

Traditional Medical Plan

Summary Plan Description

January 1, 2023

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, 2023. Ecolab has the right to amend or terminate all or part of the Plan at any time.

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

ADMINISTRATIVE INFORMATION
SUMMARY PLAN DESCRIPTION

EFFECTIVE JANUARY 1, 2023

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

Benefit Type	Insured or Self-Insured	Insurer/ Claims Administrator Name and Contact Information	Vendor 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
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

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	Dental Plan Option Benefit Description
Vision	Insured	VSP VSP Member Services VSP Attention: Claims Services PO Box 385018, Birmingham, AL 35238 1-800-877-7195 **www.ecolab.VSPfor me.com**	Vision Plan Option Group Vision Care Policy Evidence of Coverage / 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 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 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 FMLA leave.

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 24 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 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.	Your Plan benefit options will continue, and the pre-tax premium contributions will resume the first of the month following your return-to-work 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. 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 had 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.

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 amount of the increase charge is dependent on the additional months required.) 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 active COBRA rate will apply if your military leave is unpaid or partially paid. 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 are on military leave for less than 31 days, you will pay the active employee rate for your benefits.

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.

Refund of Overpayments.

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 HEALTH AND WELFARE BENEFITS PLAN:
TRADITIONAL MEDICAL PLAN

BENEFIT DESCRIPTION

EFFECTIVE JANUARY 1, 2023

ASO58 3331790

Traditional Medical Plan Benefit Description
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Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BENFFIT DESCRIPTION OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY ECOLAB INC., WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CIGNA HEALTH AND LIFE INSURANCE COMPANY (CIGNA) PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CIGNA DOES NOT INSURE THE BENEFITS DESCRIBED.

INTRODUCTION

This Benefit Description summarizes the main provisions of the Traditional Medical Plan option, effective as of January 1, 2023, as they apply to eligible Employees. Together with the Ecolab ***Administrative Information SPD***, this Benefit Description serves as the ERISA-required Summary Plan Description (SPD) for these benefits. The Traditional Medical Plan (Plan) and this Benefit Description are intended to comply with all applicable laws and will be interpreted in a manner that maintains compliance with those laws.

We encourage you to read this Benefit Description and the ***Administrative Information SPD*** carefully and share them with your family. If you have any questions about your benefits, please contact the Ecolab Benefits Center at 1.800.964.0265.

Note that this Benefit Description is only a summary. Complete details of the Plan are contained in the legal plan document. With one exception, the official Plan document will control in the event of any differences between this Benefit Description. However, if there is language in this Benefit Description regarding a topic the Plan document is silent on, the language in this SPD will govern with respect to that topic only.

This 2023 Benefit Description SPD, together with the ***Administrative Information SPD***, provide a summary of the provisions of the Plan. Ecolab reserves the right to change or discontinue these benefits, in whole or in part, at any time in the future.

No provision of the Traditional Medical Plan is to be considered a contract of employment between you and Ecolab.

Explanation of Terms

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

Summary of Your Traditional Plus Medical Benefits

The Summary is a brief outline of the benefits that may be payable under this Plan. 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, this Plan pays a greater share of the costs than if you select a non-Participating Provider. Participating Providers include Physicians, Hospitals and Other Health Professionals and Other Health Care Facilities. For up-to-date provider information, if you are enrolled in a Cigna medical plan, go to My Benefits, or call Cigna Member Services 1.800.900.3791 for information. If you are not enrolled in a Cigna medical plan, call 1.800.401.4041 to find a provider or confirm whether your provider is part of the Cigna network. Consult your *Physician Guide* for a list of Participating Providers in your area. Cigna's provider listing will be updated every 90 days in accordance with federal law. 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 the Plan. You can access these services by calling Cigna Member Services at the toll-free number at 1.800.900.3791.

HC-SPP70 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 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 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 Cigna Member Services at 1.800.900.3791 toll-free during normal business hours, Monday through Friday. In addition, your Employer, a claim office or a utilization review program (see the **"Pre-Admission Certification/Continued Stay Review for Hospital Confinement"** section of this Benefit Description) may refer an individual for Case Management.

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

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

HC-SPP2 04-10 V1

Additional Programs

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

HC-SPP3 04-10 V1

Care Management and Care Coordination Services

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

HC-SPP27 06-15 V1

Important Notices

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 Providers who specialize in obstetrics or gynecology, visit **myCigna.com** or contact Cigna Member Services at 1.800.900.3791.

Selection of a Primary Care Provider

This Plan generally allows, but does not require, the designation of a Primary Care Provider. You have the right to designate any Primary Care Provider who participates in the network and who is available to accept you or your Dependents. For information on how to select a Primary Care Provider, and for a list of the Participating Primary Care Providers, visit **myCigna.com** or contact Cigna Member Services at 1.800.900.3791.

For children, you may designate a pediatrician as the Primary Care Provider.

HC-NOT5 01-11

Important Information Regarding Prescription Drug Coverage

Outpatient prescription drug coverage is provided by CVS Caremark, not by Cigna. For information, see the *Prescription Drug Summary Plan Description (SPD)* available on My Benefits.

Medical Pharmaceuticals

Rebates and Other Payments

Cigna or its affiliates may receive rebates or other remuneration from pharmaceutical manufacturers in connection with certain Medical Pharmaceuticals covered under the Plan. These rebates or remuneration are not obtained on you or your Employer's or Plan's behalf, nor 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 conduct business with various pharmaceutical manufacturers separate and apart from this Plan's Medical Pharmaceutical 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. 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 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.

HC-IMP304 01-22

Discrimination Is Against the Law

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

Cigna:

- provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - qualified sign language interpreters
  - written information in other formats (large print, audio, accessible electronic formats, other formats)

- provides free language services to people whose primary language is not English, such as
  - qualified interpreters
  - information written in other languages

If you need these services, contact Cigna Member Services at 1.800.900.3791.

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

Cigna
Nondiscrimination Complaint Coordinator
P.O. Box 188016
Chattanooga, TN 37422

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.368.1019, 1.800.537.7697 (TDD)

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

HC-NOT96 07-17

Proficiency of Language Assistance Services

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

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.800.244.6224 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。 對於Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.800.244.6224 （聽障專線：請撥 711）。

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

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.800.244.6224 (TTY: 다이얼 711)번으로 전화해주십시오.

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

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

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

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

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

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

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

Japanese –

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

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

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

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

HC-NOT97 07-17

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) — Non-Quantitative Treatment Limitations (NQTLs)

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

Non-Quantitative Treatment Limitations (NQTLs) include (to the extent applicable under the plan):

- medical management standards limiting or excluding benefits based on Medical Necessity or whether the treatment is experimental or investigative;
- prescription drug formulary design;
- network admission standards;
- methods for determining In-Network and Out-of-Network provider reimbursement rates;
- step therapy, a/k/a fail-first requirements; and
- exclusions and/or restrictions based on geographic location, facility type or provider specialty.

A description of the Plan's NQTL methodologies and processes applied to medical/surgical benefits and MH/SUD benefits is available for review by Plan Administrators (e.g., employers) and covered persons:

- **Employers (Plan Administrators):**
  Please contact your Cigna Sales Representative to request the NQTL comparative analysis.

  Covered Persons: www.cigna.com\sp

To determine which document applies to your Plan, select the relevant health plan product; medical management model (inpatient only or inpatient and outpatient), which can be located in this Benefit Description immediately following the Summary; and pharmacy coverage (whether or not your Plan includes pharmacy coverage).

HC-NOT113 01-20

Eligibility — Effective Date

Employee Coverage

This Plan is offered to you as an Employee.

Eligibility for Employee Coverage

Only eligible Employees can participate in this Plan. Refer to the ***Administrative Information SPD*** for eligibility information. You and Ecolab share in the cost of your medical (including prescription drug) coverage. Your share of the cost generally is deducted from your paycheck on a pre-tax basis, that is before federal — and in most cases state — income taxes and FICA taxes are withheld. If you enroll a Domestic Partner and their children, contributions for their coverage are deducted on an after-tax basis and the value of Employer-paid coverage for the Domestic Partner and their children is imputed to you as income.

Eligibility for Dependent Coverage

If you enroll yourself for medical coverage, you may also enroll your eligible Dependents. Your eligible Dependents include your spouse, Domestic Partner, and dependent children.

You are required to provide documents supporting eligible Dependent status when you first enroll an eligible Dependent, such as a birth certificate, marriage certificate or Domestic Partner affidavit. If you fail to provide the required documentation by the enrollment deadline, your Dependent will not be enrolled and generally cannot enroll until the next open enrollment period. Refer to the ***Administrative Information SPD*** for eligibility information.

Waiting Period

None.

Effective Date of Employee Coverage

If you are a newly hired Employee, your medical coverage will become effective retroactive to your date of hire. If you become benefits eligible during the year, your medical coverage will be

effective retroactive to your benefit eligibility date. You must enroll within 31 days of your date of hire or benefits eligibility date. If you enroll during the annual open enrollment period, coverage is effective on January 1 of the next Plan year.

Benefits generally continue for the full Plan year, unless you have a special enrollment event or a mid-year change in status event. See the section **"Mid-Year Election Changes"** in the *Administrative Information SPD.*

Dependent Coverage

For your Dependents to be insured, they must be enrolled in the same medical option in which you are enrolled, and appropriate documentation of Dependent status must have been submitted and approved.

Effective Date of Dependent Coverage

Coverage for your Dependents begins on the same date your coverage begins, or, if a mid-year change or special enrollment, retroactive to the date of the event for newborns, adopted children or those placed with you for adoption. For all other mid-year change events, coverage is effective as of the date of the request.

Your Dependents will be covered only if you are insured.

Exception for Newborns

Any Dependent child born, adopted or placed with you for adoption while you are insured will be covered as of their date of birth, adoption or placement for adoption if you elect Dependent Coverage no later than 31 days after the event. If you do not elect to insure your child within 31 days, coverage for that child will end on the 31st day. No benefits for Expenses Incurred beyond the 31st day will be payable.

HC-ELG274 M 01-19

How to File Your Claim

There's no paperwork for In-Network care (i.e., from a Participating Provider). Just show your identification card and pay your share of the cost, if any; the Participating Provider will submit a claim to Cigna for reimbursement. Out- of-Network (i.e., non-Participating Provider) claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim forms from the Cigna website at **myCigna.com** or by calling Cigna Member Services at 1.800.900.3791.

CLAIM REMINDERS

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

Timely Filing of Out-of-Network Claims

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

HC-CLM25 01-11
V11

Important Information About Your Medical Plan

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

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician:

This 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 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.

Changing Primary Care Physicians:

You may request a transfer from one Primary Care Physician to another by contacting Cigna Member Services at 1.800.900.3791. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

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

HC-IMP212 01-18

Summary of Your Traditional Plus Medical Benefits

For You and Your Dependents

Traditional Plus Medical Benefits provide coverage for care In-Network and Out-of-Network. To receive Traditional 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 Copayment, Deductible or Coinsurance.

When you receive services from an In-Network Provider, remind your provider to use In-Network Providers for x-rays, lab tests and other services to ensure the cost may be considered at the In-Network level.

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 Cigna Member Services at 1.800.900.3791 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.

Coinsurance

The term Coinsurance means the percentage of Covered Expenses an insured person is required to pay under the Plan in addition to the Deductible, if any.

Copayments/Deductibles

Copayments are amounts to be paid by you or your Dependent for covered services. Deductibles are Covered Expenses to be paid by you or your Dependent before benefits are payable under this Plan. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance. Once the Deductible maximum in the Summary has been reached, you and your family need not satisfy any further medical Deductible for the rest of that year.

Out-of-Pocket Expenses — For In-Network Charges Only

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

Out-of-Pocket Expenses — For Out-of-Network Charges Only

Out-of-Pocket Expenses are Covered Expenses incurred for Charges that are not paid by the Plan. The following Expenses contribute to the Out-of-Pocket Maximum, and when the Out-of-Pocket Maximum shown in the Summary is reached, they are payable by the Plan at 100%:

- Coinsurance.
- Plan Deductible.

Once the Out-of-Pocket Maximum is reached for covered services that apply to the Out-of-Pocket Maximum, any copayments and/or benefit deductibles 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 Plan at 100% when the Out-of-Pocket Maximum shown in the Summary is reached:

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

Accumulation of Plan Deductibles and Out-of-Pocket Maximums

Expenses incurred for out-of-network services will count towards your in-network deductible and out-of-pocket maximum. This means there's no separate out-of-pocket maximum for out-of-network services; instead, they accumulate together with in-network expenses.

Summary of Your Traditional Plus Medical Benefits

Multiple Surgical Reduction

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

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

The maximum amount payable will be limited to Charges made by an assistant surgeon that do not exceed a percentage of the surgeon's Allowable Charge as specified in Cigna Reimbursement Policies. (For purposes of this limitation, Allowable Charge means the amount payable to the surgeon prior to any reductions due to Coinsurance or Deductible amounts.)

Co-Surgeon

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

Out-of-Network Charges for Certain Services

Charges for services furnished by an Out-of-Network provider in an In-Network facility while you are receiving In-Network services at that In-Network facility: (i) are payable at the In-Network cost-sharing level; and (ii) the allowable amount used to determine the Plan's benefit payment is the amount agreed to by the Out-of-Network provider and Cigna, or as required by applicable state or federal law.

The member is responsible for applicable In-Network cost-sharing amounts (any Deductible, Copayment 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 Member Services at 1.800.900.3791.

Out-of-Network Emergency Services Charges

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

The member is responsible for applicable In-Network cost-sharing amounts (any Deductible, Copayment 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 Member Services at 1.800.900.3791.

Summary of Your Traditional Plus Medical Benefits

Out-of-Network Air Ambulance Service Charges

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

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is not responsible for any charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	
The Percentage of Covered Expenses the Plan Pays **Note:** "No charge" means an insured person is not required to pay Coinsurance.	80%	60% of the Maximum Reimbursable Charge
Maximum Reimbursable Charge The Maximum Reimbursable Charge for Out-of-Network services other than those described in the Summary sections **"Out-of-Network Charges for Certain Services"** and **"Out-of-Network Emergency Services Charges"** is determined based on the lesser of the provider's normal Charge for a similar service or supply; or the amount agreed to by the Out-of-Network provider and Cigna, or a policyholder-selected percentage of a fee schedule Cigna has developed that is based upon a methodology similar to a methodology used by Medicare to determine the allowable reimbursement for the same or similar services within the geographic market. In some cases, a Medicare-based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of: • the provider's normal Charge for a similar service or supply; or • the 80th percentile of Charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient Charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used.	Not Applicable	150%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Note: The provider may bill you for the difference between the provider's normal Charge and the Maximum Reimbursable Charge, in addition to applicable Deductibles and/or Coinsurance. **Note:** Some providers forgive or waive the cost share obligation (e.g., your Deductible and/or Coinsurance) this Plan requires you to pay. Waiver of your required cost share obligation can jeopardize your coverage under this Plan. For more details, see the **"Exclusions"** section.		
Calendar Year Deductible Individual Family Maximum **Family Maximum Calculation/ Individual Calculation:** Family members meet only their individual Deductible and then their claims will be covered under the Plan Coinsurance; if the family Deductible has been met prior to their individual Deductible being met, their claims will be paid at the Plan Coinsurance.	 $750 per person $2,250 per family	 $1,500 per person $4,500 per family
Out-of-Pocket Maximum Individual Family Maximum **Family Maximum Calculation/ Individual Calculation:** Family members meet only their individual Out-of-Pocket Maximum and then their claims will be covered at 100%; if the family Out-of-Pocket Maximum has been met prior to their individual Out-of-Pocket Maximum 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

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician's Services		
Primary Care Physician's Office Visit	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Specialty Care Physician's Office Visit	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Consultant and Referral Physician's Services		
Note: OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company.		
Surgery Performed in the Physician's Office	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Second Opinion Consultations (provided on a voluntary basis)	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Allergy Treatment/Injections	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Allergy Serum (dispensed by the Physician in the office)	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Convenience Care Clinic (includes any related lab and x-ray services and surgery)	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Telemedicine **Dedicated Virtual Providers** Dedicated virtual care services may be provided by MDLIVE, a Cigna affiliate. Services available through contracted virtual providers as medically appropriate **Notes:** Primary Care cost share applies to routine care. Virtual wellness screenings are payable under preventive care. MDLIVE Behavioral Services, please refer to the Mental Health and Substance Use Disorder section (below).		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lab services supporting a virtual visit must be obtained through dedicated labs.		
MDLIVE Urgent Care Services	80% after Plan Deductible	In-Network coverage only
MDLIVE Primary Care Services	80% after Plan Deductible	In-Network coverage only
MDLIVE Specialty Care Services	80% after Plan Deductible	In-Network coverage only
Virtual Physician Services Services available through Physicians as medically appropriate. **Note:** Physicians may deliver services virtually that are payable under other benefits (e.g., Preventive Care, Outpatient Therapy Services).		
Physician Virtual Office Visit	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Preventive Care (see **"Covered Expenses"** for details) **Note:** Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.		
Routine Preventive Care — all ages	No Charge	In-Network coverage only
Immunizations — all ages	No Charge	In-Network coverage only
Mammograms, PSA, PAP Smear		
Preventive Care Related Services (i.e., "routine" services)	No Charge	60% of the Maximum Reimbursable Charge after Plan Deductible
Diagnostic Related Services (i.e., "non-routine" services)	No Charge	60% of the Maximum Reimbursable Charge after Plan Deductible
Inpatient Hospital – Facility Services	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Semi-Private Room and Board	Limited to the semi-private room negotiated 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
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Facility Services		
Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Inpatient Hospital Physician's Visits/Consultations	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Urgent Care Services		
Physician's Office Visit	80% after Plan Deductible	80% of the Maximum Reimbursable Charge after Plan Deductible
Urgent Care Facility or Outpatient Facility	80% after Plan Deductible	80% of the Maximum Reimbursable Charge after Plan Deductible
Outpatient Professional Services (radiology, pathology, Physician)	80% after Plan Deductible	80% of the Maximum Reimbursable Charge after Plan Deductible
X-ray and/or Lab performed at the Urgent Care Facility (billed by the facility as part of the UC visit)	80% after Plan Deductible	80% of the Maximum Reimbursable Charge after Plan Deductible
Advanced Radiological Imaging (i.e., MRIs, MRAs, CAT Scans, PET Scans, etc.)	80% after Plan Deductible	80% of the Maximum Reimbursable Charge after Plan Deductible
Emergency Services		
Physician's Office Visit	80% after Plan Deductible	80% after Plan Deductible
Hospital Emergency Room	80% after $150 per visit Copay* and Plan Deductible *Copay waived if admitted	80% after $150 per visit Copay* and Plan Deductible *Copay waived if admitted
Outpatient Professional Services (radiology, pathology, ER Physician)	80% after Plan Deductible	80% after Plan Deductible
X-ray and/or Lab performed at the Emergency Room Facility (billed by the facility as part of the ER visit)	80% after Plan Deductible	80% after Plan Deductible
Independent X-ray and/or Lab Facility in conjunction with an ER visit	80% after Plan Deductible	80% after Plan Deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Advanced Radiological Imaging (i.e., MRIs, MRAs, CAT Scans, PET Scans, etc.)	80% after Plan Deductible	80% after Plan Deductible
Air Ambulance	80% after Plan Deductible	80% after Plan Deductible
Ambulance	80% after Plan Deductible	80% of the Maximum Reimbursable Charge after Plan Deductible
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: 120 days combined	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Laboratory and Radiology Services (includes pre-admission testing)		
Physician's Office Visit	80% after Plan Deductible	80% of the Maximum Reimbursable Charge after Plan Deductible
Outpatient Hospital Facility	80% after Plan Deductible	80% of the Maximum Reimbursable Charge after Plan Deductible
Independent X-ray and/or Lab Facility	80% after Plan Deductible	80% of the Maximum Reimbursable Charge after Plan Deductible
Advanced Radiological Imaging (i.e., MRIs, MRAs, CAT Scans and PET Scans, etc.)		
Physician's Office Visit	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Inpatient Facility	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Outpatient Facility	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Therapy Services (The limit is not applicable to mental health conditions.) Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy	80% after Plan Deductible Calendar Year Maximum: UNLIMITED days for all therapies combined **Note:** Speech, physical, and occupational therapy for the treatment of Autism Spectrum Disorder equals unlimited days	60% of the Maximum Reimbursable Charge after Plan Deductible Calendar Year Maximum: 20 days for all therapies combined **Note:** Speech, physical, and occupational therapy for the treatment of Autism Spectrum Disorder equals 20 days
Chiropractic Care Physician's Office Visit	Calendar Year Maximum: 30 days 80% after Plan Deductible	Calendar Year Maximum: 20 days 60% of the Maximum Reimbursable Charge after Plan Deductible
Acupuncture Self-referred, Medically Necessary treatment of pain or disease by acupuncture provided on an outpatient basis, limited to a 30-day maximum per person per calendar year for In-Network and 20-day maximum per person per calendar year for Out-of-Network Physician's Office Visit	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Home Health Care Services Calendar Year Maximum: Unlimited Includes outpatient private nursing when approved as Medically Necessary	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Hospice Inpatient Services Outpatient Services (same Coinsurance level as Home Health Care Services)	80% after Plan Deductible 80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible 60% of the Maximum Reimbursable Charge after Plan Deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Bereavement Counseling		
Services provided as part of Hospice Care		
Inpatient	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Outpatient	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Services provided by Mental Health Professional	Covered under Mental Health benefit	Covered under Mental Health benefit
Gene Therapy		
Includes prior authorized gene therapy products and services directly related to their administration, when Medically Necessary.		
Gene therapy must be received at an In-Network facility specifically contracted with Cigna to provide the specific gene therapy. Gene therapy at other In-Network facilities is not covered.		
Gene Therapy Product	Subject to In-Network facility cost share based on place of service; separate from facility Charges	In-Network coverage only
Inpatient Facility	80% after Plan Deductible	In-Network coverage only
Outpatient Facility	80% after Plan Deductible	In-Network coverage only
Physician's Services	80% after Plan Deductible	In-Network coverage only
Travel Maximum: $10,000 per episode of gene therapy	No charge (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
Maternity Care Services		
Initial Visit to Confirm Pregnancy **Note:** OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with the Insurance Company.	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e., global maternity fee)	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Delivery – Facility (Inpatient Hospital, Birthing Center)	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Abortion		
Includes elective and non-elective procedures		
Physician's Office Visit	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Inpatient Facility	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Outpatient Facility	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Physician's Services	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Women's Family Planning Services		
Office Visits, Lab and Radiology Tests and Counseling	No Charge	60% of the Maximum Reimbursable Charge after Plan Deductible
Note: Includes coverage for contraceptive devices (e.g., Depo-Provera and Intrauterine Devices (IUDs)) as ordered or prescribed by a Physician. Diaphragms also are covered when services are provided in the Physician's office.		
Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)		
Physician's Office Visit	No Charge	60% of the Maximum Reimbursable Charge after Plan Deductible
Inpatient Facility	No Charge	60% of the Maximum Reimbursable Charge after Plan Deductible
Outpatient Facility	No Charge	60% of the Maximum Reimbursable Charge after Plan Deductible
Physician's Services	No Charge	60% of the Maximum Reimbursable Charge after Plan Deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Men's Family Planning Services		
Office Visits, Lab and Radiology Tests and Counseling	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Surgical Sterilization Procedures for Vasectomy (excludes reversals)		
Physician's Office Visit	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Inpatient Facility	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Outpatient Facility	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Physician's Services	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Infertility and Conception Services **Services offered through WINFertility** Coverage will be provided for the following services: • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g., procedures to correct an infertility condition). • Treatment and/or procedures performed to enable conception with or without an infertility condition. • Artificial Insemination/Intrauterine insemination, regardless of an infertility condition, In-vitro, GIFT, ZIFT, etc. • Fertility preservation when an infertility condition is imminent. • Access to reproductive services for the purpose of pre-implantation genetic diagnosis (PGD) and embryo selection when parent(s), though fertile, are known carriers of genes associated with birth defects.		
Physician's Office Visit (Lab and Radiology Tests, Counseling)	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Inpatient Facility	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Outpatient Facility	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Physician's Services	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Cryopreserved Reproductive Material Storage Maximum 1 Year Lifetime Maximum: $30,000 per member In-Network and Out-of-Network services accumulate to the one maximum		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Transplant Services and Related Specialty Care Includes all medically appropriate, non-experimental transplants		
Physician's Office Visit	80% after Plan Deductible	In-Network coverage only
Inpatient Facility	100% at LifeSOURCE center, otherwise 80% after Plan Deductible	In-Network coverage only
Physician's Services	100% at LifeSOURCE center, otherwise 80% after Plan Deductible	In-Network coverage only
Lifetime Travel Maximum: $10,000 per transplant	No Charge (only available when using LifeSOURCE facility)	In-Network coverage only
Durable Medical Equipment Calendar Year Maximum: Unlimited	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Outpatient Dialysis Services		
Physician's Office Visit	80% after Plan Deductible	In-Network coverage only
Outpatient Facility	80% after Plan Deductible	In-Network coverage only
Physician's Services	80% after Plan Deductible	In-Network coverage only
Home Setting	80% after Plan Deductible	In-Network coverage only
Breast Feeding Equipment and Supplies **Note:** Includes the rental of 1 breast pump per birth as ordered or prescribed by a Physician. Includes related supplies.	No Charge	60% of the Maximum Reimbursable Charge after Plan Deductible
External Prosthetic Appliances Calendar Year Maximum: Unlimited	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Nutritional Counseling Calendar Year Maximum: 3 visits per person; however, the 3-visit limit will not apply to treatment of Mental Health and Substance Use Disorder conditions.		
Physician's Office Visit	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Inpatient Facility	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Outpatient Facility	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Physician's Services	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Genetic Counseling Calendar Year Maximum: 3 visits per person for Genetic Counseling for both pre- and post-genetic testing; however, the 3-visit limit will not apply to Mental Health and Substance Use Disorder conditions.		
Physician's Office Visit	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Inpatient Facility	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Outpatient Facility	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Physician's Services	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Dental Care Limited to Charges made for a continuous course of dental treatment started within 6 months of an injury to teeth. Dental surgery is covered, but limited to Medically Necessary dental surgery, including Dental Anesthesia, Apicoectomy, Gingivectomy or Gingivoplasty, Clinical Crown Lengthening, Osseous Surgery, Bone Replacement Graft, Soft Tissue Graft, Guided Tissues Regeneration, Distal or Proximal Wedge Procedure, Surgical Removal of Erupted Tooth requiring elevation of Mucoperiosteal Flap and removal of Bone and/or Section of Tooth, Removal of Impacted Teeth and Surgical Removal of Residual Tooth Roots.		
Physician's Office Visit	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Inpatient Facility	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Outpatient Facility	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Physician's Services	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
TMJ Surgical and Non-Surgical Always excludes appliances and orthodontic treatment.		
Physician's Office Visit	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Inpatient Facility	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Outpatient Facility	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Physician's Services	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Bariatric Surgery **Note:** Subject to any limitations shown in the **"Exclusions, Expenses Not Covered and General Limitations"** section of this Benefit Description		
Physician's Office Visit	80% after Plan Deductible	In-Network coverage only
Inpatient Facility	80% after Plan Deductible	In-Network coverage only
Outpatient Facility	80% after Plan Deductible	In-Network coverage only
Physician's Services	80% after Plan Deductible	In-Network coverage only
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes, peripheral neuropathies and peripheral vascular disease when Medically Necessary.	Not covered except for services associated with foot care for diabetes, peripheral neuropathies and peripheral vascular disease when Medically Necessary.
Foot Orthotics	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Varicose Vein Treatment	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Hearing Aids Calendar Year Maximum: $500	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Hearing Services **Note:** Limited to routine hearing exam Physician's Office Visit	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Wigs Calendar Year Maximum: $1,000 **Note:** For loss of hair when connected to a medical condition or treatment.	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Travel Services Authorized travel and lodging expenses for designated covered services administered at an In-Network facility/provider when an In-Network facility/provider is not available within a 100-mile radius of your primary home residence not subject to any plan deductible. The following designated services are covered by your plan and may be eligible for this travel benefit: • all Medical and Mental Health and Substance Use Disorder services. **Lifetime Maximum for Travel and Lodging Expenses for Designated Services Combined** **Note:** Does not include other services with separate travel and lodging dollar maximum(s) as noted in The Summary. Medical Benefit services other than Mental Health and Substance Use Disorder services: $10,000 Mental Health and Substance Use Disorder services: Unlimited		
Treatment Resulting from Life-Threatening Emergencies Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is Stabilized. Once the medical condition is Stabilized, whether the treatment will be characterized as either a medical expense or a Mental Health and Substance Use Disorder expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.		
Mental Health		
Inpatient Includes Acute Inpatient and Residential Treatment Calendar Year Maximum: Unlimited	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Outpatient		
Outpatient — Office Visits Includes individual, family and group psychotherapy; medication management, telemedicine, etc. Calendar Year Maximum: Unlimited	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Dedicated Virtual Providers MDLIVE Behavioral Services	80% after Plan Deductible	In-Network coverage only
Outpatient — All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, telemedicine, etc. Calendar Year Maximum: Unlimited	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Substance Use Disorder		
Inpatient Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment Calendar Year Maximum: Unlimited	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Outpatient		
Outpatient — Office Visits Includes individual, family and group psychotherapy; medication management, telemedicine, etc. Calendar Year Maximum: Unlimited	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible
Dedicated Virtual Providers MDLIVE Behavioral Services	80% after Plan Deductible	In-Network coverage only
Outpatient — All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, telemedicine, etc. Calendar Year Maximum: Unlimited	80% after Plan Deductible	60% of the Maximum Reimbursable Charge after Plan Deductible

Traditional Plus Medical Benefits

Certification Requirements — 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, it is suggested, but not required, that you 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 will not include the first $500 of Hospital Charges made for each separate admission to the Hospital unless PAC is received: prior to the date of admission; or in the case of an emergency admission, within 48 hours after the date of admission.

Covered Expenses Incurred for which benefits would otherwise be payable under this Plan for the Charges listed below will not include:

- Hospital Charges for Room and Board, for treatment listed above for which PAC was performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- 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 – 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 I.D. 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 it should be requested by you or your Dependent at least 4 working days (Monday through Friday) prior to having the procedure performed or the service rendered.

Covered Expenses Incurred will not include the first $500 for Charges made for any outpatient diagnostic testing or outpatient procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

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.

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Prior Authorization

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

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, including a Skilled Nursing Facility.
- residential treatment.
- outpatient facility services.
- partial hospitalization.
- advanced radiological imaging.
- non-emergency Ambulance.
- certain Medical Pharmaceuticals.
- home health care services.
- radiation therapy.
- transplant services.

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Covered Expenses

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

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

As determined by Cigna, Covered Expenses may also include all Charges made by an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies listed below. **Any applicable Copayments, Deductibles or limits are shown in the Summary.**

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 Summary.
- 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 Summary.
- licensed Ambulance service to the nearest Hospital where the needed medical care and treatment can be provided.
- outpatient medical care and treatment received at a Hospital.
- outpatient medical care and treatment received at a Free-Standing Surgical Facility.
- Emergency Services.
- Urgent Care.
- a Physician or a Psychologist for professional services.
- a Nurse for professional nursing service.
- anesthetics, including, but not limited to, supplies and their administration.
- diagnostic x-ray.
- 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.
- chemotherapy.
- blood transfusions.
- oxygen and other gases and their administration.
- Medically Necessary foot care for diabetes, peripheral neuropathies, and peripheral vascular disease.
- screening prostate-specific antigen (PSA) testing.
- laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- 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, implanted/injected contraceptives, and, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
- the following Preventive Care services as defined by recommendations from the following:
  - the U.S. Preventive Services Task Force (A and B recommendations);
  - the Advisory Committee on Immunization Practices (ACIP) for immunizations;
  - the American Academy of Pediatrics' Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care;
  - the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; 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 healthcare.gov. For additional information on immunizations, visit the immunization schedule section of cdc.gov.

- surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ).
- acupuncture.
- hearing aids and associated exam for device testing and fitting, including, but not limited to, semi- implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- Medically Necessary orthognathic surgery to repair or correct a severe facial deformity or disfigurement.

Telemedicine

Dedicated Virtual Providers

Charges for the delivery of medical and health-related services and consultations by dedicated virtual providers as medically appropriate through audio, video, and secure internet-based technologies.

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

Virtual Physician Services

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

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

Convenience Care Clinic

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

Nutritional Counseling

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

Enteral Nutrition

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

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

Internal Prosthetic/Medical Appliances

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

HC-COV1122 M 01-22

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 Other Health Professionals.
- necessary consumable medical supplies and home infusion therapy administered or used by a health care provider.

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

The following are excluded from coverage:

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

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

HC-COV1123 01-22

Hospice Care Services

Charges for services for a person diagnosed with advanced illness having a life expectancy of 12 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.

Hospice Care Programs rendered by Hospice Facilities or Hospitals include services:

- by a Hospice Facility for Room and Board and Necessary 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;

Hospice Care Programs rendered by Other Health Care Facilities or in the patient's home include services:

- for part-time or intermittent nursing care by or under the supervision of a Nurse;
- for 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 Plan 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 Plan;
- services or supplies that are primarily to aid you or your Dependent in daily living.

HC-COV1180 01-22

Mental Health and Substance Use Disorder Services

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

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

Inpatient Mental Health Services

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

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

Mental Health Residential Treatment Center means an institution that specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment programs under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when they are a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

Outpatient Mental Health Services

Services of providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group or Mental Health Partial Hospitalization or Intensive Outpatient Therapy Program.

Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression that interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

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

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

Inpatient Substance Use Disorder Rehabilitation Services

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

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

Substance Use Disorder Residential Treatment Center means an institution that specializes in the treatment of psychological and social disturbances that are the result of Substance Use Disorder; provides a subacute, structured, psychotherapeutic treatment program under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Use Disorder Residential Treatment Center when they are a registered bed patient in a Substance Use Disorder Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Use Disorder Rehabilitation Services

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

Substance Use Disorder Partial Hospitalization Services are rendered no less than 4 hours and not more than 12 hours in any 24-hour period by a certified/licensed Substance Use Disorder program in accordance with the laws of the appropriate legally authorized agency.

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

Substance Use Disorder Detoxification Services

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

Mental Health and Substance Use Disorder Exclusions

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

- treatment of disorders that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- developmental disorders, including, but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- counseling for activities of an educational nature.
- counseling for borderline intellectual functioning.
- counseling for occupational problems.
- counseling related to consciousness raising.
- vocational or religious counseling.
- I.Q. testing.

- custodial care, including, but not limited to, geriatric day care.
- psychological testing on children requested by or for a school system.
- occupational/recreational therapy programs, even if combined with supportive therapy for age-related cognitive decline.

HC-COV481 12-15

Durable Medical Equipment

Charges for:

- purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by Cigna for use outside a Hospital or Other Health Care Facility.
- 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 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 wheelchairs.

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

- **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, and 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, handheld showers, paraffin baths, bath mats, and spas.
- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
- **Car/Van Modifications**.
- **Air Quality Items:** room humidifiers, vaporizers and air purifiers.
- **Other Equipment:** centrifuges, needleless injectors, heat lamps, heating pads, cryounits, cryotherapy machines, ultraviolet cabinets that emit Ultraviolet A (UVA) rays, sheepskin pads and boots, postural drainage board, AC/DC adaptors, scales (baby and adult), stair gliders, elevators, saunas, cervical and lumbar traction devices, exercise equipment and diathermy machines.

HC-COV1124 02-21

External Prosthetic Appliances and Devices

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

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

Prostheses/Prosthetic Appliances and Devices

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts.

Prostheses/prosthetic appliances and devices include, but are not limited to:

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

Orthoses and Orthotic Devices

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

- **Non-foot orthoses** – only the following non-foot orthoses are covered:
  - rigid and semi-rigid custom fabricated orthoses;
  - semi-rigid prefabricated and flexible orthoses; and
  - rigid prefabricated orthoses, including preparation, fitting and basic additions, such as bars and joints.
- **Custom foot orthoses** – custom foot orthoses are only covered as follows:
  - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g., diabetic neuropathy and peripheral vascular disease);
  - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
  - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g., amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
  - for persons with neurologic or neuromuscular conditions (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;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- non-foot orthoses primarily used for cosmetic rather than functional reasons; and
- non-foot orthoses primarily for improved athletic performance or sports participation.

Braces

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

The following braces are specifically excluded: Copes scoliosis braces.

Splints

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

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

- replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- replacement required because anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- replacement due to a surgical alteration or revision of the impacted site.

Coverage for replacement is limited as follows:

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

The following are specifically excluded external prosthetic appliances and devices:

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

HC-COV1125 M 01-22

Infertility and Conception Services
Services offered through WINFertility

Charges made for services related to:

- diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed;
- intrauterine insemination/artificial insemination services related to enabling conception regardless of an infertility diagnosis;
- access to harvesting of sperm and oocytes for the purposes of cryopreservation and short-term storage of sperm, oocytes, and embryos when an infertility condition is imminent; and
- access to reproductive services for the purpose of pre-implantation genetic diagnosis (PGD) and embryo selection when parent(s), though fertile, are known carriers of genes associated with birth defects.

Services include, but are not limited to:

- infertility drugs that are administered or provided by a Physician;
- cryopreservation, storage, and thawing of sperm and eggs and embryos;
- approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy;
- laboratory tests;
- sperm washing or preparation;
- artificial insemination;
- diagnostic evaluations;
- gamete intrafallopian transfer (GIFT);
- in vitro fertilization (IVF);
- zygote intrafallopian transfer (ZIFT); and
- the services of an embryologist.

Infertility is defined as:

- the inability of opposite-sex partners to achieve conception after at least 1 year of unprotected intercourse;
- the inability of opposite-sex partners to achieve conception after 6 months of unprotected intercourse, when the female partner trying to conceive is age 35 or older;
- the inability of a woman, with or without an opposite-sex partner, to achieve conception after at least 6 trials of medically supervised artificial insemination over a 1-year period; and
- the inability of a woman, with or without an opposite-sex partner, to achieve conception after at least 3 trials of medically supervised artificial insemination over a 6-month period of time, when the female partner trying to conceive is age 35 or older.

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

However, the following are specifically excluded infertility services:

- reversal of male and female voluntary sterilization;
- infertility services when the infertility is caused by or related to voluntary sterilization;
- donor Charges and services;
- pre-implantation genetic screening (PGS) and genetic screening of parents/donors beyond what is covered as by the medical Plan;
- any experimental, investigational or unproven infertility procedures or therapies.

HC-COV734 M 01-19

Outpatient Therapy Services

Charges for the following therapy services:

- cognitive therapy,
- occupational therapy,
- osteopathic manipulation,
- physical therapy,
- pulmonary rehabilitation,
- speech therapy

Charges for therapy services are covered when provided as part of a program of treatment. Coverage is administered according to the following:

- multiple therapy services provided on the same day constitute one day of service for each therapy type.

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.

Occupational Therapy

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

Therapy services that are not covered include:

- sensory integration therapy.
- treatment of dyslexia.
- maintenance or Preventive Treatment provided to prevent recurrence or to maintain the patient's current status.
- Chiropractic Care not provided in an office setting.
- vitamin therapy.

HC-COV982 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 that is accompanied by functional deficit (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that:

- the surgery or therapy restores or improves function;
- reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or
- the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part.

Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

HC-COV631 12-17

Transplant Services and Related Specialty Care

Charges made for human organ and tissue transplant services that include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories. This coverage is subject to the following conditions and limitations.

- Transplant services include the Recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement.
- Transplant services are covered only if they are required to perform any of the following human-to-human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine that includes small bowel-liver or multi-visceral.
- Implantation procedures are covered for artificial heart, percutaneous ventricular assist device (PVAD), extracorporeal membrane oxygenation (ECMO) ventricular assist device (VAD) and intra-aortic balloon pump (IABP).
- All transplant services and related specialty care services, other than cornea transplants, are covered when received at Cigna LifeSOURCE Transplant Network® facilities.
  - Transplant services and related specialty care services received at Participating Provider facilities specifically contracted with Cigna for those transplant services and related specialty care services, other than Cigna LifeSOURCE Transplant Network® facilities, are payable at the In-Network level.
  - Transplant services and related specialty care services received at any other facility, including non-Participating Provider facilities and Participating Provider facilities not specifically contracted with Cigna for transplant services and related specialty care services, are not covered.
- Cornea transplants received at a facility that is specifically contracted with Cigna for this type of transplant are payable at the In-Network level.
- Coverage for organ procurement costs is limited to costs directly related to the procurement of an organ, from a cadaver or a live donor.
  - Organ procurement costs shall consist of 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.

- Advanced cellular therapy, including, but not limited to, immune effector cell therapies and Chimeric Antigen Receptor Therapy (CAR-T) cellular therapy, is covered when performed at a Cigna LifeSOURCE Transplant Network® facility with an approved stem cell transplant program.
  - Advanced cellular therapy received at Participating Provider facilities specifically contracted with Cigna for advanced cellular therapy, other than Cigna LifeSOURCE Transplant Network® facilities, are payable at the In-Network level.
  - Advanced cellular therapy received at any other facility, including non-Participating Provider facilities and Participating Provider facilities not specifically contracted with Cigna for advanced cellular therapy, are not covered.

Transplant and Related Specialty Care Travel Services

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, domestic partner, 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
  - transportation costs that exceed coach class rates.

These benefits for Transplant Services and Related Specialty Care, and for Transplant and Related Specialty Care Travel Services are only available when the covered person is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered Recipient are covered subject to the same conditions and limitations noted above.

Charges for the expenses of a donor Companion are not covered. No Transplant and Related Specialty Care Services or Travel Services are available when the covered person is the donor for an organ/tissue transplant. The transplant recipient's plan would cover all donor costs.

HC-COV1126 01-22

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

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

Utilization management requirements or other coverage conditions are based on a number of factors, which may include clinical and economic factors. Clinical factors may include, but are not limited to, the Pharmacy & Therapeutics (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 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 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.

HC-COV1168 01-22

Gene Therapy

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

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

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

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

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

Gene Therapy Travel Services

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

- Benefits for transportation and lodging are available to you only when you are the Recipient of a prior authorized gene therapy; and when the gene therapy products and services directly related to their administration are received at a Participating In-Network Facility specifically contracted with Cigna for the specific gene therapy service. The term Recipient is defined to include a person receiving prior authorized gene therapy related services during any of the following: evaluation, candidacy, event, or post care.
- Travel expenses for the person receiving the gene therapy include Charges for:
  - transportation to and from the gene therapy site (including Charges for a rental car used during a period of care at the facility); and
  - lodging while at, or traveling to and from, the site.

In addition to your coverage for the Charges associated with the items above, such Charges will also be considered covered travel expenses for one Companion to accompany you. The term Companion includes your spouse, domestic partner, 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
- transportation costs that exceed coach class rates.

HC-COV873 01-20

Clinical Trials

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

- the referring Health 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, DOD, or VA, 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 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-COV1128 01-22

Travel Services

Charges for non-taxable travel and lodging expenses incurred by you and one accompanying Companion/Caregiver (or up to two caregivers for a Dependent minor) are covered in connection with designated services.

Travel services for a designated covered service may be authorized for coverage when an In-Network facility/provider is not available within a 100-mile radius of your primary home residence. Travel and lodging expenses are covered for designated services administered at a participating In-Network facility/provider, subject to the maximum shown in The Summary.

Travel is available for the following designated services when covered by your plan:

• all Medical and Mental Health and Substance Use Disorder services.

Pre-authorization of travel is required by contacting Cigna at the number on the back of your ID card. Pre-authorization of

the covered designated service also may be required. The Companion/Caregiver can be 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. Covered travel expenses are reimbursed within daily limits as defined by the Internal Revenue Service and include charges for:

• airfare (coach or economy), including baggage fees.

• bus fare, train fare, taxi/Uber/Lyft, etc.

• vehicle rentals.

• gasoline.

• highway tolls (not prepaid).

• parking.

• shuttle services.

• wheelchair van service to travel from local housing to facility/provider.

• lodging up to $50 per night, per person for up to two people (maximum of $100 per night, inclusive of taxes and nonrefundable fees), including but not limited to: hotel, motel, rental from businesses such as Airbnb, VRBO, etc.

Excluded travel expenses include but are not limited to the following:

• any expenses that if reimbursed would be taxable income.

• travel within the mile radius defined above of your primary home residence.

• food and meals.

• mileage.

• incidentals, including but not limited to: laundry bills, telephone bills, alcohol or tobacco products.

• charges for transportation that exceed coach class rates.

• durable medical equipment, medical supplies, ambulance.

• refundable deposits for housing, utilities, etc.

• travel for services not designated above.

• services that are not covered by the plan.

HC-COV1317 10-22

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 Summary. Payment for the following is specifically excluded from this Plan:

- care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- charges which you are not obligated to pay and/or for which you are not billed. This exclusion includes, but is not limited to:
- any instance 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 Summary) without Cigna's express consent.
  - charges of a non-Participating Provider who has agreed to charge you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.
- In the event that Cigna determines that this exclusion applies, then Cigna in its sole discretion shall have the right to:
  - require you and/or any provider or Pharmacy submitting claims on your behalf to provide proof sufficient to Cigna that you have made your required cost-share payment(s) prior to the payment of any benefits by Cigna.
  - deny the payment of benefits in connection with the Covered Expense regardless of whether the provider or the Pharmacy represents that you remain responsible for any amounts that your plan does not cover, or
  - reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider or Pharmacy represents that you remain responsible for any amounts that your plan does not cover.

- charges or payment for healthcare-related services that violate state or federal law.
- assistance in the activities of daily living, including, but not limited to, eating, bathing, dressing or other Custodial

Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.

- for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorder or other health care technologies, supplies, treatments, procedures, drug or Biologic therapies or devices that are determined by the utilization review Physician to be:
  - not approved by the FDA or other appropriate regulatory agency to be lawfully marketed;
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the **"Clinical Trials"** section of this Plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the **"Clinical Trials"** section of this Plan.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to FDA-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.
- 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: rhinoplasty; redundant skin surgery; removal of skin tags; acupressure; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental Injury to teeth are covered provided a continuous course of dental treatment is started within 6 months of an accident. Additionally, Charges made by a Physician for any of the following Surgical Procedures are covered: excision of unerupted impacted tooth, including removal of alveolar bone and sectioning of tooth; removal of residual root (when performed by a dentist other than the one who extracted the tooth).
- for medical and surgical services intended primarily for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the Body Mass Index (BMI) classifications of the National Heart, Lung, and Blood Institute (NHLBI) guideline is covered only at approved centers if the services are demonstrated, through existing peer-reviewed, evidence-based, scientific literature and scientifically based guidelines, to be safe and effective for treatment of the condition. Clinically severe obesity is defined by the NHLBI as a BMI of 40 or greater without comorbidities, or 35-39 with comorbidities. The following are specifically excluded:
  - medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; 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 such treatment is prescribed by a Physician and listed as covered in this Plan.
- any medications, drugs, 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.
- 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 that 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 that 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 dentures.
- aids or devices that assist with non-verbal communications, including, but not limited to, communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- eyeglass lenses and frames, contact lenses and associated services (exams and fittings) (except for the initial set after treatment of keratoconus or following cataract surgery).
- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- all non-injectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this Plan.
- routine foot care, including the paring and removing of corns and calluses and toenail maintenance. However, foot care services for diabetes, peripheral neuropathies and peripheral vascular disease are covered when Medically Necessary.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services when medical management review determines the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- health and beauty aids, cosmetics, and dietary supplements.
- all nutritional supplements, formulae, enteral feedings, supplies and specially formulated medical foods that are prescribed and non-prescribed, except for infant formula needed for the treatment of inborn errors of metabolism.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- charges related to an Injury or Sickness payable under worker's compensation or similar laws.
- massage therapy.
- expenses incurred by a Participant to the extent reimbursable under automobile insurance coverage. Coverage under this Plan is secondary to automobile no-fault insurance or similar coverage. The coverage provided under this Plan does not constitute "Qualified Health Coverage" under Michigan law and therefore does not replace Personal Injury Protection (PIP) coverage provided under an automobile insurance policy issued to a Michigan resident. This Plan will cover expenses only not otherwise covered by the PIP coverage.
- intensive behavior treatment of autism including, but not limited to, applied behavior analysis, Lovaas therapy, Floortime, and Relationship Development Intervention.

General Limitations

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

- for Charges by a Hospital owned or operated by or 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.
- for charges which would not have been made if the person did not have coverage.
- to the extent they are more than Maximum Reimbursable Charges.

- to the extent of the exclusions imposed by any certification requirement shown in this Plan.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- Charges by any covered provider who is a member of your family or your Dependent's family.
- expenses incurred outside the United States other than expenses for Medically Necessary urgent or emergent care while temporarily traveling abroad.
- occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

HC-EXC466 M 01-22

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.

Coverage under this Plan plus another Plan will not guarantee 100% reimbursement.

Definitions

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

Plan

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

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

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

Closed Panel Plan

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

Primary Plan

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

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

Reasonable Cash Value

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

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 a person as an enrollee or an Employee shall be the Primary Plan, and the Plan that covers that person as a Dependent shall be the Secondary Plan;
- For a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan that covers the parent whose birthday falls first in the calendar year;
- For the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states one parent is responsible for the child's health care expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the noncustodial parent of the child; and

- finally, the Plan of the spouse of the parent not having custody of the child.

- The Plan that covers you as an active Employee (or as that Employee's Dependent) shall be the Primary Plan and the Plan that covers you as a laid-off or retired Employee (or as that Employee's Dependent) shall be the Secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- The Plan that covers you under a right of continuation, which is provided by federal or state law, shall be the Secondary Plan, and the Plan that covers you as an active Employee or retiree (or as that Employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- If one of the Plans that covers you is issued out of the state whose laws govern this Plan 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 the Primary Plan.

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, the benefits that would be payable under this Plan in the absence of Coordination will be reduced by the benefits payable under all other Plans for the expense covered under this Plan.

When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service rendered will be considered both an Expense Incurred and a benefit payable.

Recovery of Excess Benefits

If Cigna pays Charges for Necessary Services and Supplies that should have been paid by the Primary Plan, Cigna will have the right to recover such payments.

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 were made by any insurance company, health care plan or other organization. If we request, you shall execute and deliver to us such instruments and documents as we determine are necessary to secure the right of recovery.

Right to Receive and Release Information

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

Medicare Eligibles

Cigna will pay as the Secondary Plan as permitted by the Social Security Act of 1965 as amended for the following:

(a) a former Employee who is eligible for Medicare and whose coverage is continued for any reason as provided in this Plan;

(b) a former Employee's Dependent, or a former Dependent spouse, who is eligible for Medicare and whose coverage is continued for any reason as provided in this Plan;

(c) an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Employee is eligible for Medicare due to disability;

(d) the Dependent of an Employee whose Employer and each other Employer participating in the Employer's plan have fewer than 100 Employees and that Dependent is eligible for Medicare due to disability;

(e) an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees, if that person is eligible for Medicare due to age;

(f) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

Cigna will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.
- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.

- Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for them.

This reduction will not apply to any Employee and Dependent or any former Employee and Dependent unless they are listed under (a) through (f) above.

Domestic Partners

Under federal law, the Medicare Secondary Payer Rules do not apply to Domestic Partners covered under a group health plan when Medicare coverage is due to age. Therefore, when Medicare coverage is due to age, Medicare is always the Primary Plan for a person covered as a Domestic Partner, and Cigna is the Secondary Plan. However, when Medicare coverage is due to disability, the Medicare Secondary Payer Rules explained above will apply.

HC-COB274 01-21

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 coverage (other than Medicaid), or similar type of insurance or coverage. The coverage under this Plan is secondary to any automobile no-fault insurance or similar coverage.

Subrogation/Right of Reimbursement

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

- Subrogation: The Plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the Plan. A Participant or their 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 that 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 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 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 their 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-SUB128 03-20

Payment of Benefits

Assignment and Payment of Benefits

You may not assign to any party, including, but not limited to, a provider of health care services/items, your right to benefits under this Plan, nor may you assign any administrative, statutory, or legal rights or causes of action you may have under ERISA, 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 health care benefits under this Plan to a Participating or Non-Participating Provider. When you authorize the payment of your health care 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 health care benefits for Covered Expenses directly to a Participating Provider without your authorization. You may not interpret or rely upon this discrete authorization or permission to pay any health care benefits to a Participating or non-Participating Provider as the authority to assign any other rights under this Plan to any party, including, but not limited to, a provider of health care services/items.

Even if the payment of health care 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 Dependent, 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 them, such payment will be made to their legal guardian. If no request for payment has been made by their legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed their custody and support.

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

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

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment. In addition, your acceptance of benefits under this Plan and/or assignment of medical 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.

HC-POB132 01-19

Termination of Coverage

Employees

Your coverage 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 coverage.
- the last day for which you have made any required contribution for the coverage.
- the date the Plan is terminated.
- the last day of the calendar month in which your Active Service ends except as described below.

Any continuation of coverage must be based on a plan that precludes individual selection.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your coverage will be continued until the date as determined by your Employer.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your coverage will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness.

However, your coverage will not continue past the date your Employer terminates your coverage.

Dependents

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

- the date your coverage ceases.
- the date you cease to be eligible for Dependent coverage.
- the last day for which you have made any required contribution for the coverage.
- the date Dependent coverage is terminated.

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

HC-TRM128 12-17

Rescissions

In general, Ecolab is not allowed to rescind (i.e., retroactively cancel or terminate) your (or your Dependent's) Ecolab medical plan coverage once you (or your Dependents) become covered under the Plan. However, your (and/or your Dependent's) coverage under the Plan may be rescinded (i.e., terminated or discontinued with a retroactive effective date) if you (and/or your Dependent) performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact as prohibited under the terms of this Plan.

For example, if Ecolab determines you have enrolled an individual who does not meet the Plan's eligibility requirements as stated in this SPD or as stated in the enrollment materials, your enrollment of such Plan ineligible individual(s) will be treated as an intentional misrepresentation of a material fact, or fraud, and Ecolab reserves the right to rescind your (and/or your Dependent's) Plan coverage. If Ecolab seeks to rescind coverage for fraud or an intentional misrepresentation of a material fact, Ecolab will provide at least 30-days advance written notice to each Participant who would be affected before coverage is rescinded. Your (and/or your Dependent's) coverage also may be terminated retroactively for failure to pay the required premiums or contributions on a timely basis, or in certain other limited circumstances without Ecolab having to provide 30-days advance written notice.

HC-TRM80 01-11

Federal Requirements

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

HC-FED1 10-10

Notice Regarding Provider Directories and Provider Networks

A list of In-Network providers is available to you without charge by visiting myCigna.com or by calling Cigna Member Services at 1.800.900.3791. The network consists of providers, including Hospitals, of varied specialties as well as general practice, affiliated or contracted with Cigna or an organization contracting on its behalf. Provider directories will be updated every 90 days.

HC-FED78 10-10

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

If a QMCSO is issued for your child, that child will be eligible for coverage as required by the order.

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.

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

See **"Qualified Medical Child Support Orders"** in the *Administrative Information SPD*.

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.

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

If you are declining medical plan enrollment for yourself or your Dependents (including your spouse) because of other health coverage or group health plan coverage, you may be able to enroll yourself and your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the Employer stops contributing toward your or your Dependents' other non-COBRA coverage), provided you enroll within applicable time frames. Special enrollment events include the following:

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment to add any of the following combinations of individuals if not already enrolled in the Plan: Employee only; spouse only (if Employee is enrolled); Employee and spouse; Dependent child(ren) only (if Employee is enrolled); 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 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 that 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.
- **Loss or gain of eligibility for employment assistance under State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) becomes eligible for, or loses eligibility for, assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

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

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

HC-FED96 04-17

Making Mid-Year Election Changes

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you pay for your medical benefits with pre-tax salary reductions. See **"Mid-Year Election Change Events"** in the *Administrative Information SPD* for information on the mid-year changes allowed by Ecolab and what you need to do to make a change.

HC-FED95 04-17

Eligibility for Coverage for Adopted Children

Any child who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent coverage, 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 it will not be continued.

The provisions in the **"Exception for Newborns"** section of this document that describe requirements for enrollment and effective date of coverage 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)

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 Cigna Member Services at 1.800.900.3791 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.

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

Under federal FMLA, if you meet eligible service requirements, you are entitled to take up to 12 weeks of unpaid leave for certain family and medical situations and continue your elected medical coverage benefits during this time. The Employer is required to maintain group health plan coverage for an Employee on FMLA leave a) if you had that coverage before taking the leave, and b) on the same terms as if you had continued to work. Depending on the state where you live, the number of weeks of unpaid leave available to you for family and medical reasons may vary based on state law requirements.

The cost of your health coverage during such leave will be put in arrears and deducted from your future pay. You may elect to discontinue your benefits options within 31 days from the start of your FMLA leave.

Reinstatement of Terminated Coverage Following Leave

Upon your return to Active Service following a leave of absence that qualifies under FMLA, any terminated coverage (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 they had been satisfied prior to the start of such leave of absence.

See **"Impact of Leaves of Absence on Benefits"** in the *Administrative Information SPD* for detailed information.

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

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. See **"Impact of Leaves of Absence on Benefits"** in the *Administrative Information SPD* for detailed information.

HC-FED18 10-10

Claim Determination Procedures under ERISA

The following procedure for filing and appealing medical claims complies with federal law. Provisions of applicable laws of your state may supersede. Claims regarding eligibility for participation in the Plan are determined by Ecolab. See "Participation Claims and Appeals" in the *Administrative Information SPD*.

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 post service basis, as described below:

Certain services require Prior Authorization to be covered. The Benefit Description 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 this Benefit Description, 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. You may appeal the determination. Appeal procedures are described in this Benefit Description, 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 that cannot be managed without the requested services, Cigna will make the preservice determination on an urgent basis. Cigna will defer to the determination of the treating health care professional regarding whether an urgent determination is necessary. Cigna will notify you or your representative of an urgent 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 urgent benefit determination within 48 hours after you or your representative responds to the notice. Urgent 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 urgent 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.

Post service Determinations

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

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

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination:

- information sufficient to identify the claim including, if applicable, the date of service, provider and claim amount; diagnosis and treatment codes, and their meanings;
- the specific reason or reasons for the adverse determination including, if applicable, the denial code and its meaning and a description of any standard that was used in the denial;
- reference to the specific Plan provisions on which the determination is based;
- a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;
- a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal, (if applicable);
- upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim;
- an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit;
- a description of any available internal appeal and/or external review process(es);

- information about any office of health coverage consumer assistance or ombudsman available to assist you with the appeal process; and
- in the case of a claim involving Urgent Care, a description of the urgent review process applicable to such claim.

HC-FED104 01-19

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 a prior appointment remains valid, Cigna may require you to re-appoint your authorized representative, from time to time.

Cigna reserves the right to refuse to honor the appointment of a representative if Cigna reasonably determines that:

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

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

HC-FED88 01-17

Medical — When You Have a Complaint or an Appeal

For the purposes of this section, any reference to "you" or "your" 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 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, contractual benefits, or a rescission of coverage, you may call Cigna Member Services at the toll-free number (1.800.900.3791) on your ID card, explanation of benefits, or claim form and explain your concern to one of our Customer Service representatives. You may also express that concern in writing.

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 may start the appeals procedure.

Internal Appeals Procedure

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

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone. Call Cigna Member Services at the toll-free number (1.800.900.3791) on your ID card, explanation of benefits, or claim form.

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

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

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

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

If you request your appeal be expedited, you may also ask for an expedited external Independent Review at the same time, if

the time to complete an expedited level-one appeal would be detrimental to your medical condition.

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

External Review Procedure

If you are not fully satisfied with the decision of Cigna's internal appeal review and the appeal involves medical judgment or a rescission of coverage, you may request your appeal be referred to an Independent Review Organization (IRO). The IRO is composed of persons who are not employed by Cigna, or any of its affiliates. A decision to request an external review to an IRO will not affect the claimant's rights to any other benefits under the Plan.

There is no charge for you to initiate an external review. Cigna and your benefit plan will abide by the decision of the IRO.

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

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

Notice of Benefit Determination on Appeal

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

- information sufficient to identify the claim including, if applicable, the date of service, provider and claim amount; 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 below; 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), if applicable;
- upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and
- information about any office of health coverage consumer assistance or ombudsman available to assist you in the appeal process.

A final notice of an adverse determination will include a discussion of the decision.

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

Relevant Information

Relevant Information is any document, record or other information that:

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

Legal Action

If your Plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the appeal processes. However, no action will be brought at all unless brought within 3 years after a claim is submitted for in-network services or within 3 years after proof of claim is required under the Plan for out- of-network services.

HC-FED110 01-21

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 coverage 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 the 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. Please see **"COBRA Continuation Coverage"** in the *Administrative Information SPD* for details about electing COBRA continuation coverage, if eligible, at Ecolab.

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 termination of a domestic partnership; 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/Domestic Partner, 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.

Note: While not required to do so, Ecolab extends COBRA continuation coverage to Domestic Partners.

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 termination of a domestic partnership; 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 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 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;
- termination of the Employer's Plan 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 that 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/Domestic Partner'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 time frames:
  - 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/Domestic Partner 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 those 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 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;
- your child ceases to qualify as a Dependent under the Plan; or
- 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).

Notice must be provided to ThrivePass via email at tpa@thrivepass.com or for questions please contact them at 1.866.855.2844

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/Domestic Partner 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.

Interaction with Other Continuation Benefits

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace (healthcare.gov). By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse/Domestic Partner's plan), even if that plan generally doesn't accept late enrollees.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- the month after your employment ends; or
- the month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your COBRA continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit medicare.gov/medicare-and-you.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. 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 dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your rights as well as the rights of your spouse/Domestic Partner and Dependent children, you should keep the Plan Administrator informed of any address changes for your spouse/Domestic Partner and/or Dependent children. You should also keep a copy for your records of any notices you send to the Plan Administrator.

Plan Contact Information

ThrivePass
PO Box 220
Minneapolis, MN 55440-0220
1.866.855.2844

-FED66 07-14

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
Benefits Dept. EGH-03
1 Ecolab Place
St. Paul, MN 55102
1.800.964.0265

Employer Identification Number (EIN): 41-0231510

Plan Number: 501

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

Ecolab Health and Welfare Benefits Plan
Benefits Dept. EGH-03,
1 Ecolab Place
St. Paul, MN 55102
1.800.964.0265

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

Ecolab
1 Ecolab Place
Benefits Dept. EGH-03
St. Paul, MN 55102-1390
1.800.964.0265

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

Cigna
PO Box 182223
Chattanooga, TN 37422-7223

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 Type

The Plan is a health care 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 be 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 that has been appealed by the claimant or their 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 Plan for any Covered Medical Expenses Incurred prior to the date the Plan terminates. Likewise, any extension of benefits under the Plan due to you or your Dependent's total disability that began prior to and has continued beyond the date the Plan 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 Plan terminated may arise under the terms of the Plan. A subsequent Plan termination will not affect the extension of benefits and rights under the Plan.

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

- the date you leave Active Service (or later as explained in the **"Termination of Coverage"** 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 Plan terminates.

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

Statement of ERISA 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 (EBSA).
- 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/Domestic Partner 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 Plan Administrator. If you have a claim for benefits that 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 (EBSA), 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 EBSA.

HC-FED72 M 05-15

Definitions

Active Service

You will be considered in Active Service:

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

HC-DFS1095 M 12-17

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-DFS1480 01-21

Biologic

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

HC-DFS840 10-16

Biosimilar

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

HC-DFS841 10-16

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 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 Medical Pharmaceuticals.

HC-DFS1494 07-20

Charges

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

HC-DFS1193 01-19

Chiropractic Care

The conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

HC-DFS55 04-10 V1

Convenience Care Clinics

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

HC-DFS1629 07-21

Custodial Services

Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living.

Custodial care also can provide medical services, given mainly to maintain the person’s current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for themself. Custodial Services include, but are not limited to:

- services related to watching or protecting a person;

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

HC-DFS4 04-10 V1

Dependent

Dependents are:

- your lawful spouse; or
- your same-sex or opposite-sex Domestic Partner; and
- any child of yours who is:
  - less than 26 years old; and
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability that 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 or placed for legal adoption with you. It also includes a stepchild, or a child for whom you are the legal guardian. If your Domestic Partner has a child, that child will also be included as a Dependent.

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

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

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

HC-DFS872 10-16

Domestic Partner

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

- shares your principal residence and intends to do so indefinitely;
- has resided with you for no less than 6 months;
- has an ongoing and committed spouse-like relationship and intends to do so indefinitely;
- is no less than 18 years of age and legally competent to enter into a contract;
- is financially interdependent with you and has proven such interdependence by providing documentation 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 the Plan 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 has been provided to the Plan.

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:

- is currently legally married to another person; or
- has any other Domestic Partner, spouse or spouse equivalent of the same or opposite sex.

HC-DFS47 04-10 V1

Emergency Medical Condition

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

HC-DFS394 11-10

Emergency Services

With respect to an Emergency Medical Condition, a medical screening examination that is within the capability of the

emergency department of a Hospital or of an independent freestanding emergency facility, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or emergency department, as are required to Stabilize the patient.

HC-DFS1482M M 01-21

Employee

A full-time or part-time Employee of the Employer who is currently in Active Service. The term does not include Employees who are temporary or who normally work less than 20 hours a week for the Employer.

HC-DFS1094 M 12-17

Employer

The Plan sponsor self-insuring the benefits described in this Benefit Description, on whose behalf Cigna is providing claim administration services.

HC-DFS1615 01-22

Expense Incurred

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

HC-DFS10 04-10 V1

Free-Standing Surgical Facility

An institution that meets all of the following requirements:

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

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

HC-DFS1484 01-21

Hospice Care Program

A Hospice Care Program may include:

- 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; or
- a program for persons who have a Terminal Illness and for the families of those persons.

HC-DFS51 04-10 V1

Hospice Care Services

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

HC-DFS52 04-10 V1

Hospice Facility

An institution or part of it that:

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

HC-DFS53 04-10 V1

Hospital

A Hospital is:

- an institution licensed as a Hospital that 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 that qualifies as a Hospital, a psychiatric Hospital or a tuberculosis Hospital, and a provider of services under Medicare, if such institution is accredited as a Hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution that 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 that is primarily a place for rest, a place for the aged, or a nursing home.

HC-DFS1485 01-21

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if they are:

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

HC-DFS807 12-15

Injury

An accidental bodily injury.

HC-DFS12 04-10 V1

Maximum Reimbursable Charge — Medical

The Maximum Reimbursable Charge for covered services for Traditional Plus (the Plan) is determined based on the lesser of:

- the provider's normal Charge for a similar service or supply;
- the amount agreed to by the Out-of-Network provider and Cigna; or
- a policyholder-selected percentage of a fee schedule Cigna has developed that is based upon a methodology similar to a methodology used by Medicare to determine the allowable reimbursement for the same or similar service within the geographic market.

The percentage used to determine the Maximum Reimbursable Charge is listed in the Summary.

In certain cases, the Maximum Reimbursable Charge is not determined using a Medicare-based schedule. The decision to use an alternative methodology may depend on various factors, including your location. When this occurs, the Maximum Reimbursable Charge for covered services is calculated based on the lowest of the following:

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

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

HC-DFS1631 01-22

Medicaid

A state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

HC-DFS16 04-10 V1

Medical Pharmaceutical

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.

HC-DFS1632 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 and peer-reviewed, evidence-based scientific literature or guidelines.

HC-DFS1486 01-21

Medicare

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

HC-DFS17 04-10 V1

Necessary Services and Supplies

Includes any Charges, except Charges for Room and Board, made by a Hospital for medical services and supplies actually used during Hospital Confinement.

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

HC-DFS1488 01-21

Nurse

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

HC-DFS22 04-10 V1

Other Health Care Facility

A facility other than a Hospital or Hospice Facility. Examples of Other Health Care Facilities include, but are not limited to, licensed Skilled Nursing Facilities, rehabilitation Hospitals and subacute facilities.

HC-DFS1489 01-21

Other Health Professional

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

HC-DFS1490 01-21

Participating Provider

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

HC-DFS1194 01-19

Patient Protection and Affordable Care Act of 2010 ("PPACA")

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

HC-DFS412 01-11

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

HC-DFS1495 07-20

Physician

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

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

HC-DFS25 04-10 V1

Prescription Drug 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 in 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.

HC-DFS1633 01-22

Preventive Treatment

Treatment rendered to prevent disease or its recurrence.

HC-DFS57 04-10 V1

Primary Care Physician

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

HC-DFS40 04-10 V1

Psychologist

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 they are operating within the scope of their license and performing a service for which benefits are provided under this Plan when performed by a Psychologist.

HC-DFS26 04-10 V1

Review Organization

An affiliate of Cigna or another entity to which Cigna has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians, which may include Physicians, Registered Graduate Nurses, licensed Mental Health and Substance Use Disorder professionals, and other trained staff members who perform utilization review services.

HC-DFS808 12-15

Room and Board

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-DFS1481 01-21

Sickness – For Medical Coverage

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

HC-DFS50 04-10 V1

Skilled Nursing Facility

A licensed institution (other than a Hospital, as defined) which specializes in:

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

but only if that institution:

- maintains on the premises all facilities necessary for medical treatment;
- provides such treatment, for compensation, under the supervision of Physicians; and
- provides Nurses' services.

HC-DFS31 04-10 V1

Specialist

A Physician who provides specialized services and is not engaged in general practice, family practice, internal medicine, obstetrics/gynecology or pediatrics.

HC-DFS33 04-10 V1

Stabilize

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

HC-DFS413 01-11

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of 6 months or less to live, as diagnosed by a Physician.

HC-DFS54 04-10 V1

Urgent Care

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

HC-DFS34 04-10 V1