

Benefit Options Chart

Benefit Type	Insured or Self-Insured	Insurer/ Claims Administrator Name and Contact Information	Vendor Benefit Description
Medical	Self-Insured	Cigna PO Box 182223 Chattanooga, TN 37422-7223 1-800-900-3791 www.mycigna.com	Health Savings Account Medical Plan Option (for Employees Residing in US Other than Alaska, Wyoming and Hawaii) Benefit Description
Medical	Self-Insured	Cigna PO Box 182223 Chattanooga, TN 37422-7223 1-800-900-3791 www.mycigna.com	Traditional Medical Plan Option (for Employees Residing in US Other Than Alaska, Wyoming and Hawaii) Benefit Description
Medical	Insured	HMSA PO Box 1958 Honolulu, HI 96805-1958 1-800-810-2583 www.hmsa.com	Hawaii Medical Plan Option Benefit Description

Benefit Type	Insured or Self-Insured	Insurer/ Claims Administrator Name and Contact Information	Vendor Benefit Description
Medical	Self-Insured	Cigna PO Box 182223 Chattanooga, TN 37422-7223 1-800-900-3791 www.mycigna.com	Health Savings Account Medical Plan Option (for Employees Residing in Alaska and Wyoming) Benefit Description
Medical	Self-Insured	Cigna PO Box 182223 Chattanooga, TN 37422-7223 1-800-900-3791 www.mycigna.com	Traditional Medical Plan Option (for Employees Residing in Alaska and Wyoming) Benefit Description
Medical, Prescription Drug, Dental and Vision and EAP	Insured	Cigna Global PO Box 15050 Wilmington DE 19850-5050 1-800-441-2668 www.cignaenvoy.com	International Benefits Plan Option Benefit Description
Prescription Drug	Self-Insured	CVS/caremark PO Box 52136 Phoenix, AZ 85072-2136 1-866-490-0021 www.caremark.com (See Benefit Description for addresses for out-of-network claim reimbursement, appeals and mail order prescriptions.)	Health Savings Account Prescription Drug Plan Option Benefit Description
Prescription Drug	Self-Insured	CVS/caremark PO Box 52136 Phoenix, AZ 85072-2136 1-866-490-0021 www.caremark.com (See Benefit Description for addresses for out-of-network claim reimbursement, appeals and mail order prescriptions.)	Traditional Prescription Drug Plan Option Benefit Description
Dental	Insured	MetLife Dental Claims PO Box 981282 El Paso, TX 79998-1282 1-800-942-0854 www.mybenefits.metlife.com	Premier Dental Plan Option Benefit Description

Benefit Type	Insured or Self-Insured	Insurer/ Claims Administrator Name and Contact Information	Vendor Benefit Description
Dental	Insured	MetLife Dental Claims PO Box 981282 El Paso, TX 79998-1282 1-800-942-0854 www.mybenefits.metlife.com	Standard Dental Plan Option Benefit Description
Vision	Insured	EyeMed Fidelity Security Life Insurance Company 3130 Broadway Kansas City, MO 64111-2406 1-833-918-1259 member.eyemedvisioncare.com/ecolab/en	Vision Plan Option Group Vision Insurance Certificate / Benefit Description
EAP	Insured	Cigna Behavioral Health 11095 Viking Drive Suite 350 Eden Prairie, MN 55344 Member Services at: 1-800-900-3791 www.mycigna.com	Employee Assistance Plan (EAP) Option Benefit Description
Flexible Benefit	Self-Insured	ThrivePass 1-866-855-2844 mybenefits.us.ecolab.com	Flexible Benefit Plan Option Benefit Description

Eligible Employees

You are eligible to participate in the Plan if you are an Eligible Employee. If you and your family member are both employed by Ecolab or another Participating Employer ("Employer"), you cannot be enrolled as both an employee and a dependent (you and your family member will both be enrolled as employees, provided you are Eligible Employees). To enroll for coverage under an Insurance Policy, you must also satisfy the eligibility requirements for coverage as set forth in the Policy.

Eligible Employee. You are an Eligible Employee if you are:

1. employed by the Employer;
2. in a budgeted position;
3. regularly scheduled to work at least 20 hours per week; and
4. not excluded from the definition of Eligible Employee.

Not Eligible Employee (Excluded). You are not an Eligible Employee (excluded from the definition of Eligible Employee) if you are:

1. classified by the Employer as a temporary employee, a leased employee, or independent contractor;
2. covered by a collective bargaining agreement or contract that does not provide for your participation; or

3. employed by an Ecolab subsidiary that has not adopted the Plan.

Foreign Service for Eligible Employees. If you are a U.S. citizen or resident alien who is transferred to a full-time position with Ecolab or an Ecolab subsidiary in a foreign country (outside of the United States) on a temporary basis for 6 months or more, you will be eligible for coverage under the Ecolab Expatriate option.

Union Employees. If you are covered by a collective bargaining agreement, you are eligible for coverage only if your union agreement provides for your Plan participation.

Reclassification as an Eligible Employee. If you are reclassified as an Eligible Employee by a court, an administrative body or the Employer on a retroactive basis, you will be eligible for coverage only during periods that follow the reclassification. No Plan coverage will be retroactive.

Eligible Dependents

Eligible Dependents are: (1) your Spouse or your Domestic Partner; and (2) your Dependent Child(ren).

You must enroll your Eligible Dependents within the period required by the Plan. Refer to the "Enrollment Periods and Coverage Effective Dates" section below. You must be enrolled in an option to enroll your Eligible Dependents in that option.

Proof of Dependent Status. You must provide documents supporting Eligible Dependent status when you first enroll your Spouse or Domestic Partner or your Dependent Child, such as a birth certificate, marriage certificate or domestic partner affidavit.

If you fail to provide the required documentation by the deadline imposed by the Plan Administrator, your dependent will not be enrolled and cannot enroll until the next Open Enrollment Period (unless you experience a qualifying election change event before then).

You may periodically be required to provide proof of Eligible Dependent status after initial enrollment as well.

Spouse. Spouse means your spouse through marriage recognized as valid under U.S. federal law.

Domestic Partner. To be a Domestic Partner, your partner must be:

1. of the same gender as you and the two of you must be in a civil union, in a registered domestic partnership or a similar arrangement that is legally recognized under the laws of a state in the United States or under the laws of a jurisdiction outside of the United States; or

2. of the same or opposite gender as you and the two of you must:

    a. be at least 18 years old and legally competent to enter into a contract;

    b. not be married to or the domestic partner of anyone else;

    c. be jointly responsible for each other's well-being and financial obligations;

    d. not be related to you by blood to a degree that would prohibit your marriage in your state of residence;

    e. have an ongoing and committed spouse-like relationship and intend to do so indefinitely;

    f. live together in the same principal residence and intend to do so indefinitely; and

g. be jointly responsible for the direction and financial management of your household and take joint financial responsibility for each other's financial obligations.

You must submit your certificate of civil union or registered domestic partnership, or a domestic partner affidavit signed by you and your Domestic Partner. Domestic Partner benefits are only available for an option if provided in the Vendor Benefit Description. Federal tax rules generally require your contribution for coverage for a Domestic Partner and his or her children to be paid on an after-tax basis and the value of employer-paid coverage for the Domestic Partner and his or her children to be imputed to you as income.

Dependent Child. Dependent Child means a child who:

1. has one of the following relationships to you or to your Spouse or Domestic Partner:
    a. biological child;
    b. legally adopted child;
    c. child placed for legal adoption;
    d. foster child; or
    e. legal ward (child for whom you or your Spouse or Domestic Partner are legal guardian); and
2. is either:
    a. under the Limiting Age; or
    b. is eligible for Extended Disabled Dependent Coverage.

Limiting Age. The Limiting Age is age 26, regardless of marital, support, or student status.

Extended Disabled Dependent Coverage. To be eligible for Extended Disabled Dependent Coverage, a child must: (1) provide proof of eligibility for Extended Disabled Dependent Coverage when requested; and (2) not be self-supporting due to physical, mental or intellectual disability.

Enrollment Periods and Coverage Effective Dates

You must enroll in the manner directed by Human Resources.

Initial Enrollment. If you are a new Eligible Employee (a new hire or newly eligible for coverage), you must make your benefit elections within 31 days of your hire date or date of initial eligibility, and must be an Eligible Employee on the date of your enrollment. Your coverage will be retroactive to your hire date.

Annual Open Enrollment. All Eligible Employees can make new elections or changes for the next Plan Year during the Open Enrollment Period that occurs in the fall. Open enrollment elections are effective on January 1 following the Open Enrollment Period.

Mid-Year Special Enrollment. Mid-year special enrollment is provided for medical and prescription drug options pursuant to HIPAA for birth or adoption of a child, marriage, loss of other health plan coverage, losing a child's health insurance coverage through the state or becoming eligible for a premium subsidy from the state to obtain coverage for a child under this Plan. Additional details are provided in the medical Vendor Benefit Description.

Mid-Year Election Changes. Mid-year election changes can only be made if you have experienced a qualifying Mid-Year Election Change Event (see the list below) and make new elections within 31 days of the event. You must make the election in the manner directed by the Plan Administrator. You are required to provide documents supporting your qualifying Mid-Year Election Change Event when you submit your election change form (for example, birth certificate, marriage certificate, divorce decree).

The Plan Administrator will determine whether you have experienced a qualifying Mid-Year Election Change Event and whether the change you are requesting is consistent with that event in accordance with IRS regulations.

An election change will generally be effective on the date of the Mid-Year Election Change Event. Adjusted premium contributions will begin the first pay period after the effective date of your election change. Premium payments will be made for any period of retroactive coverage. Refunds or retroactive adjustments will be made to your premium contributions.

Mid-Year Election Change Events

The following are qualifying Mid-Year Election Change Events for purposes of the Plan:

1. Change in Status Events. The following are change in status events. An election change will be consistent with a change in status only if the change in status: affects eligibility for coverage under an employer plan, or some other plan such as for medical coverage, or coverage under this Plan; and the election change is on account of, and corresponds with, the change in status.

    a. Gain or loss of a Spouse or Domestic Partner;

    b. A change in the number of your Dependent Children, such as through birth or adoption;

    c. A change in your employment or the employment of your Spouse, Domestic Partner or Dependent Child, including:

        i. starting or losing a job;

        ii. a reduction or increase in the hours of employment (including going on and returning from unpaid leave),

        iii. gain or loss of eligibility for benefits under another employer's plan.

    d. Your child satisfying or ceasing to satisfy eligibility requirements for coverage, such as reaching the limiting age.

2. Change in Cost or Coverage Events. The change in cost or coverage events, and the election changes that are permitted as a result, are:

    a. An insignificant cost change in your contribution for Plan coverage will result in an automatic adjustment to your pre-tax contribution.

    b. A significant increase in the cost of a coverage option will permit you to switch to a similar coverage option or, if one is not available, to cancel coverage.

    c. A significant decrease in the cost of a coverage option will permit you to elect that coverage option, even if you are not currently a participant.

    d. The loss of a coverage option will permit you to change to a similar coverage option if any or, if one is not available, to cancel coverage.

e. The reduction of coverage within a coverage option will permit you to switch to a similar coverage option.

f. The addition or significant improvement of a coverage option will permit you to switch to the new or improved coverage option.

3. Election Lock Events. An election change made under another employer's plan, such as the plan of your Spouse's employer, will permit a corresponding change under this Plan if the other plan permits its participants to make an election change in accordance with the IRS cafeteria plan regulations or the other employer's plan and this Plan have different plan years.

4. QMCSO Events. You may change your election for Plan coverage in a manner that is consistent with a judgment, decree or order (including a Qualified Medical Child Support Order) resulting from a divorce, legal separation, annulment or change in legal custody ("Order") that requires health coverage to be provided for your child by you or another individual, such as your ex-Spouse. You may only elect to cancel coverage for your child under this Plan if the Order requires another individual to provide health coverage for your child and that coverage is actually provided.

> The Plan is not obligated to comply with any order requiring you to add your ex-spouse to coverage. The Plan does not cover ex-spouses other than under COBRA continuation coverage. You must notify the Plan of a divorce for your ex-spouse to be eligible for COBRA. See the *COBRA Continuation Coverage* section of this SPD for details. You may be in violation of a court order if you drop your Spouse from coverage prior to divorce or fail to notify the Plan of the divorce and elect COBRA Continuation Coverage for your ex-spouse. You should consult with your divorce attorney.

5. Gain or Loss of Other Health Coverage Events. You may change your election for Plan coverage in a manner that is consistent with the gain or loss by you or your Spouse, Domestic Partner or Dependent Child of entitlement to Medicare or Medicaid. If you or your Spouse, Domestic Partner or Dependent Child loses group health plan coverage under a state children's health insurance program under Title XXI of the Social Security Act (“SCHIPS”), a tribal plan, a state health benefits risk pool, or a foreign governmental plan, you may enroll the individual(s) losing the coverage in corresponding Plan coverage.

6. Mid-Year Special Enrollment Events. If you exercise HIPAA special enrollment rights for medical Plan coverage because you gained an Eligible Dependent through marriage, birth, adoption or placement for adoption or lost other health coverage, pre-tax contributions for premiums for the coverage will be changed automatically.

7. FMLA Events. You may change your elections for Plan coverage when going on or returning from FMLA leave in a manner that is consistent with FMLA requirements and Plan rules.

8. Other Approved Leaves of Absence. Refer to the section entitled “Impact of Leaves of Absence on Benefits.”

Coverage and Benefits Information in Benefits Description

The terms and conditions of coverage and benefits for an option are in the Benefit Description, including:

1. additional eligibility requirements for coverage (if any);

2. commencement and termination of coverage;

3. type and amount of benefits provided;

4. deductibles, co-insurance, co-payments, and benefit maximums;

5. restrictions, limitations and conditions of coverage and benefits;

6. procedure for filing a benefit claim, including the period within which claims must be filed, and the appeal procedure for a denied benefit claim; and

7. the Plan's reimbursement and subrogation rights (for a self-insured option, the *Subrogation and Reimbursement* section of this SPD below will apply to the extent that it is not inconsistent with the subrogation and reimbursement language in the Benefit Description).

Benefit Payments

Benefits do not vest under this Plan. Benefit payments are limited to the amount due under the Plan and late benefit payments will not include interest or penalties.

If a benefit overpayment is made, you are required to promptly repay it. If you do not, the overpayment may be offset from future benefit payments.

Impact of Leaves of Absence on Benefits

Your participation in the Plan during leave of absence depends on whether it is paid or unpaid and the type of leave (for example, FMLA).

Type of Leave	Going on Approved Leave	Returning from Approved Leave (before or at expiration of Approved Leave)
Paid/Partially Paid Leave	Your participation in Plan benefit options (at the active employee premium rates) will continue while you receive pay (health & safe time, vacation time, parental leave or short-term disability). Premiums will be deducted, in whole or in part, from the pay you receive during your leave. If your pay does not cover them in full, they will be deducted in the order determined by the Plan Administrator (e.g., medical premiums will be deducted first, then dental premiums, etc.) and any premiums that are not deducted will be deducted from future pay. If you experience a qualifying Mid-Year Election Change Event, refer to the Mid-Year Election Change Events section of this SPD.	Your Plan benefit options, and pre-tax premium contribution elections remain in place. You will not be able to make a benefit election change on your return from leave unless you experience a qualifying Mid-Year Election Change Event. Refer to the Mid-Year Election Change Events section of this SPD.
Unpaid Leave, FMLA	Your participation in Plan benefit options will continue at the active employee premium rates. Your premium contributions will be put in arrears and deducted from future pay. You may elect to discontinue your benefits options within 31 days from the start of your FMLA leave. Your coverage under the pre-tax benefit options will end as specified in the various	Your Plan benefit options and pre-tax contribution elections that were in place during your leave will continue, but you can change your elections within 31 days from the date of your return. You will be required to reimburse the Employer for unpaid premium contributions during your FMLA leave.

	SPDs for those benefits, and expenses that you incur during your period of non-participation will not be eligible for reimbursement. If you continue coverage during your leave, but do not return to work at the end of your leave, you may be eligible to continue coverage through COBRA. Refer to the COBRA Continuation Coverage section of this SPD for details.	
Unpaid/Partially Paid Leave, Military	If your military leave is unpaid or partially paid, your Plan benefit options continue at the active employee premium rates through the end of the month following the month in which your military leave begins. If your military leave is partially paid, your premiums will be deducted, in whole or in part, from the pay you receive during your leave. If your pay does not cover them in full, they will be deducted in the order determined by the Plan Administrator (e.g., medical premiums, then dental premiums, etc.) and any premiums that are not deducted will be deducted from future pay. You may elect to continue your Plan benefit options under COBRA beyond the end of the month following the month in which your leave began to the extent required by USERRA. If you elect to continue your Plan benefits options, you will pay the active employee premium rates for the first 12 months of COBRA.	If you did not continue your coverage during the entire period of your leave, coverage (and pre-tax premiums for the coverage) will be offered upon your re-employment in accordance with Plan rules and to the extent required by USERRA. You will be required to reimburse the Employer for unpaid premium contributions during your Military leave.
Unpaid Leave, Special	Your participation in Plan benefit options will continue at the active employee premium rates. Your premium contributions will be put in arrears and deducted from future pay. You may elect to discontinue your benefit options within 31 days from the start of your special leave. Your coverage under the pre-tax benefit options will end as specified in the various SPDs for those benefits, and expenses that you incur during your period of non-participation will not be eligible for reimbursement. If you continue coverage during your leave, but do not return to work at the end of your leave, you may be eligible to continue coverage through COBRA. Refer to the COBRA Continuation Coverage section of this SPD for details.	Your Plan benefit options and pre-tax contribution elections that were in place during your leave will continue, but you can change your elections within 31 days from the date of your return. You will be required to reimburse the Employer for unpaid premium contributions during your Special leave.
Long-Term Disability Leave	When you transition to Long-Term Disability leave, your participation in Plan benefit options will continue at the active	Your Plan benefit options will continue, and the pre-tax premium contributions will resume the first of the month following your return to work

	employee premium rates. Your premium contributions will be paid on an after-tax basis to Ecolab's direct bill vendor. You may elect to discontinue your benefit options within 31 days from the start of your Long-Term Disability leave. Your coverage under the benefit options will end as specified in the various SPDs for those benefits, and expenses that you incur during your period of non-participation will not be eligible for reimbursement. If you continue coverage during your leave, but do not return to work at the end of your leave, you may be eligible to continue coverage through COBRA. Refer to the COBRA Continuation Coverage section of this SPD for details.	date. You can change your benefit elections within 31 days from the date of your return.

Benefit Claims and Appeals

Benefit claims must be filed with the Insurer or Claims Administrator in the period and in the manner provided in the Benefit Description.

The Insurer or Claims Administrator is the named fiduciary for benefit claims and appeals and has complete discretionary power and authority to make benefit determinations. A benefit is not payable unless the Insurer or Claims Administrator says that it is.

You are required to complete the claims and appeal procedure outlined in the Benefit Description before you can bring a claim in a court. After you have completed the claims and appeal procedure, you have a limited time to bring a claim in court. See the "Limitation of Legal Action" section below for more information.

Participation Claims and Appeals

If you believe that you have been improperly denied eligibility to participate in the Plan, enroll dependents, make election changes or correct premium contributions, you may file a Participation Claim with the Plan Administrator. Direct your Participation Claim to the attention of the Human Resources Benefits Department.

Definitions.

1. "Participation Claim" is a claim that relates to anything other than a claim for the payment of benefits that is made by a Claimant in accordance with the Plan's procedures for filing a Participation Claim. Participation Claim includes claims of eligibility to participate in the Plan, enroll dependents, make coverage changes, and to correct Employee contributions. A Participation Claim does not include an eligibility claim arising out of a request for a Plan benefit (such a claim is subject to the benefit claim and appeal procedures in the Vendor Benefit Description).

2. "Claimant" means an individual who, individually or through a Representative, has made a Participation Claim.

3. A “Representative” is an individual who can act on behalf of the Claimant. A parent or guardian will generally be considered the Representative of a child. In all other situations, the Claimant must notify the Plan in writing of a Representative.

Claim Submission.

1. A Participation Claim must be submitted to the Plan Administrator in writing and include the reason why the Claimant believes that the Participation Claim is valid. Completion and submission of enrollment, coverage change or other forms required by the Plan Administrator satisfies these requirements.

2. A Participation Claim must be made in the manner required by the Plan Administrator and within the period applicable to the type of Claim at issue:

    a. An Employee’s request to enroll himself or herself or a Spouse, Dependent, Domestic Partner or Domestic Partner's Child in Plan coverage must be made within the enrollment or coverage change period required by the Plan (for example, during open enrollment, within 31 days of an Employee’s hire or becoming eligible for coverage, within 31 days of the acquisition of a new Dependent or the date of loss of coverage for special enrollment or within 31 days of an event that permits a coverage change).

    b. A request to correct the amount of an Employee coverage contribution must be made within 60 days of the date of the improper contribution. A contribution is made on the date that it is deducted from the Employee’s pay.

Initial Review.

1. The Plan Administrator will provide its initial review determination to the Claimant within 90 days of receiving the Participation Claim. This period can be extended by up to 90 days in special circumstances, provided notice is given to the Claimant.

2. If a Participation Claim is denied in whole or part, the Plan will provide a written notice to the Claimant that includes:

    a. the reason(s) for the denial;

    b. a description of any additional material or information necessary for the Claimant to perfect the Participation Claim and an explanation as to why the information or material is necessary; and

    c. an explanation of the Plan’s appeal review procedure for the Participation Claim, including the applicable time limits.

Appeal Review.

1. The Claimant must appeal an initial Participation Claim denial within 30 days of his or her receipt of the denial. The appeal must be in writing and include the reason why the Claimant believes that the Participation Claim is valid.

2. The Claimant may submit written comments, documents, records, and other information to the Plan Administrator and the information will be considered on review regardless of whether it was submitted or considered in the initial review.

3. The Plan will provide to the Claimant reasonable access to documents, records, and other information which are, in the judgment of the Plan Administrator, relevant to the Participation Claim.

4. The Plan Administrator will provide its appeal review determination to the Claimant within 60 days of receiving the appeal of the denial of the Participation Claim. This period can be extended by up to 60 days in special circumstances, provided notice is given to the Claimant.

5. If the Participation Claim is denied on appeal review, the Plan will provide written notice to the Claimant that includes the reason(s) for the continued denial.

Qualified Medical Child Support Orders

The Plan Administrator will determine whether an order requiring the Plan to provide group health coverage to a child is a Qualified Medical Child Support Order. You can obtain a copy of the QMCSO procedures on request and free of charge from the Plan Administrator. If you are not enrolled, you will be required to enroll in order to enroll your child pursuant to a QMCSO. You must pay the premium required for your coverage and your child's coverage.

The Plan is not obligated to comply with any order requiring you to add your ex-spouse to coverage. The Plan does not cover ex-spouses other than under COBRA continuation coverage. You must notify the Plan of a divorce for your ex-spouse to be eligible for COBRA. See the COBRA Continuation Coverage section of this SPD for details. You may be in violation of a court order if you drop your Spouse from coverage prior to divorce or fail to notify the Plan of the divorce allowing your ex-spouse to elect COBRA Continuation Coverage. You should consult with your divorce attorney.

Post Retirement Benefits

The Ecolab Post Retirement Benefits Plan and certain other Ecolab plans currently provide eligible retirees with medical, dental and vision benefits, in addition to a small death benefit. For eligibility information, refer to the Ecolab Post Retirement Benefit Plan Summary Plan Description (SPD).

Under the terms of the plans applicable to Nalco Company retirees, you will lose eligibility for retiree medical and dental benefits if (i) you directly or indirectly in any manner or under any circumstances or conditions, engage in, as a partner, principal, agent, employee, stockholder, officer, director, trustee, consultant, or in any other capacity whatsoever, except as a nominal owner of stock of a public corporation, any business that in any way competes with the Company within any geographic area in which you had direct or indirect responsibility during the last two (2) years of your employment; or (ii) you, at any time, solicit any employee of the Company, or any person who served as an employee of the Company during the six (6) months immediately before your termination from employment, for employment or service or retain, hire or encourage any other person to solicit employees of the Company. You will forfeit eligibility under the retiree plans effective as of the last day of the month in which the Plan sponsor reasonably determines you are in competition with the Company, and you will not become eligible to participate in the retiree plans again.

COBRA Continuation Coverage

If you or your dependent loses coverage due to a COBRA qualifying event (reduction of hours, termination of employment, death, divorce or loss of dependent status), COBRA continuation coverage may be elected to temporarily continue your coverage as provided in this section. You must notify Ecolab Human Resources in writing within 60 days of a death, divorce or loss of Eligible Dependent status. If you do not notify Ecolab within 60 days, COBRA continuation coverage rights will be lost.

Any covered Eligible Employee or Eligible Dependent who loses Plan coverage as a result of a "qualifying event" will be eligible to elect to temporarily continue Plan coverage under a federal law called COBRA as described below.

For employees, the qualifying events are: (1) termination of employment for any reason other than gross misconduct; and (2) a reduction in hours.

For dependents, the qualifying events are: (1) the employee's termination of employment for any reason other than gross misconduct; (2) the employee's loss of eligibility for coverage due to a reduction in work hours; (3) the employee's death; (4) the employee's divorce, legal separation or termination of domestic partnership; or (5) loss of Eligible Dependent status under the Plan.

"You" or "your" refers to an Eligible Employee who is eligible for (and when required, has elected) COBRA continuation coverage. Your "dependent" means your Eligible Dependent who is eligible for (and when required, has elected) COBRA continuation coverage.

"Employer" means Ecolab Inc. or a Participating Employer.

Maximum COBRA Coverage Period

If your qualifying event was termination of employment or reduction of hours, your coverage and the coverage of your dependents can generally be continued for up to 18 months from the date of the employment termination or hours reduction. The coverage period can be extended to up to 29 months if you or your dependent is determined to be disabled for Social Security purposes at any time during the first 60 days of coverage continuation and you satisfy the notice requirement stated in "Disability Determination" below.

The continuation coverage period for your dependent can be extended to up to 36 months if, within the initial 18-month period (or 29-month extended period), coverage under the Plan would otherwise terminate because you die, your dependent ceases to meet the eligibility requirements of the Plan, you and your Spouse become legally separated or divorced, or you and your Domestic Partner end your domestic partnership. This is called a "second qualifying event."

If you enrolled in Medicare benefits before you lost coverage because of a reduction in hours or termination of employment, coverage for your dependents can be extended until up to 18 months after the reduction or termination or up to 36 months after the date of Medicare enrollment, whichever is later.

If the qualifying event was your death, legal separation, divorce, termination of domestic partnership or your dependent's ceasing to meet the eligibility requirements of the Plan, the continuation period would be up to 36 months from the date of the event.

The maximum COBRA coverage periods described above will not be extended even though coverage under the Plan is continued unintentionally, resulting in a delay in termination of coverage, or the Employer reduces or subsidizes, in whole or in part, the premium an individual is required to pay for COBRA coverage. The continuation coverage periods described above are maximum periods that will be reduced as described below.

You Must Provide Notice to the Plan Administrator of Certain Events

There are four instances in which you are required to notify the Plan Administrator or COBRA Administrator of an event. They are below. If you fail to provide the required notice within the period noted below, the right to elect to continue coverage will be lost. The notice must be in writing, must contain the information described below, and must be mailed by first class mail, postage prepaid.

1. *Divorce, Legal Separation, Termination of Domestic Partnership or Loss of Dependent Child Status.* You or your dependent must notify the COBRA Administrator of your divorce, legal separation, termination of domestic partnership or your child's ceasing to qualify as a dependent under the Plan within 60 days of the date of the qualifying event. If the COBRA Administrator is not given the required notice within 60 days, the right to continue coverage will be lost. The notice must contain the following information:

    a. The name, address and Social Security Number of the employee;

b. The name, address and Social Security Number of each dependent covered by the Plan;

c. A description of the qualifying event;

d. The date of the qualifying event; and

e. A list of the health plan options under which the affected individuals are covered.

2. *Disability Determination.* If you or any of your dependents were eligible for COBRA coverage as a result of your termination of employment or reduction in hours and elected COBRA coverage, and you or any dependent was determined to be disabled by the Social Security Administration at any time within the first 60 days of COBRA continuation coverage (whether or not the disabled person elected COBRA coverage), you and your dependents who elected COBRA coverage will be eligible for an additional 11 months of COBRA continuation coverage if you notify the COBRA Administrator of such determination within 60 days after the Social Security Administration determination and prior to the expiration of 18 months following the qualifying event. If the COBRA Administrator is not given the required notice within 60 days after the Social Security Administration determination and within the 18 month continuation period, the right to the disability extension will be lost. The notice must contain the following information:

a. The name, address and Social Security Number of the employee;

b. The name, address and Social Security Number of each dependent covered by the Plan; and

c. A copy of the Social Security Administration notice of determination.

3. *End of Disability.* If the Social Security Administration determines that the person has ceased to be disabled, you or your dependent must notify the COBRA Administrator within 30 days. The notice must contain the following information:

1. The name, address and Social Security Number of the employee;

2. The name, address and Social Security Number of each dependent covered by the Plan;

3. A copy of the Social Security Administration notice of determination; and

4. A list of the group health plan options under which the affected individuals are covered.

4. *Second Qualifying Event.* If during an 18-month or 29-month period of continuation coverage your dependent would otherwise lose coverage because of a second qualifying event which is the employee's divorce, legal separation, or termination of domestic partnership or the child's ceasing to qualify as a dependent under the Plan, you or your dependent must notify the COBRA Administrator within 60 days of the date of the second qualifying event. If the COBRA Administrator is not given the required notice within 60 days, the right to extend continuation coverage to a maximum of 36 months will be lost. The notice must contain the following information:

a. The name, address and Social Security Number of the employee;

b. The name, address and Social Security Number of each dependent covered by the Plan;

c. A description of the second qualifying event;

d. The date of the second qualifying event; and

e. A list of the group health plan options under which the affected individuals are covered.

Type of COBRA Coverage Available

An individual electing COBRA continuation coverage may elect to continue the Plan coverage in effect immediately before the qualifying event. If, however, the coverage provided to similarly situated employees is eliminated and the Employer continues to maintain other medical coverage, the individual will have the right to elect that coverage.

While the individual can only elect to continue health care coverage he or she had at the time of the qualifying event, as long as he or she continues the coverage, he or she will have the same coverage options that he or she would have had if the qualifying event had not occurred. For example, he or she may be able to change to a different option offered by the Employer during an open enrollment period or add coverage for newly acquired Eligible Dependents. (Dependents who are added during coverage continuation (after the qualifying event) will not have any independent continuation rights, except for children born to, placed for adoption with or adopted by the employee during the employee's continuation coverage period.)

Who May Elect COBRA Coverage

If you are eligible for COBRA coverage, you can make the election for yourself and for any one or more of your dependents who are eligible for COBRA coverage. If you do not make the election, your Spouse or Domestic Partner can make the election for himself or herself and any covered Dependent Child. Finally, if neither you nor your Spouse or Domestic Partner make the election for a covered Dependent Child, the dependent may make the election for himself or herself. (A child who is born to, or placed for adoption with, the employee while the employee is continuing coverage under COBRA and who becomes covered by the Plan will have independent COBRA election rights as if he or she were covered at the time of the qualifying event.)

Impact of COBRA on other Federal Law Rights

In considering whether to elect continuation coverage, you should take into account that a failure to continue group health plan coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of a qualifying event. You will also have the same special enrollment right at the end of the continuation coverage period if you get continuation coverage for the maximum time available to you.

COBRA Election Period

After a qualifying event or receiving notice of a qualifying event (if notice is required), the COBRA Administrator will send a notice regarding COBRA election rights to individuals eligible for COBRA. The individuals will have 60 days from the date of such notice (or from the date coverage would otherwise terminate because of the qualifying event, if the coverage would stop after the notice is sent) in which to file a written election to continue your coverage. If the individual does not file the required election form within this 60-day period, he or she will lose the right to continue coverage under the Plan. The election form must be submitted to the address specified in the election form.

The Trade Act of 2004 created a tax credit for certain individuals who become eligible for trade adjustment assistance ("eligible individuals"). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. An eligible individual who did not elect COBRA coverage will have a second 60-day COBRA election period beginning on the first day of the month in which he or she is determined to be

an eligible individual, but only if the election is made within six months after the original termination of employment. Any COBRA coverage elected during the second election period will begin with the first day of the second election period, rather than on the date coverage terminated.

COBRA Premium

You (or your dependent) must pay the full premium (both the employee and employer contribution), plus a 2% administration fee, for any coverage you continue. (The charge will be higher for coverage extended on account of disability.) The premium will be the same premium that would be paid for a person in your situation with respect to whom no qualifying event had occurred (but will include any portion the Employer normally pays for active employees). The first premium payment, covering the period between the date coverage would otherwise stop and the date of the payment, must be made within 45 days after the date you file the election to continue coverage. Subsequent premiums are due monthly on the day of the month coverage would have stopped if COBRA continuation had not been elected, and coverage will end if your or your dependent fails to pay the premium for any month within 30 days after the due date.

Under its current practice, if you die while actively employed by Ecolab or its subsidiary, Ecolab will subsidize the first 6 months of COBRA premiums for your dependents enrolled in medical coverage at the time of your death. Each dependent can elect to continue coverage at the full COBRA premium cost for the remaining 30 months of the continuation period.

No COBRA Coverage Pending Election or Payment

You will not have COBRA coverage until you have elected the coverage and made the required premium payment. Once you make the election and pay the premium, coverage will be reinstated retroactively to the date you lost your coverage.

Termination of Coverage

The continuation coverage will terminate when the first of the following events occurs.

1. The 18-, 29- or 36-month maximum continuation period ends.

2. You fail or your dependent fails to pay the initial premium within 45 days after your election, in which case you will be treated as not having elected to continue your coverage.

3. You fail or your dependent fails to pay any other premium within 30 days after it is due, in which case your coverage will end as of the end of the last period for which you made a timely premium payment.

4. After electing continuation coverage, you become or your dependent enrolls in Medicare benefits or becomes covered by any other group health plan that does not limit or exclude coverage because of a preexisting condition. Coverage already in place at the time of the continuation coverage election will not cause termination of continuation coverage.

5. The Employer ceases to provide group health benefits to any of its employees.

6. For coverage that is continued beyond 18 months because of disability, the disabled person ceases to be disabled, in which case the coverage will terminate as of the first day of the month that begins at least 30 days after date of the Social Security Administration’s determination that the person is no longer disabled.

7. The continuation coverage is terminated for cause (for example, you commit fraud against the Plan).

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator (see contact information below) or the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep the Plan and COBRA Administrator Informed of Address Changes

To protect your family's COBRA continuation rights, you should keep the Plan and COBRA Administrator informed of any changes in the addresses of family members.

Keep Copies of Any Notices You Send to the Plan or COBRA Administrator

You should also keep a copy, for your records, of any notices you send to the Plan and COBRA Administrator.

Plan Administrator Contact Information

Ecolab Inc.
Attn: Benefits Department – EGH3
1 Ecolab Place
St. Paul, MN 55102
If you have questions, call: (800) 964-0265

COBRA Administrator Contact Information:

ThrivePass
PO Box 220
Minneapolis, MN 55440-0220
(866) 855-2844

USERRA Continuation Coverage

If you leave your job with a Participating Employer to go on a qualifying military leave of absence as defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), you may elect to continue your coverage as provided in this section.

You will have the right to elect to continue Plan coverage for yourself and your Eligible Dependents during a period of Uniformed Service for up to 24 months, or the date on which you fail to return to work following your period of Uniformed Service, whichever is earlier. USERRA Continuation Coverage will begin on the first day of your leave of absence due to Uniformed Service.

Definitions

1. "Uniformed Service" includes service by an Employee in the Armed Forces, Reserves, federally activated National Guard and volunteers in the National Disaster Medical System.

2. "Service" means the performance of duty on a voluntary or involuntary basis in the Uniformed Services, including active and inactive duty training or service, examination to determine fitness for duty, certain funeral honors duties, and certain service by intermittent disaster-response personnel of the National Disaster Medical System.

3. "USERRA Continuation Coverage" means continuation of Plan coverage pursuant to USERRA.

Election of USERRA Continuation Coverage

You will be required to elect USERRA coverage. COBRA election procedures as set forth in COBRA Continuation Coverage Rights section will apply, except that an election for USERRA Continuation Coverage is not required if advance notice of leave is excused under USERRA. If you elect COBRA, you will be considered to have elected USERRA continuation coverage as well.

Cost of USERRA Continuation Coverage

The COBRA rate will apply. You will only be required to pay the active employee rate, however, for a USERRA leave of less than 31 days if you notify the Plan that your Uniformed Service is scheduled to last less than 31 days.

Termination of USERRA Continuation Coverage

USERRA Continuation Coverage will end when the earliest of the following occurs:

1. The 24-month USERRA Continuation Coverage period ends;

2. You fail to report back to work or apply for reemployment within the period required under USERRA after completing Service;

3. The Employer ceases to offer any group health plan to any of its employees; or

4. You fail to pay the required premium contribution within 30 days of the due date.

Coordination of COBRA Coverage and USERRA Coverage

The maximum USERRA Continuation Coverage period is 24 months. The maximum COBRA continuation coverage period may be 18 months, 29 months or 36 months depending on the qualifying event. The USERRA Continuation Coverage period and the COBRA continuation coverage period will run concurrently.

Covered dependents do have independent election rights under COBRA but not under USERRA. You must elect continuation coverage for yourself in order for your Spouse or Domestic Partner or Dependent Child to be eligible for any USERRA Continuation Coverage period that extends beyond the COBRA continuation coverage period.

Reinstatement of Coverage on Return from Service

To the extent required by USERRA, Plan coverage will be reinstated after you return to work even if you do not elect USERRA Continuation Coverage or your USERRA Continuation Coverage terminates for failure to pay a premium. No waiting period will be imposed.

Other Notices

Conditions of Participation

Participation in the Plan by an Eligible Employee is voluntary. Participation in the Plan does not give any Employee the right to continued employment.

As a condition of participation, each Eligible Employee and Eligible Dependent agrees to:

1. be bound by all of the terms and conditions of the Plan and, for an insured option, the Insurance Policy;

2. make the contributions required; and

3. furnish such information and execute such instruments and forms as the Plan Administrator and Insurer or Claims Administrator may request.

Committing Fraud or Intentional Misrepresentation Against the Plan

If you commit fraud or intentional misrepresentation of a material fact against the Plan (which may include enrolling someone in coverage who you know or should know does not qualify as your Eligible Dependent, continuing enrollment of someone in coverage who you know or should know has lost eligibility or filing a false claim) the Plan (or your Participating Employer) may take action, which may include the following:

1. Termination of Plan Coverage. Your coverage may be terminated. Coverage for the person you enrolled may be terminated. If you have committed fraud or made an intentional misrepresentation of a material fact, coverage may be terminated retroactively.

2. Repayment of Plan Benefits. You may be responsible for all benefits paid for a person who was not eligible for coverage or as a result of a false claim.

3. Discipline. You may be subject to discipline, including termination of your employment.

4. Notification of Law Enforcement. Law enforcement may be notified that you have committed intentional misrepresentation or fraud against the Plan.

Limitation of Legal Action

For insured options, the limitation of actions provision contained in the Policy will apply.

For self-insured options (and insured options if the Policy does not contain a limitation of action provision), the following will apply:

No action with respect to eligibility to participate or for any benefit under this Plan may be brought more than six months following the final decision in the final appeal review brought pursuant to the claim and appeal procedure set forth in the Vendor Benefit Description, or for eligibility claims, the participation and claims procedure described in this SPD. In no event can any action with respect to eligibility to participate or with respect to any benefit under this Plan be brought more than three years after the date the event giving rise to the claim occurred.

No Guarantee of Tax Consequences

Although Ecolab intends to provide certain Plan benefits on a tax-free basis, Ecolab does not guarantee that the benefits are tax-free or the tax consequences to you. You are responsible to pay any local, state or federal taxes that you owe as a result of your Plan participation or receipt of Plan benefits.

Availability of the Plan's HIPAA Notice of Privacy Practices

You can obtain a copy of the Plan's HIPAA Notice of Privacy Practices, which describes your privacy rights under the Health Insurance Portability and Accountability Act of 1996, from the Plan Administrator or from the Insurer for an insured option.

The separate HIPAA Plan amendment is part of the Plan document.

Health Care Providers

You are responsible for choosing your own health care provider. You must decide if any provider treating you (including an in-network provider) is right for you. You must decide with your health care provider which care you will receive. Your health care provider, whether in- or out-of-network, is responsible for the care provided to you.

The Plan pays for certain health care expenses. It does not provide health care. Determinations that health care services or supplies are not Covered Expenses (including that they are not medically necessary) are for payment purposes only.

The Insurer or Claims Administrator pays network providers through various types of contractual arrangements, which may include financial incentives to promote the delivery of care in a cost- effective manner (for example, bonuses based on quality, member satisfaction and cost-effectiveness). The financial incentives are not intended to affect your access to health care. If you have questions about whether your network provider's contract includes any financial incentives, you should discuss them with your provider and the Insurer or Claims Administrator.

Wellness Program Incentives

The Insurer, Claims Administrator or Plan may offer incentives to encourage you to participate in wellness programs or disease management programs. The decision whether to participate is yours alone and will not impact your eligibility to participate in the Plan or your employment at Ecolab.

Subrogation and Reimbursement

Insured vs. Self-insured. Subrogation and reimbursement under a fully insured Option will be as provided in the Policy. This section applies to self-insured medical options to the extent not inconsistent with the Vendor Benefit Description. If it is inconsistent with the Vendor Benefit Description, the Vendor Benefit Description controls.

Subrogation and Reimbursement Rights. Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any benefit, the Plan shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and benefits the Plan provided to Eligible Employees or Eligible Dependents ("Covered Persons"), from any or all the following listed below. In addition to any subrogation rights and in consideration of the coverage provided by this Summary Plan Description, the Plan shall also have an independent right to be reimbursed by Covered Persons for the reasonable value of any services and benefits the Plan provides to Covered Persons, from any or all of the following listed below.

1. Third parties, including any person alleged to have caused a Covered Person to suffer injuries or damages.

2. Any person or entity who is or may be obligated to provide benefits or payments to a Covered Person, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third-party administrators.

3. Any person or entity who is liable for payment to a Covered Person on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties".

Responsibilities of Covered Persons. Covered Persons agree as follows:

1. The Covered Person will cooperate with the Plan in a timely manner in protecting the Plan's legal and equitable rights to subrogation and reimbursement, including, but not limited to:

    a. providing any relevant information requested by the Plan;

    b. signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim;

    c. responding to requests for information about any accident or injuries;

    d. appearing at depositions and in court; and

    e. obtaining the consent of the Plan or its agents before releasing any party from liability or payment of medical expenses.

2. Failure to cooperate in this manner shall be deemed a breach of contract, and may result in the termination of health benefits and/or the institution of legal action against a Covered Person.

3. The Plan has the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

4. No court costs or attorneys' fees may be deducted from the Plan's recovery without the Plan's express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and the Plan is not required to participate in or pay court costs or attorneys' fees to the attorney hired by a Covered Person to pursue his or her damage/personal injury claim.

5. Regardless of whether a Covered Person has been fully compensated or made whole, the Plan may collect from Covered Persons the proceeds of any full or partial recovery that a Covered Person or his or her legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment. The proceeds available for collection shall include, but not be limited to, any and all amounts earmarked as non-economic damage settlement or judgment.

6. Benefits paid by the Plan may also be considered to be benefits advanced.

7. Covered Persons agree that if they receive any payment from any potentially responsible party as a result of an Injury or Sickness, whether by settlement (either before or after any determination of liability), or judgment, the Covered Person will serve as a constructive trustee over the funds and failure to hold such funds in trust will be deemed as a breach of the Covered Person's duties hereunder.

8. Covered Persons or an authorized agent, such as the Covered Person's attorney, must hold any funds received from any potentially responsible party that are due and owed to the Plan, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the institution of legal action against the Covered Person.

9. The Plan shall be entitled to recover reasonable attorney fees from Covered Persons incurred in collecting from the Covered Person any funds held by the Covered Person that he or she recovered from any Third Party.

10. The Plan may set off from any future benefits otherwise allowed by the Plan the value of benefits paid or advanced under this section to the extent not recovered by the Plan.

11. Covered Persons will neither accept any settlement that does not fully compensate or reimburse the Plan without the Plan's written approval, nor will the Covered Person do anything to prejudice the Plan's rights under this section.

12. Covered Persons will assign to the Plan all rights of recovery against Third Parties, to the extent of the reasonable value of services and benefits the Plan provided, plus reasonable costs of collection.

13. The Plan's rights will be considered as the first priority claim against Third Parties, including tortfeasors for whom Covered Persons are seeking recovery, to be paid before any other of the Covered Person's claims are paid.

14. The Plan' rights will not be reduced due to the Covered Person's own negligence.

15. The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including filing suit in the Covered Person's name, which does not obligate the Plan in any way to pay the Covered Person part of any recovery the Plan might obtain.

16. The Plan shall not be obligated in any way to pursue this right independently or on behalf of the Covered Person.

17. If the injury or condition giving rise to subrogation or reimbursement involves a minor child, this section applies to the parents or guardian of the minor child.

18. If the injury or condition giving rise to subrogation or reimbursement involves the wrongful death of a Plan beneficiary, this section applies to the personal representative of the deceased Plan beneficiary.

<u>Refund of Overpayments.</u>

1. If the Plan pays benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if either of the following apply:

   a. all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person; or

   b. all or some of the payment we made exceeded the benefits under the Plan.

2. The refund equals the amount we paid in excess of the amount we should have paid under the Plan.

3. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

4. If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future benefits that are payable under the Plan. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

ERISA Plan Information

Plan Name and Type: Ecolab Health and Welfare Benefits Plan. The Plan provides health and other welfare benefits to Eligible Employees of Ecolab Inc. and other Participating Employers.

Participating Employers: Ecolab Inc. and subsidiaries of Ecolab Inc. that have adopted the Plan. If you have questions about whether your employer is a Participating Employer, contact the Plan Administrator.

Plan Number: The Plan number is 501.

Plan Year: The Plan Year is the 12-month period beginning each January 1 and ending the following December 31.

Plan Sponsor Taxpayer Identification Number: Ecolab's Taxpayer Identification Number is 41-0231510.

Plan Sponsor and Plan Administrator: Ecolab Inc. is the Plan Sponsor and Plan Administrator of the Plan.

Ecolab Inc.
Attn: Benefits Department - EGH3
1 Ecolab Place
St. Paul, MN 55102
(800) 964-0265

Plan Administrator Discretionary Authority: The Plan Administrator's determinations regarding coverage, claims and all other aspects of the Plan are binding. The Plan Administrator has complete discretionary power and authority with respect to all Plan matters, including eligibility and benefits, factual determinations and Plan interpretation. A benefit is not payable unless the Plan Administrator determines that it is. The Plan Administrator may delegate its authority to Plan service providers, such as the Insurer or Claims Administrator.

Right to Amend or Terminate Plan: Ecolab reserves the right to amend or terminate all or part of this Plan and will do so by written instrument signed by an authorized Ecolab officer. Plan terms cannot be modified by oral statements made by anyone. Misinformation or a mistake does not create a right to eligibility or benefits.

Insurer or Claims Administrator: The name, address and contact information for the Insurer or Claims Administrator for each option is listed in the *Benefits Options Chart* at the front of this SPD.

Premium Contributions and Plan Funding: Premiums for the Plan benefits you elect are paid through your contributions and contributions by your Participating Employer, if any. The Plan Administrator will inform you what Premium amount you will be required to pay for your coverage. To the extent permitted by federal law, your Premium contributions will automatically be paid on a pre-tax basis. Benefits for insured options are paid by the Insurer. Ecolab has no responsibility to pay any benefits under this Plan for insured options. Benefits for self-insured options are paid from Ecolab's general corporate assets.

Legal Process: Legal process may be served on the Plan Administrator at the following address:

Ecolab Inc.
Attn: General Counsel's Office
1 Ecolab Place
St. Paul, MN 55102

Collective Bargaining Agreements:

A copy of any collective bargaining agreement that provides for participation in this Plan is available for examination.

Provider Lists: Provider lists are furnished automatically, without charge, upon request.

Statement of ERISA Rights

As a participant in this 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

You have the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, 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 operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest Form 5500 and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report, if applicable. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You have the right to continue health care coverage for yourself, spouse or dependents if there is a loss of group health plan coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review *COBRA Continuation Coverage and USERRA Continuation Coverage* on the rules governing your COBRA continuation coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of this 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 benefit provided under this Plan or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, 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.

There are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. 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 Plan Administrator's control. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

If the 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 this 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.

Ecolab Inc.

MEDICAL BENEFITS (OPEN ACCESS PLUS)

EMERGENCY MEDICAL EVACUATION AND REPATRIATION BENEFITS

VISION BENEFITS

DENTAL BENEFITS

EFFECTIVE DATE: January 1, 2025

CN016
04048A
1716080

This document printed in March, 2025 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

Page

Certification **5**

Special Plan Provisions **7**

Important Information **8**

How To File Your Claim **10**

Eligibility - Effective Date **10**

Member Insurance 10

Waiting Period 11

Dependent Insurance 11

Important Information About Your Medical Plan U.S. **11**

Open Access Plus Medical Benefits **12**

The Schedule 12

Certification Requirements U.S. Out-of-Network 36

Prior Authorization/Pre-Authorized U.S. 36

Covered Expenses 37

Emergency Medical Evacuation and Repatriation Benefits **50**

Prescription Drug Benefits Inside the United States **53**

The Schedule 53

Covered Expenses 57

Limitations 57

Your Payments 59

Exclusions 60

Reimbursement/Filing a Claim 61

Prescription Drug Benefits International **62**

The Schedule 62

Covered Expenses 64

Your Payments 64

Exclusions 64

Reimbursement/Filing a Claim 65

Vision Benefits **66**

The Schedule 66

Covered Expenses 67

Expenses Not Covered 67

Cigna Dental Preferred Provider Benefits **68**

The Schedule....68
Covered Dental Expense....70
Participating and Non-Participating Provider....70
Dental Expenses Not Covered....72
Exclusions, Expenses Not Covered and General Limitations....72
Coordination of Benefits....75
Expenses for Which a Third Party May be Responsible....78
Payment of Benefits....80
Termination of Insurance – Members....80
Termination of Insurance - Dependents....81
Medical Benefits Extension....81
Dental Benefits Extension....81
Federal Requirements....82
Notice of Provider Directory/Networks....82
Qualified Medical Child Support Order (QMCSO)....82
Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)....82
Effect of Section 125 Tax Regulations on This Plan....84
Eligibility for Coverage for Adopted Children....85
Coverage for Maternity Hospital Stay....85
Women's Health and Cancer Rights Act (WHCRA)....85
Group Plan Coverage Instead of Medicaid....85
Requirements of Family and Medical Leave Act of 1993 (as amended) (FMLA)....86
Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA)....86
Claim Determination Procedures under ERISA....86
COBRA Continuation Rights Under Federal Law....88
ERISA Required Information....91
Notice of an Appeal or a Grievance....93
Appointment of Authorized Representative....93
When You Have A Complaint Or An Appeal....93
Definitions....98

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 Members for the benefits provided by the following policy(s):

POLICYHOLDER: Wilmington Trust National Association

GROUP: Ecolab Inc.

GROUP POLICY(S) — COVERAGE
04048A - MEDICAL BENEFITS (OPEN ACCESS PLUS)
04048A - EMERGENCY MEDICAL EVACUATION AND REPATRIATION BENEFITS
04048A - VISION BENEFITS
04048A - DENTAL BENEFITS

EFFECTIVE DATE: January 1, 2025

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.
This certificate takes the place of any other issued to you on a prior date which described the insurance.

Geneva Cambell Brown, Corporate Secretary

Explanation of Terms

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

The Schedule

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

Special Plan Provisions

When you select a Participating Provider, the cost for medical services provided will be less than when you select a non-Participating Provider. Participating Providers include Physicians, Hospitals and Other Health Professionals and Other Health Care Facilities. For a list of Participating Providers in your area, visit www.cignaenvoy.com or contact customer service at the phone number listed on the back of your ID card. 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.

GC-SPP10 01-21

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. In addition, the Group, a claim office or a utilization review program (see the Pre-Admission Certification (PAC)/Continued Stay Review (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 are 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.

GC-SPP6 09-19

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 Group. Contact us for details regarding any such arrangements.

GC-SPP7 09-19

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 Group'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.

GC-IMP8 09-19
V1

Federal CAA - Consolidated Appropriations Act Coverage Notice

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 a Group without an integrated pharmacy product aggregated at the market segment and state level, as outlined in guidance.

GC-IMP12 01-23

Continuity of Care

In certain circumstances, if you are receiving continued care from an in-network provider or facility, and that provider's network status changes from in-network to out-of-network, you may be eligible to continue to receive care from the provider at the in-network cost-sharing amount for up to 90 days from the date you are notified of your provider's termination. A continuing care patient is an individual who is:

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

- 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 a surgery.
- determined to be terminally ill and is receiving treatment for such illness from the provider or facility.

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

Appeals

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

Provider Directories and Provider Networks

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

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

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

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

Direct Access to Obstetricians and Gynecologists

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

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 in the United States, 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 in the United States, 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 in the United States, 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 in the United States, 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 in the United States:

- 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 www.cms.gov/nosurprises for more information about your rights under federal law.

GC-IMP14 01-24

How To File Your Claim

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

CLAIM REMINDERS

- BE SURE TO USE YOUR ACCOUNT NUMBER WHEN YOU FILE CIGNA'S CLAIM FORMS, OR WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.
- YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR ID 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 and International Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within one year (365 days) for Out-of-Network benefits or for International 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 one year for Out-of-Network benefits or for International 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.

GC-CLM2 09-19

Eligibility - Effective Date

Member Insurance

This plan is offered to you as a Member.

Eligibility for Member Insurance

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

- you are in a Class of Eligible Members as determined by the Group; and
- you pay any required contribution.

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

None.

Classes of Eligible Members

All active full-time Expatriates, Inpatriates, and Select Key Local Nationals as reported to the insurance company by the Group.

Expatriates means a Member who is working outside his Country of Citizenship (for U.S. citizens, a Member working outside their Home Country or outside the United States for at least 180 days in a consecutive 12 month period that overlaps with the plan year and their covered dependents).

Inpatriates means a Member of the Group who is a citizen of another country working in the United States.

Key Local Nationals means a Member of the Group working and residing within his Country of Citizenship and who the Group has designated as essential to the management of that country's operation.

Persons for whom coverage is prohibited under applicable law or sanctions rules will not be considered eligible under this plan.

Effective Date of Member 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.

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 when you become eligible for Member Insurance and your Dependent(s) become eligible for Dependent Insurance and when you elect it by signing an approved payroll deduction or enrollment form, as applicable.

All of your Dependents as defined will be included.

Your Dependents will be insured only if you are insured.

Exception for Newborns

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

GC-ELG7 01-22

Important Information About Your Medical Plan U.S.

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

Opportunity to Select a Primary Care Physician

Choice of 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.

GC-IMP5 11-18

Open Access Plus Medical Benefits

The Schedule

For You and Your Dependents

Open Access Plus Medical Benefits provide coverage for care inside the United States (in-network and out-of-network) and internationally (outside the United States). To receive Open Access Plus 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 Deductible or Coinsurance, if any.

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

Important Notice on Mental Health and Substance Use Disorder Coverage

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.

Deductibles

Deductibles are Covered Expenses to be paid by you or your Dependent before benefits are payable under this plan. 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 plan year.

Prescription Drug Cost Share

Your Copayment and/or Coinsurance payment, if any, for covered Prescription Drug Products under the Prescription Drug Benefit section counts toward your Out of Network Deductible and counts toward your Out-of-Pocket Maximum.

Any discount that is used to satisfy your Copayment and/or Coinsurance, if any, for covered Prescription Drug Products under the Prescription Drug Benefit section counts toward your Out of Network Deductible and counts toward your Out-of-Pocket Maximum.

Open Access Plus Medical Benefits

The Schedule

Out-of-Pocket-Expenses

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan. The following Expenses contribute to the Out-of-Pocket Maximum, and when the Out-of-Pocket Maximum shown in The Schedule is reached, they are payable by the benefit plan at 100% for the rest of that plan year.

- Coinsurance, if any
- Plan Deductible
- Prescription Drug Copayments and Coinsurance, if any

Once the Out-of-Pocket Maximum is reached for covered services that apply to the Out-of-Pocket Maximum, any copayments are no longer required.

The following Out-of-Pocket Expenses and charges do not contribute to the Out-of-Pocket Maximum, and they are not payable by the benefit plan at 100% when the Out-of-Pocket Maximum shown in The Schedule is reached:

- Non-compliance penalties
- Provider charges in excess of the Maximum Reimbursable Charge

Accumulation of Plan Deductibles and Out-of-Pocket Maximums

Deductibles and Out-of-Pocket Maximums will cross-accumulate between In-Network, Out-of-Network and International. All other plan maximums and service-specific maximums (dollar and occurrence) also cross-accumulate between In-Network, Out-of-Network and International unless otherwise noted.

Multiple Surgical Reduction

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

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

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 in the United States

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.

Open Access Plus Medical Benefits

The Schedule

Out-of-Network Emergency Services Charges in the United States

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 other facility as required by Delaware law, 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.

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 except as described in the arbitration provision. 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 in the United States

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 except as described in the arbitration provision. 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.

Arbitration protections available for services rendered in Delaware – If the Emergency Service is rendered in Delaware, the allowable amount may be based on an agreed-upon or negotiated rate. If the provider and Cigna cannot agree on an allowable amount, Cigna or the provider may request arbitration pursuant to Delaware law. Following arbitration, your cost-share may be recalculated to reflect a reduction or increase in the allowable amount determined by the Arbitrator. The provider may not attempt to collect from you any amount in excess of applicable In-Network cost-sharing amounts based upon the allowable amount.

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Lifetime Maximum	Unlimited		
The Percentage of Covered Expenses the Plan Pays See Definitions section for an explanation of Maximum Reimbursable Charge	80%	60% of the Maximum Reimbursable Charge	80% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Calendar Year Deductible Individual Family **Family Calculation** **Individual Calculation** Family members must 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.	 $750 per person $2,250 per family	 $1,500 per person $4,500 per family	 $0 per person $0 per family
Combined Medical/Pharmacy Calendar Year Deductible	No	Yes	No
Calendar Year Out-of-Pocket Maximum Individual Family Maximum **Family Maximum Calculation** **Individual Calculation:** Family members must 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%.	 $2,250 per person $6,750 per family	 $4,500 per person $13,500 per family	 $2,250 per person $6,750 per family
Combined Medical/Pharmacy Out-of-Pocket Maximum Combined Medical/Pharmacy Out-of-Pocket: includes retail and home delivery drugs	Yes	Yes	Yes

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Combined Medical/Vision Out-of-Pocket Maximum	Yes	Yes	Yes
Emergency Medical Evacuation & Repatriation Benefit Maximum: Unlimited			
Emergency Medical Evacuation	100%	100%	100%
Repatriation Following a Medical Evacuation	100%	100%	100%
Primary Repatriation to the Permanent Residence after a Serious Medical Event	100%	100%	100%
Repatriation of Mortal Remains	100%	100%	100%
Emergency Family Travel Arrangements and Confinement Visitation	100%	100%	100%
Return of Dependent Children	100%	100%	100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Physician's Services			
Physician Office Visit	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Consultant and Referral Physician's Services	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Surgery Performed In the Physician's Office			
Physician Office Visit	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Second Opinion Consultations (provided on a voluntary basis)			
Physician Office Visit	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Allergy Treatment/Injections			
Physician Office Visit	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Preventive Care			
Routine Preventive Care – birth through age 2			
Physician Office Visit Calendar Year Maximum: Unlimited	100%	100% of the Maximum Reimbursable Charge	100%
Routine Preventive Care – ages 3 and over			
Physician Office Visit Calendar Year Maximum: Unlimited	100%	100% of the Maximum Reimbursable Charge	100%
Immunizations – birth through age 17 Calendar Year Maximum: Unlimited	100%	100% of the Maximum Reimbursable Charge	100%
Immunizations – ages 18 and over Calendar Year Maximum: Unlimited	100%	100% of the Maximum Reimbursable Charge	100%
Travel Immunizations	100%	100% of the Maximum Reimbursable Charge	100%
Cancer Screenings			
Preventive Care Related Services (i.e. “routine” services)	100%	100% of the Maximum Reimbursable Charge	100%
Diagnostic Related Services (i.e. “non-routine” services)	100%	100% of the Maximum Reimbursable Charge	100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Inpatient Hospital - Facility Services	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Semi-Private Room and Board	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate	Limited to the semi-private room rate
Private Room	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate	Limited to the semi-private room rate. (Private room covered outside the United States only if no semi-private room equivalent is available).
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate	Limited to the ICU/CCU daily room rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Inpatient Hospital Physician's Visits/Consultations	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Inpatient Professional Services			
Surgeon	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Radiologist	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Pathologist	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Anesthesiologist	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Outpatient Professional Services			
Surgeon	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Radiologist	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Pathologist	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Anesthesiologist	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Emergency Services and Urgent Care			
Urgent Care Services			
Urgent Care Facility Includes Outpatient Professional Services X-ray and/or Lab performed at the Urgent Care Facility (billed by the facility as part of the UC visit) Services billed as Emergency Services by an Urgent Care provider will be payable at the In-Network level.	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Advanced Radiological Imaging (i.e., MRIs, MRAs, CAT Scans, PET Scans, etc.) billed by the facility as part of the UC visit	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Emergency Services			
Hospital Emergency Room Includes Outpatient Professional Services and X-ray and/or Lab performed at the Emergency Room (billed by the facility as part of the ER visit)	Plan Deductible, then 80%	Plan Deductible, then 80%	80%
Advanced Radiological Imaging (i.e., MRIs, MRAs, CAT Scans, PET Scans, etc.) billed by the facility as part of the ER visit	Plan Deductible, then 80%	Plan Deductible, then 80%	80%
Air Ambulance	Plan Deductible, then 100%	Plan Deductible, then 100%	80%
Ambulance	Plan Deductible, then 100%	Plan Deductible, then 100% of the Maximum Reimbursable Charge	80%
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: 120 days combined	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Laboratory Services			
Physician Office Visit	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Outpatient Facility	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Laboratory Services at an Independent Lab facility	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Radiology Services			
Physician Office Visit	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Outpatient Facility	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Advanced Radiological Imaging (i.e. , MRIs, MRAs, CAT Scans and PET Scans)			
Physician Office Visit	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Inpatient Facility	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Outpatient Facility	Plan Deductible then, 80%	Plan Deductible then, 60% of the Maximum Reimbursable Charge	80%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Outpatient Therapy Services			
Physician Office Visit	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Outpatient Hospital Facility	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Calendar Year Maximum: 60 days for all therapies combined (The limit is not applicable to Mental Health and Substance Use Disorder conditions.) **Note:** The Outpatient Therapy Services maximum does not apply to the treatment of autism Includes: Cardiac Rehab Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy			
Outpatient Physical/Physio Therapy			
Physician Office Visit	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Outpatient Hospital Facility	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Calendar Year Maximum: Unlimited			
Chiropractic Care			
Physician Office Visit	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Calendar Year Maximum: Unlimited			

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Home Health Care Services Calendar Year Maximum: 120 days (includes outpatient private nursing when approved as Medically Necessary) The limit is not applicable to Mental Health and Substance Use Disorder conditions.	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Hospice			
Inpatient Services	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Outpatient Services (same coinsurance level as Home Health Care Services)	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Bereavement Counseling Services provided as part of Hospice Care			
Inpatient	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Outpatient	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Services provided by Mental Health Professional	Covered under Mental Health benefit	Covered under Mental Health benefit	Covered under Mental Health benefit

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Gene Therapy Includes prior authorized gene therapy products and services directly related to their administration, when Medically Necessary. Gene Therapy is only covered in the United States when received at a provider contracted with Cigna for the specific gene therapy product and related services.			
Gene Therapy Product	Covered same as Medical Pharmaceuticals	In-Network Coverage Only	Covered same as Medical Pharmaceuticals
Inpatient Facility	Plan Deductible, then 80%	In-Network Coverage Only	80%
Outpatient Facility	Plan Deductible, then 80%	In-Network Coverage Only	80%
Travel Maximum $10,000 per episode of gene therapy	100% (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)	In-Network Coverage Only	In-Network Coverage Only

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Advanced Cellular Therapy Includes prior authorized advanced cellular therapy products and related services when Medically Necessary. Advanced cellular therapy is only covered in the United States when received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services.			
Advanced Cellular Therapy Product	Covered same as Medical Pharmaceuticals	In-Network Coverage Only	Covered same as Medical Pharmaceuticals
Inpatient Facility	Plan Deductible, then 80%	In-Network Coverage Only	80%
Outpatient Facility	Plan Deductible, then 80%	In-Network Coverage Only	80%
Advanced Cellular Therapy Travel Maximum: $10,000 per episode of advanced cellular therapy (Available only for travel when prior authorized to receive advanced cellular therapy from a provider located more than 60 miles of your primary residence and is contracted with Cigna for the specific advanced cellular therapy product and related services.)	100%	In-Network Coverage Only	In-Network Coverage Only

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Maternity Care Services			
Initial Visit to Confirm Pregnancy Physician Office Visit	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Delivery - Facility			
Inpatient Hospital	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Birthing Center	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Abortion Includes elective and non-elective procedures			
Physician Office Visit	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Inpatient Facility	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Outpatient Facility	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Women's Family Planning Services			
Office Visits and Counseling	100%	100% of the Maximum Reimbursable Charge	100%
Lab and Radiology Tests	100%	100% of the Maximum Reimbursable Charge	100%
Surgical Sterilization Procedure for Tubal Ligation (excludes reversals)			
Physician Office Visit	100%	100% of the Maximum Reimbursable Charge	100%
Inpatient Facility	100%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Outpatient Facility	100%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Men's Family Planning Services			
Office Visits and Counseling	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Lab and Radiology Tests	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Surgical Sterilization Procedures for Vasectomy (excludes reversals)			
Physician Office Visit	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Inpatient Facility	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Outpatient Facility	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Infertility, Fertility and Conception Services			
Physician's Office Visit and Counseling	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Lab and Radiology Tests	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Inpatient Facility	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Outpatient Facility	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Transplant Services and Related Specialty Care Includes all medically appropriate, non-experimental transplants			
Physician Office Visit	Plan Deductible, then 80%	In-Network Coverage Only	80%
Inpatient Facility	Plan Deductible, then 80%	In-Network Coverage Only	80%
Travel Maximum: $10,000 per transplant	100% (only available when using Cigna LifeSOURCE Transplant Network® facilities)	In-Network Coverage Only	In-Network Coverage Only
Durable Medical Equipment Calendar Year Maximum: Unlimited	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
External Prosthetic Appliances Calendar Year Maximum: Unlimited	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Hearing Exam Includes hearing exams, diagnosis, testing and fitting of hearing aid devices One examination per 24 month period	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Hearing Aids One hearing aid necessary for each hearing impaired ear up to $1,000 per hearing aid every - 3 years for a dependent child under age 24	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Insulin Pumps Calendar Year Maximum: Unlimited	100%	100% of the Maximum Reimbursable Charge	100%
Blood Glucose Meters Calendar Year Maximum: Unlimited For In-Network and International, your cost share is capped at $35 per person per month, regardless of the amount or types of diabetes equipment or supplies needed.	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Diabetic Supplies For In-Network and International, your cost share is capped at $35 per person per month, regardless of the amount or types of diabetes equipment or supplies needed.	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Wigs (for hair loss due to alopecia areata) Calendar Year Maximum: $500	100%	100% of the Maximum Reimbursable Charge	100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Nutritional Counseling Calendar Year Maximum: 3 visits; the visit limit does not apply to treatment of diabetes and to Mental Health and Substance Use Disorder conditions			
Physician Office Visit	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Inpatient Facility	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Outpatient Facility	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Nutritional Formulas Unlimited	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Genetic Counseling Calendar Year Maximum: 3 visits; for counseling, pre- and post-genetic testing; the visit limit does not apply to Mental Health and Substance Use Disorder conditions			
Physician Office Visit	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Inpatient Facility	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Outpatient Facility	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an Injury to teeth.			
Physician Office Visit	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Inpatient Facility	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Outpatient Facility	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
TMJ Surgical and Non-surgical Always includes appliances and excludes orthodontic treatment. Subject to medical necessity. Lifetime Maximum (includes office visits, surgery, x-rays/advanced radiological imaging and appliances): $1,000			
Physician Office Visit	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
X-rays and Radiology Tests	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Advanced Radiological Imaging	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Surgery	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Appliances	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Dental Services for Children with Severe Disabilities Medically Necessary specialized treatment and support to secure effective access to dental care for children under age 21 with severe disabilities will be provided at the In-Network benefit level.			

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Obesity/Bariatric Surgery **Note:** Coverage is provided subject to medical necessity and clinical guidelines subject to any limitations shown in the "Exclusions, Expenses Not Covered and General Limitations" section of this certificate. Contact Cigna prior to incurring such costs.			
Physician Office Visit	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Inpatient Facility	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Outpatient Facility	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Surgical Professional Services Lifetime Maximum: $10,000 **Notes:** • Includes charges for surgeon only; does not include radiologist, anesthesiologist, etc. • Only surgical services accumulate to the maximum.			
Acupuncture Medically Necessary treatment of pain or disease by acupuncture provided on an outpatient basis Calendar Year Maximum: Unlimited	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Alternative Therapies and Non-traditional Medical Services Herbalist, Massage Therapist, Naturopath Physician Office Visit Combined Calendar Year Maximum: $1,000 (The limit is not applicable to Mental Health and Substance Use Disorder conditions.)	Not Covered	Not Covered	80%
Routine Foot Disorders Not covered except for services associated with foot care for diabetes, peripheral neuropathies and peripheral vascular disease when Medically Necessary.			
Mental Health			
Inpatient Includes Acute Inpatient and Residential Treatment Calendar Year Maximum: Unlimited	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Outpatient Outpatient – Office Visits Includes individual, family and group psychotherapy; medication management Calendar Year Maximum: Unlimited	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, Applied Behavior Analysis (ABA Therapy), Transcranial Magnetic Stimulation (TMS), etc. Calendar Year Maximum: Unlimited	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Substance Use Disorder			
Inpatient Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment Calendar Year Maximum: Unlimited	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Outpatient Outpatient – Office Visits Includes individual, family and group psychotherapy, medication management Calendar Year Maximum: Unlimited	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%
Outpatient - All Other Services Includes Outpatient Detoxification, Partial Hospitalization, Intensive Outpatient Services, etc. Calendar Year Maximum: Unlimited	Plan Deductible, then 80%	Plan Deductible, then 60% of the Maximum Reimbursable Charge	80%

Certification Requirements U.S. Out-of-Network

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the Medical Necessity and length of a Hospital Confinement when you or your Dependent require treatment in a Hospital:

- as a registered bed patient; except for 48/96 hour maternity stays;
- for Mental Health or Substance Use Disorder Residential Treatment Services.

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. CSR should be requested, prior to the end of the certified length of stay, for continued Hospital Confinement.

Covered Expenses incurred for which benefits would otherwise be payable under this plan for the charges listed below will not include:

- any Hospital charges for treatment listed above for which PAC was requested, but which was not certified as Medically Necessary.

PAC and CSR are performed through a utilization review program by a Review Organization with which Cigna has contracted.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Outpatient Certification Requirements - U.S. Out of Network

Outpatient Certification refers to the process used to certify the Medical Necessity of outpatient diagnostic testing and outpatient procedures, including, but not limited to, those listed in this section when performed as an outpatient in a Free-Standing Surgical Facility, Other Health Care Facility, or a Physician's office. You or your Dependent should call the toll-free number on the back of your ID card to determine if Outpatient Certification is required prior to any outpatient diagnostic testing or outpatient procedures. Outpatient Certification is performed through a utilization review program by a Review Organization with which Cigna has contracted. Outpatient Certification should only be requested for non-emergency procedures or services, and should be requested by you or your Dependent at least four working days (Monday through Friday) prior to having the procedure performed or the service rendered.

Covered Expenses incurred will not include expenses incurred for charges made for outpatient diagnostic testing or outpatient procedures for which Outpatient Certification was performed, but, which was not certified as Medically Necessary.

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

Outpatient Diagnostic Testing, and Outpatient Procedures

Including, but not limited to:

- advanced radiological imaging – CT Scans, MRI, MRA or PET scans.
- home health care services.
- Medical Pharmaceuticals.
- radiation therapy.

Prior Authorization/Pre-Authorized U.S.

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy.

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

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

Coverage includes immediate access, without Prior Authorization, to a 5-day emergency supply of covered, prescribed medications for the Medically Necessary treatment of Mental Health and Substance Use Disorder, where an Emergency Medical Condition exists. The emergency supply requirement includes prescribed medications for opioid overdose reversal that are otherwise covered under the health benefit plan.

GC-PRA4 01-21
V3

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, as determined by Cigna and that are not otherwise excluded from coverage by the terms of this policy, and
- as determined by Cigna, Medically Necessary Covered Expenses may also include charges for generally accepted medical standards of care and practice.

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

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

Covered Expenses

- 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 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 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 Emergency Services.
- charges for Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges incurred in Delaware for School Based Health Centers (SBHCs) at the rate established by the Divisions of Medicaid and Medical Assistance, or an agreed to network participating provider rate.
- 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 made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for family planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception; injected contraceptives; insertion, removal and Medically Necessary examination for the use of implanted contraceptives; and after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
- charges made for preventive care services as defined by recommendations from the following:
  - the U.S. Preventive Services Task Force (A and B recommendations);
  - the Advisory Committee on Immunization Practices (ACIP) for immunizations;
  - 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 made for surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ) including appliances and excluding orthodontic treatment.

Cancer Screenings

- charges made for or in connection with mammograms including; a baseline mammogram for asymptomatic women at least age 35; a mammogram every one or two years for a-symptomatic women ages 40-49, but no sooner than two years after a woman's baseline mammogram; an annual mammogram for women age 50 and over; and when prescribed by a Physician, a mammogram, anytime, regardless of the woman's age. Mammogram means a diagnostic or screening mammography exam using a low-dose X-ray to produce an image of the breast.

  Coverage is also provided for diagnostic breast examinations and supplemental breast screening examinations.

  Diagnostic breast examination means a Medically Necessary and clinically appropriate examination of the breast, including such examination using breast MRI, breast ultrasound, or mammogram, that is used for either of the following:

  - to evaluate an abnormality seen or suspected from a screening examination for breast cancer; or
  - to evaluate an abnormality detected by another means of examination.

  Supplemental breast screening examination means a Medically Necessary and clinically appropriate examination of the breast, including such examination using breast MRI, breast ultrasound, or mammogram, that is used for either of the following:

  - to screen for breast cancer when there is no abnormality seen or suspected in the breast; or
  - based on personal or family medical history or additional factors that may increase the individual's risk of breast cancer.

  Breast magnetic resonance imaging or breast MRI means a diagnostic tool, including standard and abbreviated breast MRI, that uses radio waves and magnets to produce detailed images of structures within the breast. A breast MRI may be used as a screening tool when clinically indicated, including after indeterminant results from a mammogram that requires additional evaluation and for those at high risk for breast cancer.

  Breast ultrasound means a noninvasive diagnostic tool that uses high-frequency sound waves and their echoes to produce detailed images of structures within the breast. A breast ultrasound may be used as a screening tool when clinically indicated, including after indeterminant results from a mammogram that requires additional evaluation and for those at high risk for breast cancer.

- charges made for an annual Papanicolaou laboratory screening (PAP) test.
- colorectal cancer screening for persons 45 years of age or older or those at high risk of colon cancer because of family history of familial adenomatous polyposis; family history of hereditary non-polyposis colon cancer; chronic inflammatory bowel disease; family history of breast, ovarian, endometrial, colon cancer or polyps; or a background, ethnicity or lifestyle such that the health care provider treating the participant or beneficiary believes he or she is at elevated risk. Coverage will include screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging or other screening modalities, provided as determined by the Secretary of Health and Social Services of Delaware after consideration of recommendations of the Delaware Cancer Consortium and the most recently published recommendations established by the American College of Gastroenterology, the American Cancer Society, the United States Preventive Task Force Services, for the ages, family histories and frequencies referenced in such recommendations and deemed appropriate by the attending Physician. Also included is the use of anesthetic agents, including general anesthesia, in connection with colonoscopies and endoscopies performed in accordance with generally accepted standards of medical practice and all applicable patient safety laws and regulations, if the use of such anesthetic agents is Medically Necessary in the judgment of the treating Physician.
- charges made for an annual prostate screening (PSA) for men 50 and older.
- charges for monitoring tests for ovarian cancer subsequent to ovarian cancer treatment, and annual screening tests for women at risk for ovarian cancer.

At risk for ovarian cancer means any of the following:

- having a family history of any of the following:
  - one or more first- or second-degree relatives with ovarian cancer; clusters of women relatives with breast cancer; nonpolyposis colorectal cancer; or breast cancer in a male relative;
  - testing positive for any of the following genetic mutations: BRCA1 or BRCA2; or Lynch syndrome; or
  - having a personal history of any of the following: Ovarian cancer; Endometriosis; Unexplained infertility; Uterine Fibroids; or Polycystic ovarian syndrome.

Monitoring tests and screening tests means tests and examinations for ovarian cancer using any of the following methods that are recommended by a patient's Physician:

- tumor marker tests supported by national clinical guidelines, national standards of care, or peer reviewed medical literature;
- transvaginal ultrasound; pelvic examination or other screening tests supported by national clinical guidelines, national standards of care, or peer reviewed medical literature.

- charges for developmental screenings at ages 9 months, 18 months and 30 months. Developmental screenings are any developmental screening tool favorably mentioned in the American Academy of Pediatrics Committee on Children with Disabilities paper on "Developmental Surveillance and Screening of Infants and Young Children" or any other program judged by the Department of Health and Social Services to be an equivalent program.
- charges for newborn screenings.
- charges made for or in connection with baseline lead poison screening or testing, or in connection with lead poison screening, testing, diagnostic evaluation, screening and testing supplies, and home visits for children who are at high risk for lead poisoning according to guidelines set by the Division of Public Health.
- charges for treatment of pediatric autoimmune disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including the use of intravenous immunoglobulin therapy is required.
- charges for hearing loss screening tests of newborns and infants provided by a Hospital before discharge.
- charges for the treatment of diabetes as recommended in writing or prescribed by a Physician or Other Health Professional, including:
  - insulin pumps, blood glucose meters and diabetes self-management training;
  - alcohol pads, swabs, wipes, Glucagon/Glucagen, injection aids, insulin pump accessories, needles including pen needles, syringes, test strips, lancets, urine glucose and ketone strips; and
  - insulin and pharmacological agents for controlling blood sugar.
- Ambulance runs and associated basic life support (BLS) services provided by a volunteer ambulance company.
- scalp hair prostheses and wigs worn due to alopecia areata.
- charges for smoking cessation treatment.
- charges for chronic care management services. In-Network and International services will not be subject to any Copay, Coinsurance or Deductible.
- charges made for Medically Necessary treatment of pain or disease by acupuncture provided on an outpatient basis. Acupuncture services that are not covered include but are not limited to maintenance or treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status.
- charges made for hearing aids for Dependent children up to age twenty-four (24).
- charges made for routine hearing exams as shown in The Schedule.
- charges made for an annual behavioral health well check. Behavioral health well check means a pre-deductible annual visit with a licensed mental health clinician. The behavioral health well check must include, but is not limited to:
  - a review of medical history;
  - evaluation of adverse childhood experiences;
  - use of a group of developmentally appropriate mental health screening tools; and
  - an anticipatory behavioral health guidance congruent with stage of life.
- charges made for or in connection with travel immunizations for Members and their Dependents.
- charges for treatment of autism spectrum disorder including the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed Physician or a licensed Psychologist: behavioral health treatment; pharmacy care; psychiatric care; psychological care; therapeutic care; items and equipment necessary to provide, receive, or advance in the above listed services, including those necessary for applied behavioral analysis; and any care for individuals with autism spectrum disorders that is determined by the Secretary of the Department of Health

and Social Services, based upon their review of best practices and/or evidence-based research, to be Medically Necessary.

- Medically Necessary orthognathic surgery to repair or correct a severe facial deformity or disfigurement.
- charges for Medically Necessary specialized treatment and support to secure access to dental care for children under age 21 with severe disabilities due to significant mental or physical condition, illness or disease.
- charges for the delivery of telehealth services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient's health care by a health care provider legally allowed to practice in the state or country and practicing within the health care provider's scope of practice as would be practiced in-person with a patient, while such patient is at an originating site and the health care provider is at a distant site.
  - **Distant site** means a site at which a health care provider legally allowed to practice in the state or country is located while providing health care services by means of telemedicine or telehealth.
  - **Originating site** means a site at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth.
  - **Store and forward transfer** means the synchronous or asynchronous transmission of a patient's medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time.

Genetic Counseling

Charges for genetic counseling for an individual who is undergoing genetic testing or is a potential candidate for genetic testing. May be performed prior to and/or following the genetic test.

Nutritional Counseling

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

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

Coverage includes medically approved formulas and foods, low protein modified formulas and modified food products, consumed or administered enterally (via tube or orally), which are prescribed as Medically Necessary by a Physician for treatment of inborn errors of metabolism (e.g. disorders of amino acid or organic acid metabolism), and the therapeutic treatment of inherited metabolic diseases, such as phenylketonuria (PKU), when administered under the direction of a Physician.

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.

Alternative Therapies and Non-traditional Medical Services - Outside the U.S.

Charges for Alternative Therapies and Non-traditional medical services are limited to the amount shown in The Schedule. Alternative Therapies and Non-traditional medicine include services provided by an Herbalist, Naturopath, or Massage Therapist for Massage Therapy, when these services are provided for a covered condition outside the U. S. in accordance with customary local practice and the practitioner is operating within the scope of his/her license, and the treatment is Medically Necessary, cost-effective, and provided in an appropriate setting.

GC-COV76 01-24

Obesity Treatment

- charges made for medical and surgical services for the treatment or control of clinically severe (morbid) obesity as defined below and if the services are demonstrated, through existing peer reviewed, evidence based, scientific literature and scientifically based guidelines, to be safe and effective for the treatment or control of the condition. Clinically severe (morbid) obesity is defined by the National Heart, Lung and Blood Institute (NHLBI) as a Body Mass Index (BMI) of 40 or greater without comorbidities, or a BMI of 35-39 with comorbidities. The following items are specifically excluded:
  - medical and surgical services to alter appearances or physical changes that are the result of any medical or surgical services performed for the treatment or control of obesity or clinically severe (morbid) obesity; and
  - weight loss programs or treatments, whether or not they are prescribed or recommended by a Physician or under medical supervision.

GC-COV2 11-18

Home Health Care Services

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

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

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

Covered services include:

- Skilled nursing services provided by a Registered Nurse (RN); Licensed Practical Nurse (LPN); Licensed Vocational Nurse (LVN) and an Advanced Practice Registered Nurse (APRN).
- Services provided by health care providers such as physical therapist; occupational therapist and 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.
- Private duty nursing services when determined to be medically necessary.

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.

GC-COV47 01-21

Hospice Care Services

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

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

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

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

- part-time or intermittent nursing care by or under the supervision of a Nurse;
- part-time or intermittent services of an Other Health Professional;
- physical, occupational and speech therapy;
- medical supplies;
- drugs and medicines lawfully dispensed only on the written prescription of a Physician;
- laboratory services;

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

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

- services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- services for any period when you or your Dependent 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.

GC-COV59 01-22

Mental Health and Substance Use Disorder Services

The plan covers charges for mental health and substance use disorder services.

Mental Health Disorders are conditions which consider the following factors as defined in the current version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM):

- a behavioral or psychological syndrome or pattern that occurs in an individual.
- reflects an underlying psychobiological dysfunction.
- the consequences of which are clinically significant distress (such as a painful symptom) or disability (such as impairment in one or more important areas of functioning).
- must not be merely an expected response to common stressors and losses (such as loss of a loved one) or a culturally sanctioned response to a particular event (such as trance states in religious rituals).
- primarily a result of social deviance or conflicts with society.

Substance Use Disorders involve patterns of symptoms caused by using a substance that an individual continues taking despite its negative effects, considering the following factors as defined in the current version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM):

- using more of a substance than intended or using it for longer than a person is meant to use it.
- trying to cut down or stop using the substance, but unable to do so.
- experiencing intense cravings or urges to use the substance.
- needing more of the substance to get a desired effect, also referred to as tolerance.
- developing withdrawal symptoms when not using the substance.
- spending more time getting and using drugs and recovering from substance use.
- neglecting responsibilities at home, work, or school because of substance use.
- continuing to use the substance despite the substance causing problems to physical or mental health.
- giving up important or desirable social and recreational activities due to substance use.
- using substances in risky settings that put you or your Dependent in danger.

Inpatient Mental Health Services (including Mental Health Acute Inpatient Services and Mental Health Residential Treatment Services)

Mental Health Acute Inpatient Services are services provided by a Hospital while you or your Dependent are Confined in a Hospital for evaluation and treatment of an acute Mental Health Disorder.

Mental Health Residential Treatment Services are services provided by a Hospital or Mental Health Residential Treatment Center while you or your Dependent are Confined in a Hospital or Residential Treatment Center for the evaluation and treatment of a subacute Mental Health Disorder.

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of a Mental Health 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 Mental Health Residential Treatment Center.

Outpatient Mental Health Services (including Mental Health Partial Hospitalization and Mental Health Intensive Outpatient Services)

Outpatient Mental Health Services are services provided by providers who are licensed or certified in accordance with the laws of the appropriate legally authorized agency and qualified to treat Mental Health Disorders when treatment is provided on an outpatient basis, while you or your Dependent are not Confined in a Hospital or Mental Health Residential Treatment Center, for evaluation and treatment of a Mental Health Disorder.

Mental Health Partial Hospitalization Services are active, time-limited, ambulatory mental health treatment programs that offer therapeutically intensive, structured, and coordinated clinical services for Mental Health Disorders, similar in intensity to that provided in an Inpatient Hospital or Mental Health Residential Treatment Center, but for individuals who

can maintain personal safety with support systems in the community.

Mental Health Intensive Outpatient Services are active, time-limited, ambulatory mental health treatment programs that offer structured and coordinated, multi-disciplinary clinical services for Mental Health Disorders for individuals who can maintain personal safety with support systems in the community, and who can maintain some ability to fulfill family, student or work activities.

Inpatient Substance Use Disorder Services (including Acute Inpatient Detoxification, Substance Use Disorder Inpatient Rehabilitation, Substance Use Disorder Residential Treatment Services)

Acute Inpatient Detoxification Services are services provided by a Hospital or Substance Use Disorder Residential Treatment Center for around-the-clock, intensive management and monitoring of individuals requiring acute detoxification as the initial phase of evaluation and treatment for a Substance Use Disorder.

Substance Use Disorder Inpatient Treatment Services are services provided by a Hospital while you or your Dependent are Confined in a Hospital for evaluation and treatment of an acute Substance Use Disorder.

Substance Use Disorder Residential Treatment Services are services provided by a Hospital or Substance Use Disorder Residential Treatment Center while you or your Dependent are Confined in a Hospital or Residential Treatment Center for evaluation and treatment of a subacute Substance Use Disorder.

Substance Use Disorder Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of a 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 Substance Use Disorder Residential Treatment Center.

Outpatient Substance Use Disorder Rehabilitation Services (including Outpatient Detoxification, Substance Use Disorder Partial Hospitalization, and Substance Use Disorder Intensive Outpatient Services)

Outpatient Substance Use Disorder Services are services provided by providers who are licensed or certified in accordance with the laws of the appropriate legally authorized agency and qualified to treat Substance Use Disorders when treatment is provided on an outpatient basis, while you or your Dependent are not Confined in a Hospital or Substance Use Disorder Residential Treatment Center, for evaluation and treatment of a Substance Use Disorder.

Substance Use Disorder Partial Hospitalization Services are active, time-limited, ambulatory substance use disorder treatment programs that offer therapeutically intensive, structured, and coordinated clinical services for Substance Use Disorders, similar in intensity to that provided in an Inpatient Hospital or Substance Use Disorder Residential Treatment Center, but for individuals who can maintain personal safety with support systems in the community.

Substance Use Disorder Intensive Outpatient Services are active, time-limited, ambulatory substance use disorder treatment programs that offer structured and coordinated, multi-disciplinary clinical services for Substance Use Disorders for individuals who can maintain personal safety with support systems in the community, and who can maintain some ability to fulfill family, student or work activities.

Substance Use Disorder Detoxification Services are services provided for daily, active comprehensive management and monitoring of individuals requiring detoxification as part of evaluation and treatment of a Substance Use Disorder, but that do not require a person to be Confined in a Hospital or Substance Use Disorder Residential Treatment Center.

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 the 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 nonpower mattresses, custom mattresses and posturepedic mattresses.

- **Bath Related Items**: bath lifts, nonportable 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.

GC-COV64 01-22

External Prosthetic Appliances and Devices

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

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

Prostheses/Prosthetic Appliances and Devices

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

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

Orthoses and Orthotic Devices

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

- Nonfoot orthoses – only the following nonfoot orthoses are covered:
  - rigid and semirigid custom fabricated orthoses,
  - semirigid 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.

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;
- replacement due to a surgical alteration or revision of the impacted site.

The following are specifically excluded external prosthetic appliances and devices:

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

GC-COV55 01-21

Infertility, Fertility and Conception Services

- charges made for services related to:
  - diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed.
  - services related to enabling conception regardless of an infertility diagnosis.
  - fertility preservation for individuals at verified risk of iatrogenic infertility due to surgery, radiation, chemotherapy, or other medical treatment, and to enable conception.

Services include, but are not limited to: fertility drugs which are administered or provided by a Physician; cryopreservation, storage, and thawing of sperm, eggs, embryos, and ovarian and testicular tissue; 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; intrauterine insemination/artificial insemination; diagnostic evaluations; assisted reproductive techniques (ART) including in vitro fertilization (IVF); and the services of an embryologist.

Infertility is defined as a disease or condition that results in impaired function of the reproductive system whereby an individual is unable to procreate or carry a pregnancy to live birth.

Certain services related to the treatment of infertility are subject to Medical Necessity review as permitted by state law.

The following are specifically excluded services:

- reversal of male and female voluntary sterilization;
- infertility services when the infertility is caused by or related to voluntary sterilization;
- donor charges, donor services, and donor eggs, sperm, and embryos; and
- services for fertility preservation, including harvesting, cryopreservation, and storage absent a diagnosis of infertility or iatrogenic infertility and to enable conception.

GC-COV78 01-24

Outpatient Therapy Services

Charges for the following therapy services when provided as part of a program of treatment: **Cognitive Therapy, Occupational Therapy, Osteopathic Manipulation, Physical Therapy, Pulmonary Rehabilitation, Speech Therapy**

Cardiac Rehabilitation

- Charges for Phase II cardiac rehabilitation provided on an outpatient basis following diagnosis of a qualifying cardiac condition when Medically Necessary. Phase II is a Hospital-based outpatient program following an inpatient Hospital discharge. The Phase II program must be Physician directed with active treatment and EKG monitoring.

Phase III and Phase IV cardiac rehabilitation are 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 treatment for therapy (other than physical therapy or Chiropractic Care) 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.

GC-COV49 01-21

Breast Reconstruction and Breast Prostheses

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

Reconstructive Surgery

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

GC-COV13 11-18

Transplant Services and Related Specialty Care

- charges approved by medical management for human organ and tissue transplant services including solid organ and bone marrow/stem cell procedures are covered 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 at the U.S. In-Network level when received at Cigna LifeSOURCE Transplant Network® facilities.
- Transplant services and related specialty care services received at Participating Provider facilities in the United States specifically contracted with Cigna for the requested transplant services and related specialty care services are payable at the U.S. In-Network level.
- Transplant services and related specialty care services received outside the United States are covered at the International level.
- Transplant services and related specialty care services received at any other facility, including non-Participating Provider facilities and Participating Provider facilities in the United States not specifically contracted with Cigna for the requested transplant services and related specialty care services, are not covered.
- Cornea transplants received at a facility in the United States, that is specifically contracted with Cigna for this type of transplant are payable at the U.S. In-Network level.

Charges for gene therapy products and services directly related to their administration are not covered under the Transplant Services and Related Specialty Care benefit.

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 In-Network coverage only

Charges made for non-taxable travel expenses incurred by you in connection with a preapproved 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 preapproved organ/tissue transplant and/or related specialty care from a designated Cigna LifeSOURCE Transplant Network® facility.
- The term recipient is defined to include a person receiving authorized transplant related services during any of the following: evaluation, candidacy transplant event, or post-transplant care.
- Travel expenses for the person receiving the transplant will include charges for: transportation to and from the designated Cigna LifeSOURCE Transplant Network® facility (including charges for a rental car used during a period of care at the designated Cigna LifeSOURCE Transplant Network® facility); and lodging while at, or traveling to and from the designated 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 and Related Specialty Care Services and for Transplant and Related Specialty Care Travel Services are only available when the covered person is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above. Charges for the expenses of a donor companion are not covered. No transplant and related specialty care services or travel benefits are available when the covered person is the donor for an organ/tissue transplant; the transplant recipient's plan would cover all donors costs.

GC-COV79 01-24

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 U. S. 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 in the United States that is not contracted with Cigna for the specific advanced cellular therapy product and related services are not covered.

Advanced cellular therapy products and their administration received from a provider outside the United States are covered at the International benefit level when prior authorized.

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 a 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.

GC-COV75 01-23

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.

Step Therapy does not apply to FDA approved cancer drugs for the treatment of stage 4 metastatic cancer or any other cancer.

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.

For a complete list of covered Medical Pharmaceuticals visit the website shown on your ID card or call the number on the back of your ID Card.

GC-COV72 01-23

Gene Therapy

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

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

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

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

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

Gene therapy products and their administration received from a provider outside the United States are covered at the International benefit level when prior authorized.

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.

GC-COV74 01-23

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.

Clinical trials conducted by Out-of-Network providers will be covered only when the following conditions are met:

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

HC-COV62 01-22

Emergency Medical Evacuation and Repatriation Benefits

Expenses incurred for evacuation or repatriation without the approval and authorization of Cigna, and/or its designee will not be Covered Expenses. Only those expenses approved by

Cigna will be eligible for coverage and/or reimbursement under the terms of your plan.

If you or your Dependent suffer a medical emergency and, Cigna, and/or its designee, determines that appropriate medical facilities are not available locally, Cigna may arrange for an evacuation to the nearest appropriate facility.

You or your Dependent must contact Cigna at the phone number indicated on your ID card to begin this process. In making their determinations, Cigna, and/or its designee, will consider the nature of the emergency, your condition and ability to travel, as well as other relevant circumstances including airport availability, weather conditions, and distance to be covered.

Transportation will be provided by medically equipped specialty aircraft, commercial airline, train or Ambulance depending upon the medical needs and available transportation specific to the specific Medical Necessity of each case.

Repatriation Following a Medical Evacuation

Covered Expenses

Following any covered emergency medical evacuation, Cigna will pay for one of the following:

- if it is deemed Medically Necessary and appropriate by the Cigna medical director, you or your Dependent will be transferred to your permanent residence via a one-way economy airfare; or
- you or your Dependent will be transferred back to your original work location or the location from which you were evacuated via a one-way economy airfare.

If your transportation needs to be medically supervised a qualified medical attendant will escort you. Additionally, if Cigna, and/or its designee, determines a mode of transport other than economy class seating on a commercial aircraft is required for Medical Necessity reasons, Cigna, or its designee, will arrange accordingly and such will be covered by Cigna.

Primary Repatriation to the Permanent Residence after a Serious Medical Event

Following a serious medical event, if it is deemed Medically Necessary and appropriate by the Cigna medical director, Cigna may pay for you or your Dependent to be transferred to your permanent residence via a one-way economy airfare.

If the Cigna medical director determines that transportation needs to be medically supervised a qualified medical attendant will escort you. Additionally, if Cigna, determines a mode of transport other than economy class seating on a commercial aircraft is required for Medical Necessity reasons, Cigna, or its designee, will arrange accordingly and such will be covered by Cigna.

Repatriation of Mortal Remains

The costs associated with the transportation of mortal remains from the place of death to the Home Country will be covered. In addition, assistance will be provided by Cigna, or its designee, for organizing or obtaining the necessary clearances for the repatriation of mortal remains.

Emergency Family Travel Arrangements and Confinement Visitation

If Cigna determines that you or your Dependent is expected to require hospitalization in excess of 7 days at the location to which you will be evacuated, an economy round-trip airfare will be provided to the place of hospitalization for an individual chosen by you. If a Dependent child is evacuated, one economy round-trip airfare will be provided to a parent or legal guardian regardless of the number of days that the Dependent child is hospitalized. Only those expenses approved by Cigna and/or its designee prior to occurrence will be eligible for coverage and reimbursement under the terms of your plan.

Return of Dependent Children

If dependent child(ren) are left unattended by virtue of the evacuee's absence following a covered evacuation, a one-way economy airfare will be provided to their place of residence or that of an individual chosen by you.

Exclusions

No payment will be made for charges for:

- services rendered without the authorization or intervention of Cigna, or its designee.
- non-emergency routine or minor medical problems, tests and exams where there is no clear or significant risk of death or imminent serious Injury or harm to you.
- a condition which would allow for treatment at a future date convenient to you and which does not require emergency medical evacuation or repatriation.
- medical care or services scheduled for a member or a providers convenience which are not considered an emergency.
- expenses incurred if the original or ancillary purpose of your trip is to obtain medical treatment.
- services provided for which no charge is normally made.
- expenses incurred while serving in the armed forces of another country.
- transportation for your vehicle and/or other personal belongings involving intercontinental and/or marine transportation.

- services provided other than those indicated in this certificate.
- housing/lodging or accommodations, meals or travel related expenses.
- hotel and accommodations for covered Dependents post discharge or while awaiting fitness to fly approval.
- expenses incurred in the U.S. are excluded, with the exception of:
  - Repatriation following a Medical Evacuation;
  - Primary Repatriation to the Permanent Residence after a Serious Medical Event; or
  - Repatriation of Mortal Remains.
- Injury or Sickness caused by war, or an act of war, whether declared or undeclared, riot, civil commotion or police action.
- death caused by war, or an act of war, whether declared or undeclared, riot, civil commotion or police action.
- claim payments that are illegal under applicable law.

Prescription Drug Benefits

Inside the United States

The Schedule

For You and your Dependents

This plan provides Prescription Drug benefits for Prescription Drug Products provided by Pharmacies in the U.S. 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.

Supplemental Discount Programs

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

Coinsurance

The term Coinsurance means the percentage of the Prescription Drug Charge for a covered Prescription Drug Product that you or your Dependent are required to pay under this plan in addition to the Deductible, if any.

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 on a basis no less favorable than the out-of-network medical cost-share for injectable IV/Chemotherapy.

BENEFIT HIGHLIGHTS	NETWORK PHARMACY United States	NON-NETWORK PHARMACY United States
Lifetime Maximum	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Calendar Year Deductible		
Individual	$0	Refer to the Medical Benefits Schedule
Family	$0	Refer to the Medical Benefits Schedule

BENEFIT HIGHLIGHTS	NETWORK PHARMACY United States	NON-NETWORK PHARMACY United States
Patient Assurance Program Your plan offers additional discounts for certain covered Prescription Drug Products that are dispensed by a retail or home delivery Network Pharmacy included in what is known as the "Patient Assurance Program". As may be described elsewhere in this plan, from time to time Cigna may directly or indirectly enter into arrangements with pharmaceutical manufacturers for discounts that result in a reduction of your Out-of-Pocket Expenses for certain covered Prescription Drug Products for which Cigna directly or indirectly earns the discounts. Specifically, some or all of the Patient Assurance Program discount earned by Cigna for certain covered Prescription Drug Products included in the Patient Assurance Program is applied or credited to a portion of your Copayment or Coinsurance, if any. The Copayment or Coinsurance, if any, otherwise applicable to those certain covered Prescription Drug Products as set forth in The Schedule may be reduced in order for Patient Assurance Program discounts earned by Cigna to be applied or credited to the Copayment or Coinsurance, if any, as described above. For example, certain insulin product(s) covered under the Prescription Drug Benefit for which Cigna directly or indirectly earns a discount in connection with the Patient Assurance Program shall result in a credit toward some or all of your Copayment or Coinsurance, if any, which, as noted, may be reduced from the amount set forth in The Schedule, for the insulin product. In addition, the covered insulin products eligible for Patient Assurance Program discounts shall not be subject to the Deductible, if any. Your Copayment or Coinsurance payment, if any, for covered Prescription Drug Products under the Patient Assurance Program counts toward your Out-of-Pocket Maximum. Any Patient Assurance Program discount that is used to satisfy your Copayment or Coinsurance, if any, for covered Prescription Drug Products under the Patient Assurance Program counts toward your Out-of-Pocket Maximum. Please note that the Patient Assurance Program discounts that Cigna may earn for Prescription Drug Products, and may apply or credit to your Copayment or Coinsurance, if any, in connection with the Patient Assurance Program are unrelated to any rebates or other payments that Cigna may earn from a pharmaceutical manufacturer for the same or other Prescription Drug Products. Except as may be noted elsewhere in this plan, you are not entitled to the benefit of those rebates or other payments earned by Cigna because they are unrelated to the Patient Assurance Program. Additionally, the availability of the Patient Assurance Program, as well as the Prescription Drug Products included in the Patient Assurance Program and/or your Copayment or Coinsurance, if any for those eligible Prescription Drug Products, may change from time to time depending on factors including, but not limited to, the continued availability of the Patient Assurance Program discount(s) to Cigna in connection with the Patient Assurance Program. More information about the Patient Assurance Program including the Prescription Drug Products included in the program, is available at the website shown on your ID card or by calling member services at the telephone number on your ID card.		
For all insulin drugs covered by this plan, your cost share will be capped so that the amount you are required to pay for all covered prescription insulin drugs will not exceed $100 per person per month.		
For all diabetes equipment and supplies covered by this plan, your NETWORK PHARMACY cost share will be capped so that the amount you are required to pay for all covered diabetes equipment and supplies will not exceed $35 per person per month, regardless of the amount or types of diabetes equipment or supplies needed to fill your prescriptions.		
Calendar Year Out-Of-Pocket Maximum		
Individual	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Family Maximum	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule

BENEFIT HIGHLIGHTS	NETWORK PHARMACY United States	NON-NETWORK PHARMACY United States
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 Network 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. **Contraceptives** Note: Certain contraceptive devices and oral contraceptives are payable at 100% when purchased from a 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 $30 Copay	20% after plan Deductible
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after $50 Copay	20% after plan Deductible
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after $75 Copay	20% after plan Deductible
Prescription Drug Products at Retail 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.		
Tier 1 Generic Drugs on the Prescription Drug List	No charge after $90 Copay	20% after plan Deductible
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after $150 Copay	20% after plan Deductible

BENEFIT HIGHLIGHTS	NETWORK PHARMACY United States	NON-NETWORK PHARMACY United States
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after $225 Copay	20% after plan Deductible
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 Network Pharmacies.		
Tier 1 Generic Drugs on the Prescription Drug List	No charge after $90 Copay	In-network coverage only
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after $150 Copay	In-network coverage only
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after $225 Copay	In-network coverage only

Prescription Drug Benefits - U.S.

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 are shown in The Schedule.

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy for Medically Necessary Prescription Drug Products ordered by a Physician, your plan provides coverage for those expenses as shown in The Schedule. Your benefits may vary depending on, which of the Prescription Drug List tiers the Prescription Drug Product is listed, or the Pharmacy that provides the Prescription Drug Product.

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

When you or a Dependent are issued a Prescription Order or Refill for Medically Necessary Prescription Drug Products as part of the rendering of Emergency Services and Cigna determines that it cannot reasonably be filled by a Network Pharmacy, the prescription will be covered pursuant to the, as applicable, Copayment or Coinsurance for the Prescription Drug Product when dispensed by a Network Pharmacy.

Prescription Drug List Management

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

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

GC-PHR39 01-23

Limitations

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

Your plan includes a Brand Drug for Generic Drug dispensing program. This program allows certain Brand Drugs to be dispensed in place of the Therapeutic Equivalent Generic Drug at the time your Prescription Order or Refill is processed by a participating Pharmacy. Brand Drug for Generic Drug substitution will occur only for certain Brand Drugs included in the program. When this substitution program is applied, the participating Pharmacy will dispense the Brand Drug to you in place of the available Generic Drug. You will be responsible

for payment of only a Generic Drug Copayment and/or Coinsurance, after satisfying your Deductible, if any.

Prior Authorization Requirements

Coverage for certain Prescription Drug Products prescribed to you requires your Physician to obtain prior authorization from Cigna or its Review Organization. The reason for obtaining prior authorization from Cigna is to determine whether the Prescription Drug Product is Medically Necessary in accordance with Cigna's coverage criteria. It is not necessary to obtain prior authorization in an emergency situation for a 72 hour supply of a non-controlled substance. 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, your Physician will receive confirmation. The authorization will be processed in the claim system to allow you to have coverage for the Prescription Drug Product. If a prescriber indicates on the prior authorization form that the prescription medication is for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient, a reauthorization for the same prescription medication will not be required more frequently than every 12 months. The authorization will at all times be subject to the plan’s terms of coverage for the Prescription Drug Product, which may change from time to time. When your Physician advises you that coverage for the Prescription Drug Product has been approved, you can contact a Pharmacy to fill the covered Prescription Order or Refill.

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

Emergency Supplies of Prescription Drug Products

Coverage includes immediate access, without prior authorization, to a 5-day emergency supply of covered, prescribed medications for the Medically Necessary treatment of Mental Health and Substance Use Disorder, where an Emergency Medical Condition exists. The emergency supply requirement includes prescribed medications for opioid overdose reversal that are otherwise covered under the health benefit plan.

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.

If your treating health care provider submits a request for a step therapy exception determination, the request must state the circumstance that qualifies the patient for a step therapy exception. If the exception request is for a patient that is stable for the medical condition under consideration while on a Prescription Drug Product prescribed by the patient's health care provider, or prescribed under the patient's current or a previous insurance or health benefit plan, a step therapy determination will be considered granted until a step therapy determination is issued.

We will respond to the exception request with our decision within two (2) business days of receipt of the exception request. In the event we do not respond to an exception request within two (2) days, the exception request will be granted.

In cases where emergency circumstances exist, we will respond with our decision within 24 hours of receipt of an exception request. In the event we do not respond to an exception request within 24 hours for emergency circumstances, the exception request will be granted.

If we grant an exception request, we will authorize coverage for the Prescription Drug Product.

Step Therapy does not apply to FDA approved cancer drugs prescribed for the treatment of stage 4 metastatic cancer or any other cancer.

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.

Contraceptives

Benefits are provided for U.S. FDA approved prescription contraceptive drugs and devices and FDA-approved emergency contraceptive drugs, available over-the-counter.

You may obtain a twelve-month refill of covered prescription contraceptive drugs if prescribed by your provider or you may request over the course of a 12-month period.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products. If you require Specialty Prescription Drug Products, you may be directed to a Designated Pharmacy with whom Cigna has an arrangement to provide those Specialty Prescription Drug Products. If you are beginning a therapy regimen on a Specialty Prescription Drug Product, we may limit your coverage for the initial Prescription Order or Refill to multiple, separate fills of less than the total days' supply set forth in The Schedule. If applicable, you will pay a pro-rated Coinsurance or Copayment amount for each such supply.

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.

GC-PHR34 01-22

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.

Deductible

Your plan requires that you pay the costs for covered Prescription Drug Products up to the Deductible amount set forth in The Schedule, if any. Until you meet that Deductible amount, your costs under the plan for a covered Prescription Drug Product dispensed by a Network Pharmacy will be the lowest of the following amounts:

- the Prescription Drug Charge; or
- the Network Pharmacy's submitted Usual and Customary (U&C) Charge, if any.

The Schedule sets forth your costs for covered Prescription Drug Products after you have satisfied the Deductible amount.

Copayment

Your plan requires that you pay a Copayment for covered Prescription Drug Products as set forth in The Schedule, if any. 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.

Coinsurance

Your plan requires that you pay a Coinsurance amount for covered Prescription Drug Products as set forth in The Schedule, if any. After satisfying any applicable annual Deductible set forth in The Schedule, your costs under the plan for a covered Prescription Drug Product dispensed by a Network Pharmacy and that is subject to a Coinsurance requirement will be the lowest of the following amounts:

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

Payments at Non-Network Pharmacies

Any reimbursement due to you under this plan for a covered Prescription Drug Product dispensed by a non-Network Pharmacy shall be determined by applying any applicable Deductible, non-Network Pharmacy Coinsurance amount, or other cost-sharing amount set forth in The Schedule to the Prescription Drug Charge for a Prescription Drug Product dispensed by a non-Network Pharmacy.

Any reimbursement due to you for a covered Prescription Drug Product dispensed by a non-Network Pharmacy will not exceed the Prescription Drug Charge for the Prescription Drug Product, less any applicable Deductible, Copayment, Coinsurance, or other cost-sharing payment you owe.

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

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

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 which are prescribed, dispensed or intended to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home, rehabilitation facility, or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceutical products.
- Prescription Drug Products furnished by the local, state or federal government (except for a Network Pharmacy owned or operated by a local, state or federal government).
- any product dispensed for the purpose of appetite suppression (anorectics) or weight loss.
- Prescription and non-prescription supplies other than supplies covered as Prescription Drug Products.
- vitamins, except prenatal vitamins that require a Prescription Order or Refill, unless coverage for such product(s) is required by federal or state law.
- medications used for cosmetic or anti-aging purposes, including, without limitation, medications used to reduce wrinkles, medications used to promote hair growth, and fade cream products.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Medical Pharmaceuticals covered solely under the plan's medical benefits.

- any ingredient(s) in a compounded Prescription Drug Product that has not been approved by the U.S. Food and Drug Administration (FDA).
- medications available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless state or federal law requires coverage of such medications or the over-the-counter medication has been designated as eligible for coverage as if it were a Prescription Drug Product.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to an over-the-counter drug(s), or are available in over-the-counter form. Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
- any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, unless coverage for such product(s) is required by federal or state law.
- medications used for travel prophylaxis unless specifically identified on the Prescription Drug List.
- immunization agents, virus detection testing, virus antibody testing, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions unless specifically identified on the Prescription Drug List.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to another covered Prescription Drug Product(s). Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
- medications that are not FDA-approved for any indication.
- Prescription Drug Products classified as gene therapy.

GC-PHR47 01-24

Reimbursement/Filing a Claim

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 or wish to dispute the amount you were charged. For example, if you must pay the full cost of a Prescription Drug Product to the retail Network Pharmacy because you did not have your ID card, then you must submit a claim to Cigna for any reimbursement or benefit you believe is due to you under this plan. If, under this example, your payment to the retail Network Pharmacy for the covered Prescription Drug Product exceeds any applicable copay, then you will be reimbursed the difference, if any, between the applicable copay and the Prescription Drug Charge for the Prescription Drug Product. If you believe that the amount of any applicable Copayment, Coinsurance and/or Deductible you were charged was incorrect, to dispute the accuracy of the amount you were charged you must submit a claim for reimbursement according to the applicable claim filing procedures for postservice claims.

When you purchase a covered Prescription Drug Product dispensed by a non-Network Pharmacy, then you must pay the non-Network Pharmacy for the Prescription Drug Product and then submit a claim to Cigna for any reimbursement or benefit you believe is due to you under this plan. You can obtain a claim form through the website shown on your ID card or by calling member services at the telephone number on your ID card.

GC-PHR48 01-24

Prescription Drug Benefits

International

Outside the United States

The Schedule

For You and your Dependents

This plan provides Prescription Drug benefits for Prescription Drug Products provided by Pharmacies outside the U.S. as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a Deductible or Coinsurance requirement for Covered Expenses for Prescription Drug Products.

Coinsurance
The term Coinsurance means the percentage of the Prescription Drug Charge for a covered Prescription Drug Product that you or your Dependent are required to pay under this plan in addition to the Deductible, if any.

Oral Chemotherapy Medication

Prescription oral chemotherapy medication that is used to kill or slow the growth of cancerous cells is covered on a basis no less favorable than the medical cost-share for injectable/IV chemotherapy.

For all insulin drugs covered by this plan, your cost share will be capped so that the amount you are required to pay for all covered prescription insulin drugs will not exceed $100 per person per month.

For all diabetes equipment and supplies covered by this plan, your cost share will be capped so that the amount you are required to pay for all covered diabetes equipment and supplies will not exceed $35 per person per month, regardless of the amount or types of diabetes equipment or supplies needed to fill your prescriptions.

Contraceptives
Note: Contraceptive devices and oral contraceptives are payable as shown in The Schedule.

BENEFIT HIGHLIGHTS	INTERNATIONAL PHARMACY Outside the United States
Lifetime Maximum	Refer to the Medical Benefits Schedule
Calendar Year Deductible	
Individual	$0
Family	$0
Calendar Year Out-of-Pocket Maximum	
Individual	Refer to the Medical Benefits Schedule
Family	Refer to the Medical Benefits Schedule

BENEFIT HIGHLIGHTS	INTERNATIONAL PHARMACY Outside the United States
Prescription Drug Products at Pharmacies Outside the United States	**The amount you are required to pay** 20%

Prescription Drug Benefits - International

Covered Expenses

Your plan provides benefits for Prescription Drug Products dispensed by a Pharmacy outside the United States. 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 outside the United States for Medically Necessary Prescription Drug Products ordered by a Physician, your plan provides coverage for those expenses as shown in The Schedule.

Coverage 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.

Emergency Supplies of Prescription Drug Products

Coverage includes immediate access, without prior authorization, to a 5-day emergency supply of covered, prescribed medications for the Medically Necessary treatment of Mental Health and Substance Use Disorder, where an emergency medical condition exists. The emergency supply requirement includes prescribed medications for opioid overdose reversal that are otherwise covered under the health benefit plan.

Contraceptives

Benefits are provided for U.S. FDA approved prescription contraceptive drugs and devices and FDA-approved emergency contraceptive drugs, available over-the-counter.

You may obtain a twelve-month refill of covered prescription contraceptive drugs if prescribed by your provider or you may request over the course of a 12-month period.

GC-PHR18 09-19

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.

Any reimbursement due to you under this plan for a covered Prescription Drug Product dispensed by a Pharmacy shall be determined by applying any applicable Deductible, Coinsurance amount, or other cost-sharing amount set forth in The Schedule to the Prescription Drug Charge for a Prescription Drug Product dispensed by a Pharmacy. Any reimbursement due to you for a covered Prescription Drug Product dispensed by a Pharmacy will not exceed the Prescription Drug Charge for the Prescription Drug Product, less any applicable Deductible, Coinsurance, or other cost-sharing payment you owe.

GC-PHR49 01-24

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 purchased outside the United States:

- 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 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 except where covered under the medical benefits.
- Prescription Drug Products furnished by the local, state or federal government.
- any product dispensed for the purpose of appetite suppression (anorectics) or weight loss.
- prescription and non-prescription supplies other than supplies covered as Prescription Drug Products.
- vitamins, except prenatal vitamins that require a Prescription Order or Refill, unless coverage for such product(s) is required by federal or state law.
- medications used for cosmetic or anti-aging purposes, including, without limitation, medications used to reduce wrinkles, medications used to promote hair growth and fade cream products.

- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Medical Pharmaceuticals covered solely under the plan's medical benefits.
- 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 unless the over-the-counter medication has been designated as eligible for coverage as if it were a Prescription Drug Product.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to an over-the-counter drug(s), or are available in over-the-counter form. Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
- any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, unless coverage for such product(s) is required by federal or state law.
- medications used for travel prophylaxis unless specifically identified on the Prescription Drug List.
- immunization agents, virus detection testing, virus antibody testing, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions.
- medications that are not FDA-approved for any indication.
- Prescription Drug Products classified as gene therapy.

GC-PHR50 01-24

Reimbursement/Filing a Claim

When you or your Dependents purchase covered Prescription Drug Products through a Pharmacy outside the United States, you must pay the Pharmacy for the Prescription Drug Product and then submit a claim to Cigna for any reimbursement or benefit you believe is due to you under this plan. You can obtain a claim form through the website shown on your ID card or by calling member services at the telephone number on your ID card.

GC-PHR10 11-18

Vision Benefits

The Schedule

For You and Your Dependents

This plan provides Vision Benefits as shown in this Schedule. To receive Vision Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Deductible or Coinsurance if any.

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.

BENEFIT HIGHLIGHTS	UNITED STATES	INTERNATIONAL Outside the United States
Calendar Year Deductible		
Individual	$0	$0
Family	$0	$0
Calendar Year Out-of-Pocket Maximum		
Individual	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Family Maximum	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Examinations	**This Plan Will Pay:**	**This Plan Will Pay:**
Once every 24 consecutive months	80%	80%
Lenses and Frames or Contact Lenses		
One every 24 consecutive months Maximum Benefit: $150	100%	100%

Vision Benefits

For You and Your Dependents

Covered Expenses

If you or any one of your Dependents, while insured for Vision Benefits, incurs expenses for:

Examinations – One vision and eye health evaluation by an Optometrist or an Ophthalmologist including but not limited to eye health examination, dilation, refraction and prescription for glasses.

Lenses (Glasses) - One pair of prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms).

- Polycarbonate lenses for children under 18 years of age;
- Oversize lenses;
- Rose #1 and #2 solid tints;
- Progressive lenses covered up to bifocal lenses amount.

Frames – One frame.

Contact Lenses - Purchase of contact lenses in lieu of lenses and frame benefit (may not receive contact lenses and frames in same benefit year).

GC-VIS8 01-23
V1

Expenses Not Covered

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

- orthoptic or vision training and any associated supplemental testing.
- medical or surgical treatment of the eyes.
- any eye examination, or any corrective eyewear, required by the Group as a condition of employment.
- any Injury or illness when paid or payable by Workers' Compensation or similar law.
- charges incurred after the policy ends or the insured's coverage under the policy ends, except as stated in the policy.
- experimental or non-conventional treatment or device.
- charges in excess of the usual and customary charge or Maximum Reimbursable Charge for the service or materials.
- claims submitted and received in excess of twelve (12) months from the original date of service.
- magnification or low vision aids.
- any non-prescription eyeglasses, lenses, or contact lenses.
- spectacle lens treatments, "add-ons", or lens coatings not shown as covered.
- prescription sunglasses.
- two pair of glasses, in lieu of bifocals or trifocals.
- safety glasses or lenses required for employment.
- VDT (video display terminal)/computer eyeglass benefit.
- high index lenses of any material type.
- lens treatment for "add-ons," except rose tints (#1 & #2) and oversize lenses.
- other limitations shown in the "Exclusions, Expenses Not Covered and General Limitations" section.

GC-VIS7 01-22

Cigna Dental Preferred Provider Benefits

The Schedule

For You and Your Dependents

Cigna Dental Preferred Provider Benefits provide coverage for In-Network and Out-of-Network and International Dental Benefits. To receive Cigna Dental Preferred Provider Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Deductible and Coinsurance, if any.

The Dental Benefits Plan offered by the Group includes Participating and non-Participating Providers. If you select a Participating Provider, your cost will be less than if you select a non-Participating Provider.

Deductibles

Deductibles are expenses to be paid by you or your Dependent. 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 dental deductible for the rest of that plan year.

Participating Provider Payment

Participating Provider services are paid based on the Contracted Fee that is agreed to by the provider and Cigna.

Non-Participating Provider Payment

Non-Participating Provider services are paid based on the Maximum Reimbursable Charge.

Simultaneous Accumulation of Amounts

Benefits paid for Participating and non-Participating Provider and International services will be applied toward the combined Calendar year maximum shown in the Schedule.

Expenses incurred for either Participating or non-Participating Provider or International charges will be used to satisfy the combined Calendar year Deductible shown in the Schedule.

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Dental Services for Children with Severe Disabilities Medically Necessary specialized treatment and support to secure effective access to dental care for children under age 21 with severe disabilities will be provided at the benefit level for Participating Providers.			Not Applicable
Classes I, II, III, V Combined Calendar Year Maximum	$1,500		
Class IV Combined Lifetime Maximum	$2,000		

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Classes II, III, V Combined Calendar Year Deductible Individual Family	$50 per person $150 per family		
Combined Lifetime Class IV Deductible	$50 per person		
Class I Preventive Care	100%	100%	100%
Class II Basic Restorative	80% after plan deductible	80% after plan deductible	80% after plan deductible
Class III Major Restorative	50% after plan deductible	50% after plan deductible	50% after plan deductible
Class IV Orthodontia Class IV Orthodontia applies only to Dependent children less than 19 years of age.	50% after separate Class IV deductible	50% after separate Class IV deductible	50% after separate Class IV deductible
Class V Implants	50% after plan deductible	50% after plan deductible	50% after plan deductible

Dental Benefits

Covered Dental Expense

Covered Dental Expense means that portion of a Dentist's charge that is payable for a service delivered to a covered person provided:

- the service is ordered or prescribed by a Dentist;
- is essential for the necessary care of teeth;
- the service is within the scope of coverage limitations;
- the deductible amount in The Schedule has been met;
- the maximum benefit in The Schedule has not been exceeded;
- the charge does not exceed the amount allowed under the Alternate Benefit Provision;
- for Class I, II or III the service is started and completed while coverage is in effect, except for services described in the "Benefits Extension" section.

Teledentistry

Charges for the delivery of teledentistry services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support dental care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, by a Dentist legally allowed to practice in the state or country and practicing within the Dentist's scope of practice as would be practiced in-person with a patient, while such patient is at an originating site and the Dentist is at a distant site.

- **Distant site** means a site at which a Dentist legally allowed to practice in the state or country is located while providing dental services by means of teledentistry.
- **Originating site** means a site at which a patient is located at the time dental services are provided to him or her by means of teledentistry.
- **Store and forward transfer** means the synchronous or asynchronous transmission of a patient's dental information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time.

Alternate Benefit Provision

If more than one covered service will treat a dental condition, payment is limited to the least costly service provided if it is a professionally accepted, necessary and appropriate treatment.

If the covered person requests or accepts a more costly covered service, he or she is responsible for expenses that exceed the amount covered for the least costly service. Therefore, Cigna recommends Predetermination of Benefits before major treatment begins.

Predetermination of Benefits

Predetermination of Benefits is a voluntary review of a Dentist's proposed treatment plan and expected charges. It is not preauthorization of service and is not required. The treatment plan should include supporting pre-operative x-rays and other diagnostic materials as requested by Cigna's dental consultant. If there is a change in the treatment plan, a revised plan should be submitted.

Cigna will determine covered dental expenses for the proposed treatment plan. If there is no Predetermination of Benefits, Cigna will determine covered dental expenses when it receives a claim.

Review of proposed treatment is advised whenever extensive dental work is recommended when charges exceed $300.

Predetermination of Benefits is not a guarantee of a set payment. Payment is based on the services that are actually delivered and the coverage in force at the time services are completed.

Covered Services

The following section lists covered dental services. Cigna may agree to cover expenses for a service not listed. To be considered the service should be identified using the American Dental Association Uniform Code of Dental Procedures and Nomenclature, or by description and then submitted to Cigna.

GC-DEN30 01-22

Participating and Non-Participating Provider

Plan payment for a covered service delivered by a Participating Provider is the Contracted Fee for that procedure, times the benefit percentage that applies to the class of service, as specified in The Schedule.

The covered person is responsible for the balance of the Contracted Fee.

Plan payment for a covered service delivered by a non-Participating Provider is the Maximum Reimbursable Charge for that procedure times the benefit percentage that applies to the class of service, as specified in The Schedule.

The covered person is responsible for the balance of the non-Participating Provider's actual charge.

GC-DEN25 01-21

Class I Services – Diagnostic and Preventive

Clinical oral examination - only 2 per person per calendar year.

Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive Dental Services are performed. (Any x-ray taken in connection with such treatment is a separate Dental Service.)

X-rays – Complete series or Panoramic (Panorex) – Only one per person, including panoramic film, in any 3 calendar years.

Bitewing x-rays – Only 2 charges per person per calendar year.

Prophylaxis (Cleaning), including Periodontal maintenance procedures (following active therapy) – Only 2 per person per calendar year.

Topical application of fluoride (excluding prophylaxis) – Limited to persons less than 19 years old. Only 1 per person per calendar year.

Topical application of sealant, per tooth, on a posterior tooth – Only 1 treatment per tooth in any 3 calendar years.

Space Maintainers, fixed unilateral – Limited to nonorthodontic treatment.

GC-DEN26 01-21

Class II Services – Basic Restorations, Endodontics, Periodontics, Prosthodontic Maintenance and Oral Surgery

Amalgam Filling.

Composite/Resin Filling.

Root Canal Therapy – Any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Dental Service.

Osseous Surgery – Flap entry and closure is part of the allowance for osseous surgery and not a separate Dental Service.

Periodontal Scaling and Root Planing – Entire Mouth.

Adjustments – Complete Denture

Any adjustment of or repair to a denture within 6 months of its installation is not a separate Dental Service.

Recement Bridge.

Routine Extractions.

Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth

Removal of Impacted Tooth, Soft Tissue

Removal of Impacted Tooth, Partially Bony

Removal of Impacted Tooth, Completely Bony.

Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery procedures are not separately reimbursed but are considered as part of the submitted fee for the global surgical procedure.

General Anesthesia – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

I. V. Sedation – Paid as a separate benefit only when Medically or Dentally Necessary, as determined by Cigna, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

GC-DEN20 09-19

Class III Services - Major Restorations, Dentures and Bridgework

Crowns:

Note: Crown restorations are Dental Services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

- Porcelain Fused to High Noble Metal.
- Full Cast, High Noble Metal.
- Three-Fourths Cast, Metallic.

Removable Appliances

Complete (Full) Dentures, Upper or Lower

Partial Dentures

Lower, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)

Upper, Cast Metal Base with Resin Saddles (including any conventional clasps rests and teeth)

Fixed Appliances

Bridge Pontics - Cast High Noble Metal

Bridge Pontics - Porcelain Fused to High Noble Metal

Bridge Pontics - Resin with High Noble Metal

Retainer Crowns - Resin with High Noble Metal

Retainer Crowns - Porcelain Fused to High Noble Metal

Retainer Crowns - Full Cast High Noble Metal

Prosthesis Over Implant – A prosthetic device, supported by an implant or implant abutment is a Covered Expense. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only payable if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

GC-DEN21 09-19

Class IV Services - Orthodontics

Each month of active treatment is a separate Dental Service.

Covered Expenses include:

Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.

Continued active treatment after the first month.

Fixed or Removable Appliances - Only one appliance per person for tooth guidance or to control harmful habits.

The total amount payable for all expenses incurred for orthodontics during a Dependent child's lifetime will not be more than the orthodontia maximum shown in The Schedule.

GC-DEN22 09-19

Class V Services – Implants

Covered Dental Expenses include: the surgical placement of the implant body or framework of any type; any device, index, or surgical template guide used for implant surgery; prefabricated or custom implant abutments; or removal of an existing implant. Implant removal is covered only if the implant is not serviceable and cannot be repaired.

Implant coverage may have a separate deductible amount, yearly maximum and/or lifetime maximum as shown in The Schedule.

GC-DEN23 09-19

Dental Expenses Not Covered

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

- services performed solely for cosmetic reasons;
- replacement of a lost or stolen appliance;
- replacement of a bridge, crown or denture within 5 years after the date it was originally installed unless: the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an Injury received while a person is insured for these benefits;
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- procedures, appliances or restorations (except full dentures) whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint; stabilize periodontally involved teeth; or restore occlusion;
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- bite registrations; precision or semiprecision attachments; or splinting;
- instruction for plaque control, oral hygiene and diet;
- dental services that do not meet common dental standards;
- services that are deemed to be medical services;
- services and supplies received from a Hospital, except as covered under the Dental Schedule for “Dental Services for Children with Severe Disabilities”;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society;
- services for which benefits are not payable according to the "General Limitations" section.

GC-DEN31 01-22

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.
- Injury or Sickness caused by war, or an act of war, whether declared or undeclared, riot, civil commotion or police action.
- Injury or Sickness that results, directly or indirectly from: nuclear fission, fusion or radioactivity; nuclear, biological and chemical weapons and/or devices; or attacks on, or sabotage of, facilities and storage depots, which lead to the release of radioactivity or nuclear, biological or chemical warfare agents.
- charges which you are not obligated to pay and/or for which you are not billed or for which you would not have been billed. This exclusion includes, but is not limited to:
  - any instance where Cigna determines that a provider or pharmacy did not bill you for, or has waived, reduced, or forgiven any portion of its charges and/or any portion of any Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for an otherwise Covered Expense (as shown on The Schedule) without Cigna's express consent.
  - charges of a non-Participating Provider who has agreed to charge you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.

  In the event that Cigna determines that this exclusion applies, then Cigna in its sole discretion shall have the right to:
  - require you and/or any provider or pharmacy submitting claims on your behalf to provide proof sufficient to Cigna that you have made your required cost-share payment(s) prior to the payment of any benefits by Cigna;
  - deny the payment of benefits in connection with the Covered Expense, regardless of whether the provider or the pharmacy represents that you remain responsible for any amounts that your plan does not cover; or
  - reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or pharmacy represents that you remain responsible for any amounts that your plan does not cover.
- charges or payment for healthcare-related services that violate state or federal law.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be either:
  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for any indication; or
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness regardless of U.S. Food and Drug Administration (FDA) approval status.
  - not considered under the Centers for Medicare and Medicaid's National Coverage Determination List.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician relies on the coverage policies maintained by Cigna or the Review Organization. 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 therapy or device as experimental, investigational and unproven if the drug therapy or device is otherwise approved by the FDA to be lawfully marketed and is recognized for treatment of the prescribed indication in a prescription drug reference compendium approved by the Insurance Commissioner or substantially accepted peer reviewed medical literature and is considered under the Centers for Medicare and Medicaid's National Coverage Determination List.
- charges for health care services, supplies, or medications when billed for conditions or diagnoses that are not covered or reimbursable under the coverage policies maintained by Cigna or the Review Organization.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- the following services are excluded from coverage regardless of clinical indications except as may be covered under the "Reconstructive Surgery" benefit and "gender

affirmation" services: macromastia surgery; gynecomastia surgery; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.

- medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations, unless otherwise covered under this plan.
- court-ordered treatment or hospitalization, unless treatment is prescribed by a Physician and is a covered service or supply under this plan.
- reversal of male and female voluntary sterilization procedures.
- any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- 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, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs, and driver safety courses.
- non-medical living arrangements, including but not limited to, health resorts, recreational programs, outdoor skills programs, relaxation or lifestyle programs, or supportive living programs.
- 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 and wigs, except as covered under this plan as shown in the Covered Expenses section.
- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs), except as covered under this plan as shown in the Covered Expenses section. 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, except as shown in the Covered Expenses section for treatment of autism.
- 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.
- 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 and weight loss programs.

- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- fees associated with the collection, 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.
- health and beauty aids, cosmetics and dietary supplements.
- enteral feedings, supplies and specially formulated medical foods, whether prescribed or not, except as specifically provided in the "Enteral Nutrition" benefit.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- charges related to an Injury or Sickness payable under worker's compensation or similar laws.

General Limitations

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

- to the extent that payment is unlawful or prohibited by applicable sanctions rules.
- for elective or pre-scheduled treatment in sanctioned countries.
- for any person whom Cigna considers to be "ordinarily resident" in a sanctioned country. A person is considered "ordinarily resident" if she/he visits a sanctioned country for a period of longer than 6 weeks over the course of any 12 month period.
- for charges made for any service that is not covered by the terms of this policy or for coverage declined, or otherwise not elected by you, at enrollment.
- 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.
- any charges related to care provided through a public program, other than Medicaid.
- to the extent that payment is prohibited by applicable law including but not limited to sanctions rules imposed by the United Nations, the European Commission, the United States, and Canada.
- 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.
- 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 claim payments that are illegal under applicable law.

GC-EXC13 01-24

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. For claims incurred within the United States, you should file all claims under each Plan. For claims incurred outside the United States, if you file claims with more than one Plan, you must indicate at the time of filing a claim under this Plan, that you also have or will be filing your claim under another 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, dental, or vision 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, except 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. A Plan shall not include any benefits or coverage to the extent that such benefits or coverage are not covered by the terms of this

Policy or were declined, or otherwise not elected, by you, at enrollment.

Closed Panel Plan

A Plan that provides medical, dental, or vision 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 a member 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 member;
- 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 member (or as that member's Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired member (or as that member'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 U.S. federal or state law shall be the Secondary Plan and the Plan that covers you as an active member or retiree (or as that member'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 or country 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 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Coordination of Benefits with Medicare

If you, your spouse, or your Dependent are 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 Member, and the Group has fewer than 100 Members.
- Age: You, your spouse, or your covered Dependent qualify for Medicare due to age, you are an active Member, and the Group has fewer than 20 Members.
- 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 Member. 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 Member, and the Group has 100 or more Members.
- Age: You, your spouse, or your covered Dependent qualify for Medicare due to age, you are an active Member, and the Group has 20 or more Members.
- 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 Member. 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.

GC-COB5 01-23

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), occupational disease law, any employers's liability insurance 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.
- The plan hereby disavows all equitable defenses in pursuit of its right of recovery. The plan's subrogation or recovery rights are neither affected nor diminished by equitable defenses.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his 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.

GC-SUB6 01-24

Payment of Benefits

Medical, Dental and Vision

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 or your Dependents, you or your Dependents are responsible for reimbursing the non-Participating Provider.

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

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

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

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right 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 within twenty-four (24) months after the payment is made. The 24 month limit will not apply if there is reasonable belief of fraud, abuse or other intentional misconduct, or if required by a state or federal government plan. In addition, your acceptance of benefits under this plan and/or assignment of Medical, Dental and Vision benefits separately creates an equitable lien by agreement pursuant to which Cigna may seek recovery of any overpayment. You agree that Cigna, in seeking recovery of any overpayment as a contractual right or as an equitable lien by agreement, may pursue the general assets of the person or entity to whom or on whose behalf the overpayment was made.

Calculation of Covered Expenses

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

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

GC-POB4 01-21

Termination of Insurance – Members

Your insurance will cease on the earliest date below:

- the last day of the calendar month you cease to be in a Class of Eligible Members or cease to qualify for the insurance.
- the last day of the calendar month for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- 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.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date as determined by the Group. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

Injury or Sickness

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

Retirement

If your Active Service ends because you retire, your insurance will be continued until the date on which the Group stops paying premium for you or otherwise cancels the insurance.

Termination of Insurance - Dependents

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

- the last day of the calendar month your insurance ceases.
- the last day of the calendar month you cease to be eligible for Dependent Insurance.
- the last day of the calendar month for which you have made any required contribution for the insurance.
- the date Dependent insurance is canceled.

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

GC-TRM7 01-22

Medical Benefits Extension During Hospital Confinement Upon Policy Cancellation

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy (except if policy is canceled for nonpayment of premiums, and you or your Dependent is Confined in a Hospital on that date), Medical Benefits will be paid for Covered Expenses incurred in connection with that Hospital Confinement. 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 a succeeding carrier agrees to provide coverage without limitation for the Hospital Confinement;
- the date you or your Dependent is no longer Hospital Confined; or
- 10 days from the date the policy is canceled.

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

GC-BEX4 09-19

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

GC-BEX3 09-19

Federal Requirements

The following pages explain your rights and responsibilities under United States 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.

All references in this section to "Employer" shall be deemed to mean "Group" and all references to "Employee" shall be deemed to mean "Member".

Generally speaking, the following provisions apply to United States citizens or permanent United States residents. They may not apply to non-U.S. citizens or residents, nonresident aliens, nonresident aliens with no U.S. sourced income, or other foreign nationals. Contact your Group for additional information.

HC-FED1 10-10
V6

Notice of Provider Directory/Networks

Notice Regarding Provider Directories and Provider Networks

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

HC-FED121 01-25

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, or adoption or placement of 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.

Individuals who enroll in the Plan due to a special enrollment event will not be considered Late Entrants.

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-FED115 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.

HC-FED18 10-10

Claim Determination Procedures under ERISA

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

Procedures Regarding Medical Necessity Determinations

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

Certain services require prior authorization in order to be covered. The Certificate describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care professional) must request prior

authorization according to the procedures described below, in the Certificate, and in your provider's network participation documents as applicable.

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

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

Preservice Determinations

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

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

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

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

Concurrent Determinations

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

Postservice Determinations

When you or your representative requests a coverage determination or a claim payment determination after services have been rendered, Cigna will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control, Cigna will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of

the following that pertain to the determination: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action 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 judgement for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; 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 out-of-network coverage only. In-network coverage is not available outside of the Employer's service area. If the Employer offers another benefit option through Cigna or another carrier which can provide coverage in your location, you may elect COBRA continuation coverage under that option.

Employer's Notification Requirements

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

- An initial notification of COBRA continuation rights must be provided within 90 days after your (or your spouse's) coverage under the Plan begins (or the Plan first becomes subject to COBRA continuation requirements, if later). If you and/or your Dependents experience a qualifying event before the end of that 90-day period, the initial notice must be provided within the time frame required for the COBRA continuation coverage election notice as explained below.
- A COBRA continuation coverage election notice must be provided to you and/or your Dependents within the following timeframes:
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the loss of coverage, 44 days after loss of coverage under the Plan;
  - if the Plan provides that COBRA continuation coverage and the period within which an Employer must notify the Plan Administrator of a qualifying event starts upon the occurrence of a qualifying event, 44 days after the qualifying event occurs; or
  - in the case of a multi-employer plan, no later than 14 days after the end of the period in which Employers must provide notice of a qualifying event to the Plan Administrator.

How to Elect COBRA Continuation Coverage

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

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

How Much Does COBRA Continuation Coverage Cost?

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

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

When and How to Pay COBRA Premiums

First payment for COBRA continuation

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

Subsequent payments

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

Grace periods for subsequent payments

Although subsequent payments are due by the first day of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if your payment is received after the due date, your coverage under the Plan may be suspended during this time. Any providers who contact the Plan to confirm coverage during this time may be informed that coverage has been suspended. If payment is received before the end of the grace period, your coverage will be reinstated back to the beginning of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

You Must Give Notice of Certain Qualifying Events

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

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

(Also refer to the section titled “Disability Extension” for additional notice requirements.)

Notice must be made in writing and must include: the name of the Plan, name and address of the Employee covered under the Plan, name and address(es) of the qualified beneficiaries affected by the qualifying event; the qualifying event; the date

the qualifying event occurred; and supporting documentation (e.g., divorce decree, birth certificate, disability determination, etc.).

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. However, only your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event. COBRA coverage for your Dependent spouse and any Dependent children who are not your children (e.g., stepchildren or grandchildren) will cease on the date your COBRA coverage ceases and they are not eligible for a secondary qualifying event.

COBRA Continuation for Retirees Following Employer's Bankruptcy

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

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.

ERISA Required Information

The name of the Plan is:

Ecolab Health and Welfare Benefits Plan

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

Ecolab Inc.
370 Wabasha Street North
St. Paul, MN 55102
(612) 293-2854

Employer Identification Number (EIN):	Plan Number:
41-0231510	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.

HC-FED72 05-15

Notice of an Appeal or a Grievance

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

GC-NOT2 11-18

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.

GC-AAR1 11-18

When You Have A Complaint Or An Appeal

Medical and Vision

When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "you", or "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 services 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, you may call our toll-free number and explain your concern to one of our Customer Service representatives. Please call us at the Customer Service toll-free number that appears on your ID 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.

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal for most claims you must submit a request for an appeal to Cigna within 365 days of receipt of a denial notice to the address below.

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
ATTN: Appeals Department
P.O. Box 15800
Wilmington, DE 19850

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 ID card, explanation of benefits or claim form.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional in the same or similar specialty as the care under consideration, as determined by Cigna's Physician reviewer.

For level one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services.

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

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

If the appeal involves a coverage decision based on issues of Medical Necessity, clinical appropriateness or experimental treatment, a medical review will be conducted by a Physician reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Physician reviewer. For all other coverage plan-related appeals, a second-level review will be conducted by someone who was a) not involved in any previous decision related to your appeal, and b) not a subordinate of previous decision makers. Provide all relevant documentation with your second-level appeal request.

For required preservice and concurrent care coverage determinations, Cigna's review will be completed within 15 calendar days.

For postservice claims, Cigna's review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review.

You will be notified in writing of the decision within five days after the decision is made, and within the review time frames above if Cigna does not approve the requested coverage.

You may request that the appeal process be expedited if the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or your appeal involves non-authorization of an admission or continuing inpatient Hospital stay. Cigna's Physician reviewer, in consultation with the treating Physician will decide if an expedited appeal is necessary. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

Independent Review of Medical Appeals – IHCAP

Any external review procedure available under the plan will apply to any adverse determination regarding whether the plan complied with the surprise billing and cost sharing protections of the federal No Surprises Act and its implementing regulations.

If you are not fully satisfied with the decision of Cigna's level two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Health Care Appeals Program (IHCAP). The IHCAP is conducted by an Independent Utilization Review Organization (IURO)

assigned by the State of Delaware. A decision to use this level of appeal will not affect the claimant's rights to any other benefits under the plan. If the subject of an IHCAP request is appropriate for Arbitration, the Delaware Insurance Department will advise the Participant or his/her authorized representative of the Arbitration procedure.

There is no charge for you to initiate the IHCAP's independent review process. Cigna will abide by the decision of the Independent Utilization Review Organization. In order to request a referral to an Independent Utilization Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within four months of your receipt of Cigna's level two appeal review denial. Cigna will then forward the file to the Independent Utilization Review Organization.

The Independent Utilization Review Organization will render an opinion and provide written notice of its decision to the Participant or his/her authorized representative, the carrier and the Delaware Insurance Department within 45 calendar days of its receipt of the appeal. When requested and when the Participant suffers from a condition that poses an imminent, emergent or serious threat or has an emergency medical condition, the review shall be completed within 72 hours of the IURO's receipt of the appeal with immediate notification. The IURO will provide written confirmation of its decision to the Participant or his/her authorized representative, the carrier, and the Delaware Insurance Department within 1 calendar day after the immediate notification.

Assistance from the State of Delaware

You have the right to appeal a claim denial for non-medical reasons to the Delaware Insurance Department. The Delaware Insurance Department also provides free informal mediation services which are in addition to, but do not replace, your right to appeal this decision. You can contact the Delaware Insurance Department for information about an appeal or mediation by calling the Consumer Services Division at (800) 282-8611 or (302) 739-4251.

All requests for mediation or arbitration must be filed within 60 days from the date you receive this notice. Otherwise, this decision will be final.

Independent Review of Administrative Appeals - Arbitration

If you are not fully satisfied with the decision of Cigna's level two appeal review regarding the denial of claims based on grounds other than Medical Necessity or appropriateness, you may request that your appeal be referred to Arbitration by submitting the Petition for Arbitration and supporting documentation to the Delaware Insurance Department. A decision to use this level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is a $75 filing fee for you to initiate the Arbitration process; if the arbitrator rules in your favor; Cigna will reimburse you for the $75 filing fee. Cigna will abide by the decision of the Arbitrator. In order to request a referral to Arbitration, certain conditions apply. The reason for the denial must be based on grounds other than Medical Necessity or appropriateness, such as administrative, eligibility or benefit coverage limits or exclusions.

To request a review, you must submit the Petition for Arbitration and supporting documentation within 60 days of your receipt of Cigna's level two appeal review denial to the Delaware Insurance Department.

If the subject of an Arbitration request is appropriate for IHCAP review, the Petition for Arbitration will be treated as an IHCAP appeal to determine if the IHCAP appeal is timely filed. The Delaware Insurance Department may summarily dismiss a Petition for Arbitration if it determines the subject is not appropriate for Arbitration or IHCAP or is meritless on its face.

The Arbitrator will render a decision and mail a copy of the decision to the Participant and his/her authorized representative within 45 calendar days of the filing of the Petition. The Arbitrator's decision shall include allowable charges and payments for each service subject to arbitration for a period that will end on the 360th day after the date of the Arbitrator's decision.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: availability, upon request, of the 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 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.

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

Relevant Information

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

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the appeals procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the level one and level two appeal processes. If your appeal is expedited, there is no need to complete the level two process prior to bringing legal action. However, no action may be brought at all unless brought within 3 years after a claim is submitted for In-Network Services or within three years after proof of claim is required under the plan for Out-of-Network services.

Dental

When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "you", or "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 services 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, you may call our toll-free number and explain your concern to one of our Customer Service representatives. Please call us at the Customer Service toll-free number that appears on your ID 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.

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal for most claims you must submit a request for an appeal to Cigna within 365 days of receipt of a denial notice to the address below.

However, if Cigna reduces or terminates coverage (except where the reduction or termination is due to a plan amendment or termination) for an ongoing course of treatment that Cigna previously approved, and the reduction or termination in coverage will occur before the end of the period of time or number of treatments that Cigna approved, then to initiate an appeal you must submit a request for an appeal of that reduction or termination in coverage within 30 days of receipt of the denial notice. If you appeal timely 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
ATTN: Appeals Department
P.O. Box 15800
Wilmington, DE 19850

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 ID card, explanation of benefits or claim form.

Level One Appeal

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

For level one appeals, we will respond in writing with a decision.

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition.

A dental professional, in consultation with the treating Dentist, will decide if an expedited review is necessary. When a review is expedited, Cigna Dental will respond orally with a decision within 72 hours, followed up in writing.

If you are not satisfied with our level one appeal decision, you may request a level two appeal.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Dentist reviewer in the same or similar specialty as the care under consideration, as determined by Cigna's Dentist reviewer. You may present your situation to the Committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For postservice claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within 5 working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition.

A dental professional, in consultation with the treating Dentist, will decide if an expedited review is necessary. When a review is expedited, the Dental Plan will respond orally with a decision within 72 hours, followed up in writing.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); and upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse 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.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

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

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the appeals procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the level one and level two appeal processes. If your appeal is expedited, there is no need to complete the level two process prior to bringing legal action.

GC-APL9 01-24

Definitions

Active Service

You will be considered in Active Service:

- on any of the Group's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at the Group's place of business or at some location to which you are required to travel for the Group's business.
- on a day which is not one of the Group's scheduled work days if you were in Active Service on the preceding scheduled work day.

GC-DFS142 09-19

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-DFS171 01-21

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-DFS172 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).

GC-DFS5 11-18

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).

GC-DFS6 11-18

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.

GC-DFS7 11-18

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.

GC-DFS197 01-21

Charges

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

GC-DFS9 11-18

Cigna LifeSOURCE Transplant Network®

The Cigna LifeSOURCE Transplant Network® consists of designated In-Network facilities that have met quality and cost criteria and have contracted with Cigna LifeSOURCE to provide transplant services as a Participating Provider in the Cigna LifeSOURCE Transplant Network®. In order to be considered a facility in the Cigna LifeSOURCE Transplant Network®, the facility must be a designated program for the specific type of transplant requested.

GC-DFS221 01-25

Contracted Fee - Dental

The term Contracted Fee means the total compensation level that a provider has agreed to accept as payment for dental procedures and services performed on you or your Dependent, according to your dental benefit plan.

GC-DFS116 09-19

Country of Citizenship

Country of Citizenship is the nation of the Member or Dependents' birth or the country in which they have subsequently been naturalized or granted legal citizenship or recognition.

GC-DFS143 09-19

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 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.

GC-DFS222 01-24

Dentally Necessary

Services provided by a Dentist or Physician as determined by Cigna are Dentally Necessary if they are:

- required for the diagnosis and/or treatment of the particular dental condition or disease; and
- consistent with the symptom or diagnosis and treatment of the dental condition or disease; and
- commonly and usually noted throughout the dental field as proper to treat the diagnosed dental condition or disease; and
- the most fitting level or service which can safely be given to you or your Dependent.

A diagnosis, treatment and service with respect to a dental condition or disease, is not Dentally Necessary if made,

prescribed or delivered solely for convenience of the patient or provider.

GC-DFS115 09-19

Dentist

The term Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a provider operating within the scope of his license when he performs any of the Dental Services described in the policy.

GC-DFS23 11-18

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, or intellectual disabilities or a physical handicap which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

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

The term child means a child born to you or a child legally adopted by you. It also includes a stepchild. 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 a Member will not be considered as a Dependent or Dependent spouse unless the Dependent or Dependent spouse declines Member coverage. A child under age 26 may be covered as either a Member or as a Dependent child. You cannot be covered as a Member while also covered as a Dependent of a Member.

GC-DFS212 01-23
V1

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 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.

GC-DFS200 01-22

Domestic Partner

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

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

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

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

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

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

GC-DFS209 01-23

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 to themselves or others; serious impairment to bodily functions; serious dysfunction of any bodily organ or part; or serious disfigurement.

GC-DFS213 01-23

Emergency Services - Medical

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 or other provider, including ancillary services routinely available to the emergency department or to another provider to evaluate such Emergency Medical Condition.
- 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 (regardless of the Hospital department in which further examination or treatment is provided).
- after the patient is Stabilized, services rendered by an Out-of-Network provider, Hospital or facility (regardless of the Hospital department that provides the services) as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services are provided.

  However, such post-Stabilization services are not considered Emergency Services if the attending provider determines the patient is able to travel using non-medical or non-emergency transportation to an available In-Network location within reasonable travel distance and applicable state and federal notice and consent requirements are met.

A provider for Emergency Services is a licensed Physician, a licensed Nurse, a licensed physician assistant, a licensed nurse practitioner, a licensed diagnostic facility, a licensed clinical facility, a licensed Hospital or an urgent care center.

GC-DFS223 01-24
V1

Expense Incurred

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

GC-DFS32 11-18

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.

GC-DFS176 01-21

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.

GC-DFS35 11-18

Group

The term Group means an eligible organization or plan sponsor that has elected to subscribe to the Trust to which the policy is issued.

GC-DFS177 01-21

Home Country

Home Country is the nation in which the Member or Dependents have their permanent place of residence prior to an expatriate assignment and/or the indefinite intention to reside post assignment.

GC-DFS178 01-21

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.

GC-DFS39 11-18

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.

GC-DFS40 11-18

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.

GC-DFS41 11-18

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, or is appropriately accredited where located as determined by Cigna; 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.

GC-DFS179 01-21

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; and
- receiving treatment for Mental Health and Substance Use Disorder Services in a Mental Health or Substance Use Disorder Residential Treatment Center.

GC-DFS43 11-18

Injury

The term Injury means an accidental bodily injury.

GC-DFS44 11-18

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 Drug Product by calling member services at the telephone number on your ID card.

GC-DFS150 09-19

Maximum Reimbursable Charge - Medical Services in the United States

See The Medical Schedule for information about Out-of-Network Charges for Certain Services, Out-of-Network Emergency Services Charges, and Out-of-Network Air Ambulance Services Charges.

The Maximum Reimbursable Charge (also referred to as MRC) is the maximum amount that your plan will pay an Out-of-Network health care provider for a Covered Expense. Your applicable Out-of-Network Coinsurance and/or Deductible amount(s), if any, set forth in The Schedule are determined based on the MRC. Unless prohibited by applicable law or agreement, Out-of-Network providers may also bill you for the difference between the MRC and their charges, and you may be financially responsible for that amount. If you receive a bill from an Out-of-Network provider for more than the What I Owe amount on the Explanation of Benefits (EOB), please call Cigna at the phone number on your ID card.

If an Out-of-Network provider is willing to agree to a rate that Cigna, in its discretion, determines to be market competitive, then that rate will become the MRC used to calculate the Out-of-Network allowable amount for a Covered Expense. An Out-of-Network provider can agree to a rate by: (i) entering into an agreement with Cigna or one of Cigna's third-party vendors that establishes the rate the Out-of-Network provider is willing to accept as payment for the Out-of-Network Covered Expense; or (ii) receiving a payment from Cigna based on an allowed amount that Cigna or one of Cigna's third-party vendors has determined is a market competitive rate without billing you and/or obligating you to pay the difference between the payment amount and the charged amount.

If an Out-of-Network provider does not agree to a market competitive rate as described in the previous paragraph, then the MRC will be based on an amount required by law, or if no amount is required by law, then the lesser of:

- the provider's normal charge for a similar service or supply; or
- a percentage of a fee schedule Cigna has developed that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable reimbursement for the same or similar service or supply within the geographic market. In the event that Medicare does not have a published rate for a particular service or supply, Cigna may, in its discretion, determine the MRC based on a rate for the same or similar service or supply by applying a Medicare-based methodology that Cigna deems appropriate.

The percentage used to determine the Maximum Reimbursable Charge is 150%.

The Maximum Reimbursable Charge is subject to all other benefit limitations and exclusions and Cigna's applicable Coverage Policies, Reimbursement Policies, and other coding

and payment methodologies. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.

Note: Some providers attempt to forgive, waive, or not collect the cost share obligation (e.g., your Coinsurance and/or Deductible amount(s), if any), that this plan requires you to pay. This practice jeopardizes your coverage under this plan. Please read the Exclusions, Expenses Not Covered and General Limitations section, or call Cigna at the phone number on your ID card for more details.

GC-DFS225 01-24

Maximum Reimbursable Charge (MRC) – Dental and Vision

Services in the United States

The term Maximum Reimbursable Charge (MRC) means the charge for a covered service which is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or
- the 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.

The percentile used to determine the Maximum Reimbursable Charge is the 80th percentile.

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.

GC-DFS224 01-24

Maximum Reimbursable Charge – Medical, Dental, Vision and Pharmacy

Services Outside the United States

Maximum Reimbursable Charge for services outside the United States is determined based on:

- the charges contracted or otherwise agreed between the provider and Cigna; or
- Reasonable and Customary expenses. Medical expenses will be considered Reasonable and Customary if they (i) correspond to the normal charge for the service by providers in the locality where the service is rendered or performed; and (ii) the services are provided according to established clinical and medical practice.

Telehealth expenses should not exceed the cost of an equivalent face-to-face consultation.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable payment methodologies determined by Cigna.

Note: Some providers attempt to forgive, waive, or not collect the cost share obligation (e.g., your Coinsurance and/or Deductible amount(s), if any), that this plan requires you to pay. This practice jeopardizes your coverage under this plan. Please read the Exclusions, Expenses Not Covered and General Limitations section, or call Cigna at the phone number on your ID card for more details.

Cigna is not obligated to pay excessive charges.

GC-DFS226 01-24

Medicaid – U.S.

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.

GC-DFS54 11-18

Medical Pharmaceutical

An FDA-approved prescription pharmaceutical product, including a Specialty Prescription Drug Product, typically required to be administered in connection with a covered service by a Physician or Other Health Professional within the scope of the provider's license. This definition includes certain pharmaceutical products whose administration may initially or typically require Physician or Other Health Professional oversight but may be self-administered under certain conditions specified in the product's FDA labeling.

GC-DFS201 01-22

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, peer-reviewed, evidence-based scientific literature or guidelines and generally accepted medical standards of care and practice.

GC-DFS181 01-21

Medicare - U.S.

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

GC-DFS58 11-18

Member

The term Member means a full-time employee as determined by the Group who is currently in Active Service.

GC-DFS216 01-23

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.

GC-DFS183 01-21

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 the Group’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.

GC-DFS62 11-18

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.

GC-DFS194 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.".

GC-DFS66 11-18

Ophthalmologist

The term Ophthalmologist means a person practicing ophthalmology within the scope of his license. It will also include a Physician operating within the scope of his license when he performs any of the Vision Care services described in the policy.

GC-DFS184 01-21

Optometrist

The term Optometrist means a person practicing optometry within the scope of his license. It will also include a Physician operating within the scope of his license when he performs any of the Vision Care services described in the policy.

GC-DFS185 01-21

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.

GC-DFS186 01-21

Other Health Professional

The term Other Health Professional means an individual other than a Physician who is appropriately licensed and/or certified by the appropriate authorizing agency to deliver Medically Necessary 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-DFS187 01-21

Participating Provider - Dental

The term Participating Provider means a Dentist, or a professional corporation, professional association, partnership, or other entity which is entered into a contract with Cigna to provide dental services in the U.S. at predetermined fees.

The providers qualifying as Participating Providers may change from time to time. A list of the current Participating Providers will be provided by the Group. Services received from Participating Providers are considered In-Network.

GC-DFS206 01-22

Participating Provider - Medical

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 in the U.S., 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. Covered services and/or supplies received from Participating Providers are considered In-Network.

GC-DFS135 09-19

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.

GC-DFS128 09-19

Pharmacy & Therapeutics (P&T) Committee

A committee comprised of physicians and an independent pharmacist that represent a range of clinical specialties. The committee regularly reviews Medical Pharmaceuticals or Prescription Drug Products, including New Prescription Drug Products, for safety and efficacy, the findings of which clinical

reviews inform coverage determinations made by the Business Decision Team. The P&T Committee's review may be based on consideration of, without limitation, U.S. Food and Drug Administration-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.

GC-DFS193 01-21

Physician

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

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

GC-DFS77 11-18

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.

GC-DFS117 09-19

Prescription Drug Charge - International and U.S. Non-Network Pharmacies

The Prescription Drug Charge is the amount for a specific covered Prescription Drug Product dispensed at a Pharmacy, which also includes, as examples, any applicable dispensing or service fee, and/or tax.

GC-DFS229 01-24

Prescription Drug Charge - U.S. Network Pharmacies

The Prescription Drug Charge is the amount established by Cigna for a specific covered Prescription Drug Product dispensed at a Network Pharmacy, which also includes, as examples, any applicable dispensing or service fee, and/or tax. This amount is established in connection with the overall Prescription Drug Product pricing implemented in relation to the premium negotiated between Cigna and the plan sponsor.

GC-DFS228 01-24

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 the Group 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.

GC-DFS211 01-23

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; and
- 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.

The following diabetic supplies are also included under this definition: alcohol pads, swabs, wipes, Glucagon/Glucagen, injection aids, insulin pump accessories, needles including pen needles, syringes, test strips, lancets, urine glucose and ketone strips.

GC-DFS202 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.

GC-DFS81 11-18

Preventive Medication

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 Medication. You may determine whether a drug is a Preventive Medication through the Internet website shown on your ID card or by calling member services at the telephone number on your ID card.

GC-DFS190 01-22

Preventive Treatment

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

GC-DFS84 11-18

Primary Care Physician

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

GC-DFS191 01-21

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.

GC-DFS87 11-18

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.

GC-DFS90 11-18

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-DFS169 01-21

School Based Health Center

A School Based Health Center is a health clinic that is located in or near a school facility, is organized through school and health provider relationships, provides through licensed professionals primary health services to children, and is recognized by the Delaware Division of Public Health (DPH) which has sole authority to determine whether a facility is an SBHC.

GC-DFS107 11-18

Sickness – Medical

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.

GC-DFS92 11-18

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.

GC-DFS93 11-18

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.

GC-DFS96 11-18

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.

GC-DFS215 01-23

Terminal Illness

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

GC-DFS220 01-24

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.

GC-DFS98 11-18

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.

GC-DFS99 11-18

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.

GC-DFS100 11-18

Usual and Customary (U&C) Charge - Prescription Drugs

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.

GC-DFS141 09-19

Ecolab Inc.

EXTRATERRITORIAL LEGISLATION

EFFECTIVE DATE: January 1, 2025

ETALLM25A
04048A
1716086

This document printed in March, 2025 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

Table of Contents

IMPORTANT INFORMATION 4
CERTIFICATE RIDER – Florida Residents 5
CERTIFICATE RIDER – Minnesota Residents 9
CERTIFICATE RIDER – New Jersey Residents 13
CERTIFICATE RIDER – Ohio Residents 15
CERTIFICATE RIDER – Pennsylvania Residents 17

CIGNA HEALTH AND LIFE INSURANCE COMPANY a Cigna COMPANY (called Cigna)
CERTIFICATE RIDER

Policyholder: Wilmington Trust National Association
Group**:** Ecolab Inc.
Rider Eligibility: Each Member as noted within this certificate rider
Policy No.: 04048A
Effective Date: January 1, 2025

This rider forms a part of the certificate issued to you by Cigna describing the benefits provided under the policy(ies) specified above. This rider replaces any other issued to you previously.

IMPORTANT INFORMATION

For Residents of States other than Delaware:

State-specific riders contain provisions that may add to or change your certificate provisions.

The provisions identified in your state-specific rider, attached, are ONLY applicable to Members residing in that state. The state for which the rider is applicable is identified at the beginning of each state specific rider.

Additionally, the provisions identified in each state-specific rider only apply to:

(a) Benefit plans made available to you and/or your Dependents by the Group;
(b) Benefit plans for which you and/or your Dependents are eligible;
(c) Benefit plans which you have elected for you and/or your Dependents;
(d) Benefit plans which are currently effective for you and/or your Dependents.

Please refer to the Table of Contents for the state-specific rider that is applicable for your residence state.

Geneva Cambell Brown, Corporate Secretary

HC-ETRDRV4 01-20

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Florida Residents

Rider Eligibility: Each Employee who is located in Florida

The benefits of the policy providing your coverage are primarily governed by the law of a state other than Florida.

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Florida group insurance plans covering insureds located in Florida. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETFLRDR

Eligibility - Effective Date

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, but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included. A newborn child will be covered for the first 31 days of life even if you fail to enroll the child. If you enroll the child after the first 31 days and by the 60th day after his birth, coverage will be offered at an additional premium. Coverage for an adopted child will become effective from the date of placement in your home or from birth for the first 31 days even if you fail to enroll the child. However, if you enroll the adopted child between the 31st and 60th days after his birth or placement in your home, coverage will be offered at an additional premium.

HC-ELG260 01-19

ET

Covered Expenses

- charges made for or in connection with mammograms for breast cancer screening or diagnostic purposes, including, but not limited to: a baseline mammogram for women ages 35 through 39; a mammogram for women ages 40 through 49, every two years or more frequently based on the attending Physician's recommendations; a mammogram every year for women age 50 and over; and one or more mammograms upon the recommendation of a Physician for any woman who is at risk for breast cancer due to her family history; has biopsy proven benign breast disease; or has not given birth before age 30. A mammogram will be covered with or without a Physician’s recommendation, provided the mammogram is performed at an approved facility for breast cancer screening.
- charges made for diagnosis and Medically Necessary surgical procedures to treat dysfunction of the temporomandibular joint. Appliances and non-surgical treatment including for orthodontia are not covered.
- charges for the treatment of cleft lip and cleft palate including medical, dental, speech therapy, audiology and nutrition services, when prescribed by a Physician.
- charges for general anesthesia and hospitalization services for dental procedures for an individual who is under age 8 and for whom it is determined by a licensed Dentist and the child's Physician that treatment in a Hospital or ambulatory

surgical center is necessary due to a significantly complex dental condition or developmental disability in which patient management in the dental office has proven to be ineffective; or has one or more medical conditions that would create significant or undue medical risk if the procedure were not rendered in a Hospital or ambulatory surgical center.

- charges for the services of certified nurse-midwives, licensed midwives, and licensed birth centers regardless of whether or not such services are received in a home birth setting.
- charges made for medical, surgical and Hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy. Services provided to you by a certified nurse-midwife or a licensed midwife, in a home setting or in a licensed birthing center. Coverage for a mother and her newborn child shall be available for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician in consultation with the mother. Post delivery care for a mother and her newborn shall be covered. Post delivery care includes: a postpartum assessment and newborn assessment, which can be provided at the hospital, the attending Physician's office, and outpatient maternity center or in the home by an Other Health Care Professional trained in mother and newborn care. The services may include physical assessment of the newborn and mother, and the performance of any clinical tests and immunizations in keeping with prevailing medical standards.
- charges for or in connection with Medically Necessary diagnosis and treatment of osteoporosis for high risk individuals. This includes, but is not limited to individuals who: have vertebral abnormalities; are receiving long-term glucocorticoid (steroid) therapy; have primary hyperparathyroidism; have a family history of osteoporosis; and/or are estrogen-deficient individuals who are at clinical risk for osteoporosis.
- charges for an inpatient Hospital stay following a mastectomy will be covered for a period determined to be Medically Necessary by the Physician and in consultation with the patient. Postsurgical follow-up care may be provided at the Hospital, Physician's office, outpatient center, or at the home of the patient.
- charges for newborn and infant hearing screening as well as any medically necessary follow-up evaluations leading to diagnosis and subsequent medically necessary treatment of a diagnosed hearing impairment.
- charges for the coverage of child health supervision services from birth to age 16. Child health supervision services are physician-delivered or supervised services that include periodic visits which include a history, physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests.

HC-COV818 01-19
ET

Short-Term Rehabilitative Therapy and Spinal Manipulation Care Services

Any references to "Chiropractic Care" are hereby changed to "Spinal Manipulation".

HC-COV53 04-10
V1-ET

Medical Conversion Privilege

For You and Your Dependents

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy).

A Converted Policy will be issued by Cigna only to a person who:

- resides in a state that requires offering a conversion policy,
- is Entitled to Convert, and
- applies in writing and pays the first premium for the Converted Policy to Cigna within 31 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled to Convert

You are Entitled to Convert Medical Expense Insurance for yourself and all of your Dependents who were insured when your insurance ceased but only if:

- you are not eligible for other individual insurance coverage on a guaranteed issue basis.
- you have been insured for at least three consecutive months under the policy or under it and a prior policy issued to the Policyholder.

- your insurance ceased because you were no longer in Active Service or no longer eligible for Medical Expense Insurance.
- you are not eligible for Medicare.
- you would not be Overinsured.
- you have paid all required premium or contribution.
- you have not performed an act or practice that constitutes fraud in connection with the coverage.
- you have not made an intentional misrepresentation of a material fact under the terms of the coverage.
- your insurance did not cease because the policy in its entirety canceled.

If you retire, you may apply for a Converted Policy within 31 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

Dependents Entitled to Convert

The following Dependents are also Entitled to Convert:

- a child who is not eligible for other individual insurance coverage on a guaranteed issue basis, and whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse who is not eligible for other individual insurance coverage on a guaranteed issue basis, and whose insurance under this plan ceases due to divorce, annulment of marriage or your death;
- your Dependents whose insurance under this plan ceases because your insurance ceased solely because you are eligible for Medicare;

but only if that Dependent: is not eligible for other individual insurance coverage on a guaranteed issue basis, is not eligible for Medicare, would not be Overinsured, has paid all required premium or contribution, has not performed an act or practice that constitutes fraud in connection with the coverage, and has not made an intentional misrepresentation of a material fact under the terms of the coverage.

Overinsured

A person will be considered Overinsured if either of the following occurs:

- his insurance under this plan is replaced by similar group coverage within 31 days.
- the benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on Cigna's underwriting standards for individual policies.

Similar Benefits are: those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or those available for the person by or through any state, provincial or federal law.

Converted Policy

If you reside in a state that requires the offering of a conversion policy, the Converted Policy will be one of Cigna's current conversion policy offerings available in the state where you reside, as determined based upon Cigna's rules.

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you may convert. If you are not Entitled to Convert and your spouse and children are Entitled to Convert, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: class of risk and age; and benefits.

During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan (if any) will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan (if any). Cigna or the Policyholder will give you, on request, further details of the Converted Policy.

HC-CNV28 04-14
V1-ET

Termination of Insurance

Special Continuation of Medical Insurance For Dependents of Military Reservists

If your insurance ceases because you are called to active military duty in: the Florida National Guard; or the United States military reserves, you may elect to continue Dependent insurance. You must pay the required premiums to the Policyholder if you choose to continue Dependent insurance. In no event will coverage be continued beyond the earliest of the following dates:

- the expiration of 30 days from the date the Employee's military service ends;
- the last day for which the required contribution for Dependent insurance has been made;
- the date the Dependent becomes eligible for insurance under another group policy. Coverage under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is excluded from this provision;
- the date the Dependent becomes eligible for Medicare (this does not apply to Vision insurance);
- the date the group policy cancels;
- the date the Dependent ceases to be an eligible Dependent.

Reinstatement of Medical Insurance - Employees and Dependents

Upon completion of your active military duty in: the Florida National Guard; or the United States military reserves, you are entitled to the reinstatement of your insurance and that of your Dependents if continuation of Dependent insurance was not elected. Such reinstatement will be without the application of: any new waiting periods; or the Pre-existing Condition Limitation to any new condition that you or your Dependent may have developed during the period that coverage was interrupted due to active military duty.

Provisions Applicable to Reinstatement

- You must notify your Employer, before reporting for military duty, that you intend to return to Active Service with that Employer; and
- You must notify your Employer that you elect such reinstatement within 30 days after returning to Active Service with that Employer and pay any required premium.

Conversion Available Following Continuation

The provisions of the "Medical Conversion Privilege" section will apply when the insurance ceases.

HC-TRM131 01-18
ET

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, Sickness or pregnancy, Medical Benefits will be paid for Covered Expenses incurred in connection with that Injury, Sickness or pregnancy. 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 a succeeding carrier agrees to provide coverage without limitation for the disabling condition;
- the date you are no longer Totally Disabled;
- 12 months from the date the policy is canceled; or
- for pregnancy, until delivery.

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.

HC-BEX42 04-11
ET

Definitions

Dependent – For Medical Insurance

A child includes a legally adopted child, including that child from the date of placement in the home or from birth provided

that a written agreement to adopt such child has been entered into prior to the birth of such child. Coverage for a legally adopted child will include the necessary care and treatment of an Injury or a Sickness existing prior to the date of placement or adoption. Coverage is not required if the adopted child is ultimately not placed in your home.

A child includes a child born to an insured Dependent child of yours until such child is 18 months old.

HC-DFS1111 12-17
ET

Spinal Manipulation Care

The term Spinal Manipulation Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

HC-DFS164 04-10
V1-ET

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Minnesota Residents

Rider Eligibility: Each Employee who is located in Minnesota

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Minnesota group insurance plans covering insureds located in Minnesota. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETMNRDR

Special Plan Provisions

NOTICE:

MN Statute Section 60A.084 (2000) provides as follows: An Employer providing life or health benefits may not change benefits, limit coverage, or otherwise restrict participation until the certificate holder or enrollee has been notified of any changes, limitations, or restrictions. Notice in a format which meets the requirements of ERISA USCA, Title 29, Sections 1001-1461 is satisfactory for compliance with this section.

HC-SPP54 05-18
ET

Certification Requirements - Out-of-Network

Mental health treatment covered under the plan which is court-ordered by a Minnesota court of competent jurisdiction pursuant to a behavioral care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment, shall be covered without being subject to Pre-Admission Certification (PAC). A copy of the court order and behavioral care evaluations must be provided to the Plan. (Minn. Stat. 62Q.535)

HC-PAC84 01-19
ET

Prior Authorization/Pre-Authorized

Mental health treatment covered under the plan which is court-ordered by a Minnesota court of competent jurisdiction pursuant to a behavioral care evaluation performed by a licensed psychiatrist or doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment, shall be covered without being subject to prior authorization. A copy of the court order and behavioral care evaluations must be provided to the Plan. (Minn. Stat. 62Q.535)

HC-PRA47 01-19
ET

Covered Expenses

- charges made for routine procedures for cancer screening, including mammograms, digital breast tomosynthesis,

Papanicolaou tests, colorectal screening tests for men and women, and ovarian cancer screening for women considered at risk due to a prior positive test for BRCA1 or BRCA2 mutations; or a family history of: one or more first or second degree relatives with ovarian cancers; clusters of women relatives with breast cancer; or nonpolyposis colorectal cancer.

- charges for general anesthesia and for associated Hospital or facility charges for dental care for your Dependent child who is under the age of five (5) or who is severely disabled, or who has a medical condition and requires hospitalization or general anesthesia for dental care treatment. Pre-authorization of hospitalization is required. Coverage may also include general anesthesia and treatment provided by a licensed Dentist for a covered medical condition, regardless if the services are provided in a Hospital or in a dental office.

Expenses For Which A Third Party May Be Responsible

This plan does not cover:

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

The plan's subrogation right applies only after the Participant has received a full recovery from another source.

The plan's subrogation right is subject to subtraction for actual monies paid to account for the pro rata share of the Participant's costs, disbursements, and reasonable attorney fees, and other expenses incurred in obtaining the recovery from another source unless the plan is separately represented by an attorney. If the plan is separately represented by an attorney, the plan and the Participant, by their attorneys, may enter into an agreement regarding allocation of the Participant's costs, disbursements, and reasonable attorney fees and other expenses. If the plan and Participant cannot reach agreement on allocation, the plan and Participant shall submit the matter to binding arbitration.

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.

Subrogation/Right of Reimbursement

If a Participant incurs a Covered Expense for which, 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.

Cigna's claim rights under this provision will be valid only if you are fully compensated for your loss. Your costs, disbursements, attorney fees and other expenses incurred to obtain recovery from the third party will be subtracted from the amount of Cigna's claim right.

Additional Terms

- 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-SUB115 05-18
ET

Termination of Insurance

Employees

Termination of Insurance

Your insurance will cease on the earliest date below:

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

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

Special Continuation of Medical and Dental Insurance

If your Medical and Dental Insurance would otherwise cease because of a reduction in the number of hours you work or your termination of employment for any reason other than gross misconduct, you may continue the insurance by paying the required premium to the Employer. The insurance may be continued until the earliest of:

- 18 months from the date your Active Service ends;
- the last day for which you have paid the required premium;
- the date you become eligible for insurance under another group policy for medical or dental benefits, including Medicare, unless you have a pre-existing condition for which the new policy limits coverage, in which case coverage under this Plan will continue until the pre-existing condition limitation has been satisfied, unless coverage under this Plan otherwise ends in accordance with this section;
- the date the policy cancels;
- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.

Termination of Insurance

Dependents

Your insurance for all of your Dependents will cease on the earliest date below, except in the event of your death (Refer to the section titled Dependent Insurance After Your Death):

- 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 canceled.

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

For Dependents of Deceased Employee

If you die while insured for your Dependents, the insurance for your Dependents will be continued in accordance with the "Dependent Medical or Dental Insurance After Your Death" provision.

Dependent Medical, Medical with Vision, Medical with Prescription Drug Insurance After Your Death

If you are insured for Medical, Medical with Vision or Medical with Prescription Drug Insurance when you die, any of your Dependents who are then insured for such insurance, except a Dependent who is eligible for Medicare, will remain so insured without further payment of premiums for them. The insurance on any of those Dependents will remain in force until the earliest date below:

- the date that Dependent ceases to qualify as a Dependent for a reason other than lack of primary support by you;
- the date the surviving spouse becomes eligible under another group health plan.

The Dependent benefits payable after you die will be those in effect for your Dependents on the day prior to your death.

If the Dependents elect to continue the insurance beyond the last day of the "Dependent Medical or Dental Insurance After Your Death" provision, they must notify the Employer within 90 days of your death and pay the required premium. Such continued insurance will cease on the earliest date below:

- the date coverage ends due to the Dependents' failure to make payment of the required premium;

- the date the insurance for your Dependents would have ceased if you had not died;
- the date the Dependent ceases to qualify as a Dependent, except as provided in the "Continuation for Dependent Children" provision;
- the date the Dependent becomes insured under another group health plan, including Medicare, except as provided in the "Continuation for Dependent Children" provision;
- the date the policy cancels.

Dependent Medical Insurance After Divorce or Legal Separation

The Medical and Dental Expense Insurance for:

- your insured spouse; and
- any insured child who would cease to qualify as your Dependent as a result of your divorce or legal separation;

may be continued, with premium payment, if you are required by decree to provide continued Medical and Dental Expense Insurance for them. However, the insurance on those Dependents will cease on the earliest date below:

- the date coverage ends due to your failure to make payment of the required premium;
- the date your insurance ceases;
- the date your Dependent ceases to qualify as a Dependent, other than due to the spouse's remarriage;
- the date Dependent Insurance is canceled.

To have Dependent Medical and Dental Insurance continued, you must notify the Employer of the decree and pay any required contribution to the Employer within 30 days after the Dependent Medical Insurance would otherwise cease.

If you die, any other terms which continue Dependent Medical and Dental Insurance after your death will apply.

The Continuation for Dependent Children provision will be available when this Dependent Medical and Dental Insurance ceases.

Continuation for Dependent Children

If your Dependent child's insurance would otherwise cease because:

- you become eligible for Medicare; or
- the Dependent ceases to qualify as a Dependent;

such Dependent may continue his insurance by paying the required premium to the Employer.

The insurance may be continued until the earliest of:

- 36 months from the date your Dependent's insurance would otherwise cease;
- the date your Dependent becomes insured under another group policy for medical and dental benefits, including Medicare;
- the date insurance ends due to your Dependent's failure to make payment of the required premium; or
- the date the policy cancels.

HC-TRM142 01-18
ET

Medical Benefits Extension During Hospital Confinement 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 Confined in a Hospital on that date, Medical Benefits will be paid without requirement of premium for Covered Expenses incurred in connection with that Hospital Confinement. 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 plan; or
- the date you or your Dependent is no longer Hospital Confined;

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-BEX36 04-10
V1-ET

Definitions

Medically Necessary/Medical Necessity

For mental health services, Medically Necessary/Medical Necessity means health care services appropriate, in terms of type, frequency, level, setting, and duration, to your diagnosis or condition, and diagnostic testing and preventive services. Medically necessary care must be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue and must:

- help restore or maintain the enrollee's health; or
- prevent deterioration of the enrollee's condition.

HC-DFS1018 10-16
ET

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – New Jersey Residents

Rider Eligibility: Each Employee who is located in New Jersey

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of New Jersey group insurance plans covering insureds located in New Jersey. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETNJRDR

Important Notice

Your health plan provides that you will not be held financially liable for payments to health care providers for any sums, other than required copayments, coinsurance or deductibles, owed for covered expenses, if Cigna fails to pay for the covered expenses for any reason.

HC-IMP17 04-10
V1-ET

Covered Expenses

- charges for the diagnosis and treatment of autism and other developmental disabilities.

  For a primary diagnosis of autism or another developmental disability, Cigna provides coverage for the following Medically Necessary therapies as prescribed through a treatment plan:

  - occupational therapy where occupational therapy refers to treatment to develop a covered person’s ability to perform the ordinary tasks of daily living;
  - physical therapy where physical therapy refers to treatment to develop a covered person’s physical function; and
  - speech therapy where speech therapy refers to treatment of a speech impairment.

  If a covered person’s primary diagnosis is autism, and the covered person is under 21 years of age, in addition to coverage for the therapy services as described above, Cigna also covers Medically Necessary behavioral interventions based on the principles of applied behavioral analysis and related structured behavioral programs as prescribed through a treatment plan. Except as stated below, such coverage of Medically Necessary behavioral interventions based on the principles of applied behavioral analysis and related structured behavioral programs is subject to a $36,000 maximum benefit per calendar year for each year through 2011. (Thereafter the maximum benefit shall be adjusted by New Jersey regulation.)

  NOTE: ANY SUCH BEHAVIORAL INTERVENTION BENEFITS A COVERED PERSON RECEIVES AS AN OUT-OF-NETWORK COVERED CHARGE WILL REDUCE THE SERVICES AVAILABLE AS IN-NETWORK BEHAVIORAL INTERVENTION SERVICES.

  Exception: If the Employer providing coverage under the contract is subject to the Federal law governing parity in Mental Health and Substance Use Disorder benefits the maximum benefit does not apply.

  The treatment plan(s) referred to above must be in writing, signed by the treating Physician, and must include: a

diagnosis, proposed treatment by type, frequency and duration; the anticipated outcomes stated as goals; and the frequency by which the treatment plan will be updated. Cigna may request additional information if necessary to determine the coverage under this plan. Cigna may require the submission of an updated treatment plan once every six months unless Cigna and the treating Physician agree to more frequent updates.

HC-COV670 12-17
ET2

Mental Health Services for Biologically-Based Mental Illness

If you or any one of your Dependents, while insured for these benefits, incurs expenses for charges made for Medically Necessary Mental Health Services for Biologically-Based Mental Illness, Cigna will pay that portion of the expense remaining after you or your Dependent has paid any required Deductible or Coinsurance shown in the Schedule.

These benefits for Biologically-Based Mental Illness will be provided under the same terms and conditions as provided "for any other sickness" under the policy.

Same Terms and Conditions means that Cigna will not apply different copayments, deductibles or benefit limits to biologically-based mental health benefits than those applied to other medical or surgical benefits.

The term **Biologically-Based Mental Illness** means a mental or nervous condition that is caused by a biological disorder of the brain which results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to:

- schizophrenia;
- schizoaffective disorder;
- major depressive disorder;
- bipolar disorder;
- paranoia and other psychotic disorders;
- obsessive-compulsive disorder;
- panic disorder;
- pervasive developmental disorder; or
- autism.

HC-COV560 01-17
ET

Payment of Benefits

Calculation of Covered Expenses

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

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

HC-POB108 01-17
ET

Definitions

Biologically-Based Mental Illness

A mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder; and pervasive developmental disorder or autism.

HC-DFS110 4-10
V1-ET

Dependent

Dependents include:

- your lawful spouse or civil union partner; or
- any child of yours who is:
  - less than 26 years old.
  - 26 or more years old, not married nor in a civil union partnership nor in a Domestic Partnership, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this plan, or while covered as a Dependent under a prior plan with no break in coverage.

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

may require proof of the continuation of such condition and dependence.

The term child means a child born to you or a child legally adopted by you. It also includes a stepchild. If your civil union partner has a child, that child will also be included as a Dependent.

HC-DFS978 01-17
ET

Medically Necessary/Medical Necessity

Medically Necessary Covered Services and Supplies means or describes a health care service that a health care provider, exercising his prudent clinical judgment, would provide to a covered person for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that is: in accordance with the generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the covered person's illness, injury or disease; not primarily for the convenience of the covered person or the health care provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered person's illness, injury or disease.

HC-DFS113 04-10
V1-ET

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Ohio Residents

Rider Eligibility: Each Employee who is located in Ohio

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Ohio group insurance plans covering insureds located in Ohio. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETOHRDR

Eligibility - Effective Date

Dependent Insurance

Exception for Newborns

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

HC-ELG256 03-19
ET

Covered Expenses

- charges made for or in connection with: an annual cytologic screening (Pap smear) for detection of cervical cancer; a single baseline mammogram for women ages 35 to 39; a mammogram every 2 years for women ages 40 through 49, or an annual mammogram if a licensed Physician has determined the woman to be at risk; and an annual mammogram for women ages 50 through 64. Screening mammography's can be performed in a health care facility or mobile mammography screening unit that is accredited under the American College of Radiology Accreditation Program or in a Hospital. The total benefit for a screening mammography shall not exceed 130% of the lowest Medicare reimbursement rate in Ohio for screening mammography. The total amount payable (including deductibles and copayments) for the mammogram cannot exceed 130% of the Medicare reimbursement amount. The provider may only bill for deductibles and copayments up to that amount and they may not balance bill for any charges over that.
- charges for diagnostic and exploratory procedures to determine infertility, including surgical procedures to correct the medically diagnosed disease or condition of reproductive organs, including but not limited to endometriosis, collapsed/clogged fallopian tubes or

testicular failure; in vitro fertilization, gamete intrafallopian transfer and zygote intrafallopian transfer are not covered.

HC-COV807 03-19
ET2

Medical Conversion Privilege

For You and Your Dependents

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy).

A Converted Policy will be issued on a direct-payment basis by Cigna only to a person who is Entitled to Convert, and only if he applies in writing and pays the first premium for the Converted Policy to Cigna within 31 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled to Convert

You are Entitled To Convert Medical Expense Insurance for yourself and all of your Dependents who were insured when your insurance ceased, except a Dependent who is eligible for Medicare or would be Overinsured, but only if:

- you have been insured for at least three consecutive months under the policy or under it and a prior policy issued to the Policyholder.
- your insurance ceased because you were no longer in Active Service or no longer eligible for Medical Expense Insurance.
- you are not eligible for Medicare.
- you would not be Overinsured.
- you have paid all required premium or contribution.
- you have not performed an act or practice that constitutes fraud in connection with the coverage.
- you have not made an intentional misrepresentation of a material fact under the terms of the coverage.
- your insurance did not cease because the policy in its entirety canceled.

If you retire you may apply for a Converted Policy within 31 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

Dependents Entitled to Convert

The following Dependents are also Entitled to Convert:

- a child whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse whose insurance under this plan ceases due to divorce, annulment of marriage or your death;
- your Dependents whose insurance under this plan ceases because your insurance ceased solely because you are eligible for Medicare;

but only if that Dependent: is not eligible for Medicare; would not be Overinsured, has paid all required premium or contribution, has not performed an act or practice that constitutes fraud in connection with the coverage, and has not made an intentional misrepresentation of a material fact under the terms of the coverage.

Overinsured

A person will be considered Overinsured if either of the following occurs:

- his insurance under this plan is replaced by similar group coverage within 31 days.
- the benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on Cigna's underwriting standards for individual policies.

  Similar Benefits are: those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or those available for the person by or through any state, provincial or federal law.

Converted Policy

The Converted Policy will be one of Cigna's current offerings at the time the first premium is received based on its rules for Converted Policies. The Converted Policy will be on a form which meets the conversion requirements of the jurisdiction where you reside, if a Converted Policy is permitted by such jurisdiction, and there is no alternative state program available.

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you may convert. If you are not Entitled to Convert and your spouse and children are, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: class of risk and age; and benefits.

The Converted Policy may not exclude any pre-existing condition not excluded by this plan. During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan (if any) will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan (if any). Cigna or the Policyholder will give you, on request, further details of the Converted Policy.

HC-CNV26
HC-CNV27 04-10
V1-ET

Payment of Benefits

Recovery of Overpayment on a Provider Claim

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

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

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

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

HC-POB149 03-19
ET

Definitions

Synchronous, Real Time Communication

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

HC-DFS1335 03-19
ET

Teledentistry

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

HC-DFS1336 03-19
ET

CIGNA HEALTH AND LIFE INSURANCE COMPANY, a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER – Pennsylvania Residents

Rider Eligibility: Each Employee who is located in Pennsylvania

You will become insured on the date you become eligible, including if you are not in Active Service on that date due to your health status.

This rider forms a part of the certificate issued to you by Cigna.

The provisions set forth in this rider comply with the legal requirements of Pennsylvania group insurance plans covering insureds located in Pennsylvania. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

HC-ETPARDR

Important Information About Your Medical Plan

Continuity Of Care

A new enrollee may continue an ongoing course of treatment with a nonparticipating health care provider, or a covered person with a participating provider when the plan initiates termination of the provider's contract, except for cause including fraud, breach of contract, criminal activity or posing a danger to health or safety. Treatment may continue, at the covered person's option, for a transitional period of up to 60 days from enrollment from the date the covered person was notified by the plan of the termination, under the same terms and conditions as those applicable for participating providers. If considered clinically appropriate by the plan, the transitional period may be extended. When the covered person is in the second or third trimester of pregnancy, the transitional period shall extend through postpartum care related to the delivery.

HC-IMP1 04-10
V3-ET

The Schedule

The Medical Schedule is amended to indicate that no separate maximum/deductible shall apply to **Diabetic Equipment**.

The **Nutritional Evaluation** annual maximum shown in the Medical Schedule is amended to indicate the following:

"3 visits per person however, the 3 visit limit will not apply to treatment of diabetes."

SCHEDDENE-ET1

Covered Expenses

- charges made for or in connection with mammograms, including digital breast tomosynthesis, for breast cancer screening and diagnosis, not to exceed: a baseline mammogram annually for women age 40 and over; and a mammogram upon a Physician's recommendation for women under age 40.
- charges for an annual gynecological exam, including a pelvic exam and a routine pap smear. No dollar limit or Deductible may be applied to routine pap smears.
- charges for colorectal cancer screening for non-symptomatic persons who are 50 years of age or older shall include, but not be limited to: an annual fecal occult blood test; a sigmoidoscopy, a screening barium enema or a test consistent with approved medical standards and practices to detect colon cancer, at least once every 5 years; and a colonoscopy at least once every 10 years.

  Coverage for symptomatic persons shall include a colonoscopy, sigmoidoscopy or any combination of colorectal cancer screening tests at a frequency determined by a treating Physician. "Symptomatic person" means an individual who experiences a change in bowel habits, rectal bleeding or persistent stomach cramps, weight loss or abdominal pain.

  Coverage for a non-symptomatic person at high or increased risk for colorectal cancer who is under 50 years of age shall include a colonoscopy or any combination of colorectal cancer screening tests in accordance with the American Cancer Society guidelines on screening for colorectal cancer published as of January 1, 2008. "Non-symptomatic person at high or increased risk" means an individual who poses a higher than average risk for colorectal cancer.
- charges for childhood immunizations, including the immunizing agents and Medically Necessary booster doses. Immunizations provided in accordance with Advisory Committee on Immunization Practices (ACIP) standards are covered for any insured person under age 21 and are exempt from Deductibles or dollar limits.
- charges made for treatment of Serious Mental Illness. Such Covered Expenses will be payable the same as for other illness.
- charges for at least 48 hours of inpatient care following a mastectomy. A longer period of time will be covered if the treating Physician determines it is Medically Necessary. Home health care services will also be provided if the treating Physician deems these services Medically Necessary.
- charges for Hospital Confinement of a mother and her newborn child for 48 hours following a vaginal delivery, or for 96 hours following a cesarean section. The mother may request an earlier discharge, if after consulting with her Physician, it is determined that less time is needed for recovery.
- charges made for one postpartum home health care visit, within 48 hours following discharge from the Hospital of the mother and newborn, provided that discharge occurs prior to:
  - 48 hours for normal vaginal delivery; or
  - 96 hours for a cesarean section.

  Postpartum home health care visits will be covered for women if determined to be Medically Necessary. No

Copayment, Coinsurance or Deductible will apply to postpartum home health care services.

- the following benefits will apply to insulin-dependent, and non-insulin-dependent diabetics as well as covered individuals who have elevated blood sugar levels due to pregnancy or other medical conditions:
  - charges for Durable Medical Equipment, including glucometers; blood glucose monitors for the legally blind; insulin pumps; infusion devices and related accessories, including those adaptable for the legally blind; podiatric appliances; and glucagon emergency kits. A special maximum will not apply.
  - charges for training by a Physician with expertise in diabetes management, but limited to the following:
    - Medically Necessary visits when diabetes is diagnosed;
    - Medically Necessary visits following a diagnosis of a significant change in the symptoms or conditions that warrant change in self-management;
    - visits when reeducation or refresher training is prescribed by the Physician; and
    - medical nutrition therapy related to diabetes management.

HC-COV822 03-19
ET

Medical Pharmaceuticals

The following diabetic supplies are also covered under the plan's medical benefit: alcohol pads, swabs, wipes, Glucagon/Glucagen, insulin pump accessories (but excluding insulin pumps), needles including pen needles, syringes, test strips, lancets, urine glucose and ketone strips, insulin, injection aids, pre-filled insulin pens and cartridges, pharmacological agents for controlling blood sugar.

HC-COV612 10-16
ET

Mental Health and Substance Abuse Services

Inpatient Detoxification Services

Inpatient detoxification for the diagnosis and treatment of abuse of or addiction to alcohol and/or drugs, or alcohol in combination with drugs shall be provided either in a Hospital or in an inpatient non-Hospital facility which is licensed as an alcoholism and/or drug addition treatment program and meets the requirements of Pennsylvania law. Before an insured may qualify to receive benefits under this section, a Physician or Psychologist must certify the insured as a person suffering from alcohol or drug abuse or dependency and must refer the insured for the appropriate treatment. The following services are covered under inpatient detoxification:

- lodging and dietary services;
- Physician, Psychologist, Nurse, certified addictions counselor and trained staff services;
- diagnostic x-ray;
- psychiatric, psychological and medical laboratory testing; and
- drugs, medicines, equipment use and supplies.

HC-COV137 04-10
V3-ET

Medical Conversion Privilege

For You and Your Dependents

When a person's Medical Expense Insurance ceases, for a reason other than failure of the person to pay premium or if the policy is replaced by similar group insurance within 31 days, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy).

A Converted Policy will be issued by Cigna only to a person who:

- resides in a state that requires offering a conversion policy,
- is Entitled to Convert, and
- applies in writing and pays the first premium for the Converted Policy to Cigna within 31 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled to Convert

You are Entitled to Convert Medical Expense Insurance for yourself and all of your Dependents who were insured when your insurance ceased but only if:

- you are not eligible for other individual insurance coverage on a guaranteed issue basis.
- you have been insured for at least three consecutive months under the policy or under it and a prior policy issued to the Policyholder.
- your insurance ceased because you were no longer in Active Service or no longer eligible for Medical Expense Insurance.

- you are not eligible for Medicare.
- you would not be Overinsured.
- you have paid all required premium or contribution.
- you have not performed an act or practice that constitutes fraud in connection with the coverage.
- you have not made an intentional misrepresentation of a material fact under the terms of the coverage.
- your insurance did not cease because the policy in its entirety canceled.

If you retire, you may apply for a Converted Policy within 31 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

Dependents Entitled to Convert

The following Dependents are also Entitled to Convert:

- a child who is not eligible for other individual insurance coverage on a guaranteed issue basis, and whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse who is not eligible for other individual insurance coverage on a guaranteed issue basis, and whose insurance under this plan ceases due to divorce, annulment of marriage or your death;
- your Dependents whose insurance under this plan ceases because your insurance ceased solely because you are eligible for Medicare;

but only if that Dependent: is not eligible for other individual insurance coverage on a guaranteed issue basis, is not eligible for Medicare, would not be Overinsured, has paid all required premium or contribution, has not performed an act or practice that constitutes fraud in connection with the coverage, and has not made an intentional misrepresentation of a material fact under the terms of the coverage.

Overinsured

A person will be considered Overinsured if either of the following occurs:

- his insurance under this plan is replaced by similar group coverage within 31 days.
- the benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on Cigna's underwriting standards for individual policies.

Similar Benefits are: those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or those available for the person by or through any state, provincial or federal law.

Converted Policy

If you reside in a state that requires the offering of a conversion policy, the Converted Policy will be one of Cigna's current conversion policy offerings available in the state where you reside, as determined based upon Cigna's rules.

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you may convert. If you are not Entitled to Convert and your spouse and children are Entitled to Convert it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: class of risk and age; and benefits.

During the first 12 months the Converted Policy is in effect, the amount payable under it will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan (if any) will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan (if any). Cigna or the Policyholder will give you, on request, further details of the Converted Policy.

HC-CNV28 04-14
V3-ET

Definitions

Dependent

The term child means a child born to you or a child legally adopted by you including that child, from the date of placement in your home, regardless of whether the adoption has become final.

HC-DFS1007 10-16
ET

Hospital

The term Hospital means:

- a birthing facility.

- a public or private hospital or treatment facility, other than a transitional living facility, which: specializes in treatment of Substance Use Disorder; provides residential treatment programs; and is licensed by the Department of Health.
- a detoxification facility having a written agreement with a hospital for emergency, medical and psychological support services, meeting minimum client-to-staff ratios and staff qualifications set by the Department of Health and licensed as a Substance Use Disorder treatment program.

HC-DFS277 04-10
V3-ET

Prescription Drug Product

For the purpose of benefits under the plan, this definition also includes:

- Insulin
- Injection aids
- Pre-filled insulin pens and cartridges
- Pharmacological agents for controlling blood sugar.

HC-DFS1049 10-16
ET

Home Office: Bloomfield, Connecticut

Mailing Address: Hartford, Connecticut 06152

CIGNA HEALTH AND LIFE INSURANCE COMPANY

a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER

No. CR7MN017-1

Policyholder: Wilmington Trust National Association

Group: Ecolab Inc.

Rider Eligibility: Each Member who resides in Massachusetts

Account/Group Number: 04048A

Effective Date: January 1, 2025

You will become insured on the date you become eligible 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. If you are not insured for the benefits described in your certificate on that date, the effective date of this certificate rider will be the date you become insured.

This certificate rider forms a part of the certificate issued to you by Cigna describing the benefits provided under the policy(ies) specified above.



Geneva Cambell Brown, Corporate Secretary

GC-RDR7 01-21

The pages coded HC-MANCR1V1 and HC-MANCR2V15 attached to this certificate rider are added to your certificate.

Notice To Massachusetts Residents



This Open Access Plus Medical Benefits health plan, alone, **does not meet Minimum Creditable Coverage standards** and **will not satisfy** the individual mandate that you have health insurance. For additional information, please see the section "Massachusetts Requirement to Purchase Health Insurance," immediately preceding the Schedule.

HC-MANCR1V1

Massachusetts Requirement To Purchase Health Insurance:

This Open Access Plus Medical Benefits health plan, alone, **does not meet Minimum Creditable Coverage standards** that are effective January 1, 2025 as part of the Massachusetts Health Care Reform Law because:

- A broad range of medical benefits, as defined by the Connector, are not covered.
- Prescription drugs are not covered.
- Preventive care services are not covered.

If you purchase this health plan only, you **will not satisfy** the statutory requirement that you have health insurance meeting these standards.

If this health plan is offered to you through your place of employment, contact your Employer or other plan sponsor to determine if it offers other health plan options that meet Minimum Creditable Coverage standards. Your Employer or other plan-sponsor also may offer supplemental plans you can add to this insured health plan in order to meet Minimum Creditable Coverage.

If this health plan is not offered to you through your place of employment and you want to learn about other health plan options available to individuals, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi, or the Connector by calling 1-877-MA-ENROLL or visiting its website at www.mahealthconnector.org.

THIS DISCLOSURE IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2025. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

HC-MANCR2 01-25
V15

Home Office: Bloomfield, Connecticut

Mailing Address: Hartford, Connecticut 06152

CIGNA HEALTH AND LIFE INSURANCE COMPANY

a Cigna company (hereinafter called Cigna)

CERTIFICATE RIDER

No. CR7MN016-1

Policyholder: Wilmington Trust National Association

Group: Ecolab Inc.

Rider Eligibility: Each Member who resides in Massachusetts

Account/Group Number: 04048A

Effective Date: January 1, 2025

You will become insured on the date you become eligible 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. If you are not insured for the benefits described in your certificate on that date, the effective date of this certificate rider will be the date you become insured.

This certificate rider forms a part of the certificate issued to you by Cigna describing the benefits provided under the policy(ies) specified above.



Geneva Cambell Brown, Corporate Secretary

GC-RDR7 01-21

The pages coded HC-MACR1V1 and HC-MACR2V12 attached to this certificate rider are added to your certificate.

Notice To Massachusetts Residents



This Open Access Plus Medical Benefits health plan **meets Minimum Creditable Coverage standards** and **will satisfy** the individual mandate that you have health insurance. For additional information, please see the section "Massachusetts Requirement to Purchase Health Insurance," immediately preceding the Schedule.

HC-MACR1V1

Massachusetts Requirement To Purchase Health Insurance:

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This Open Access Plus Medical Benefits health plan **meets Minimum Creditable Coverage standards** that are effective January 1, 2025 as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you **will satisfy** the statutory requirement that you have health insurance meeting these standards.

THIS DISCLOSURE IS FOR MINIMUM COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2025. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR HEALTH PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

HC-MACR2 01-25
V12