EXHIBIT A-2
CIGNA OPEN ACCESS PLAN DOCUMENT
Updated with Plan Changes Effective 05/01/2023

This document, known as the "Plan Document," describes the benefits available to the Participants in the City of Houston's CIGNA Open Access Plan or "Plan". This is not an insured benefit Plan. The benefits described in this Plan are self-insured by the City of Houston ("Employer") which is responsible for their payment. Claims administration services for this Plan is provided by Cigna Health and Life Insurance Company (CIGNA).

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

You will find the following sections in this Plan Document:

SECTION 1: **Requirements.** This section describes the general requirements that apply to services covered under the Plan.

- A. Explanation of Terms
- B. Eligibility, Enrollment and Effective Date of Coverage
- C. CIGNA Open Access Plan Benefits and CIGNA Care Network (CCN)
- D. Participating Providers
- E. Prior Authorization/Pre-Authorized
- F. Covered Expenses
- G. Special Provisions
- H. Services Available in Conjunction with your CIGNA Open Access Plan
- I. How to File Your Claim
- J. Coordination of Benefits
- K. Special Requirements for Persons Covered Under Medicare
- L. Expenses for Which A Third Party May Be Responsible
- M. Payment of Benefits
- N. Termination of Coverage

SECTION 2: **What is Covered.** This section describes what services are covered under the Plan, along with any limits on coverage for specific services. **Section 2** also provides the amounts (if any) to be paid by you at the time services are received.

SECTION 3: **What is Not Covered.** This section describes services that are not covered under the plan.

SECTION 4: **Notices**. This section contains notices required by law.

- A. Qualified Medical Child Support Order (QMSCO)
- B. Special Enrollment Rights Under the Health Insurance Portability & Accountability Act
- C. Effect of Section 125 Tax Regulations on This Plan
- D. Eligibility for Coverage of Adopted Children
- E. Federal Tax Implications for Dependent Coverage
- F. Coverage for Maternity Hospital Stay
- G. Women's Health and Cancer Rights Act (WHCRA)

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SECTION 1 - REQUIREMENTS

A. Explanation of Terms

Active Service. You will be considered in Active Service:

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

Alternate Health Benefits Plan means any health benefit plan, other than the Plan, that is offered by Employer.

Anniversary Date means the annual anniversary of the Effective Date.

Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

Charges mean the actual billed charges; except when the provider has contracted directly or indirectly with CIGNA for a different amount.

Coinsurance means the percentage of charges for Covered Expenses that a Participant is required to pay under the Plan. See **Section 2 – What is Covered** for Coinsurance that will apply under this Plan.

Copayments are expenses to be paid by a Participant for Covered Expenses under the Plan. Copayments are in addition to any Coinsurance or Deductible. See **Section 2 – What is Covered** for Copayments that will apply under this Plan.

Covered Expenses mean the charges for Covered Services incurred by or on behalf of a Participant.

Covered Services mean services or supplies that are recommended by a Participating Provider (except in the case of Emergency Services) provided to a Participant, and are Medically Necessary for the care and treatment of an Injury or Sickness, as determined by CIGNA. Any applicable Copayments, Deductibles or limits are shown in **Section 2 – What is Covered** and **Section 3 – What is Not Covered**.

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

- Services related to watching or protecting a person;

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

Deductible means expenses to be paid by you and your Dependents. Deductible amounts are separate from and not reduced by Copayments. Deductibles are in addition to any coinsurance. Once the Deductible shown in **Section 2 – What is Covered** has been reached, you and your Dependents need not satisfy any further Deductible for the rest of that Plan Year.

Deferred Retired Employee is an Employee of Employer who is a member of one of the various State statutory pension plans that are offered by the Employer and:

- has completed sufficient service time and/or met any other applicable requirements to be eligible to receive a deferred pension under the terms of the pension plan;
- will attain the age necessary to commence actually receiving benefit payments under the pension plan on or before the fifth anniversary of the end of your active service with Employer; and
- has been continuously covered by an Employer sponsored health benefits plan from the end of your active service until the beginning of a deferred pension according to the terms of the pension plan.

Dependent means:

- your lawful spouse; and
- any child of yours who is
  - less than 26 years old.
  - 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage. Documentation from the Social Security Administration (SSA) may be used to show proof of disability in lieu of completion of the Plan Administrator's documentation and approval process.

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

The term child means a child born to you, foster child, stepchild, or a child legally adopted by you or a grandchild who is considered your Dependent for federal income tax purposes and is Primarily Dependent upon You. It also includes a child whose adoption is anticipated and for whom you have legal support obligations, a child for whom you are legal guardian, and a child for whom you have been ordered to assume medical responsibility by a court of law. In all instances, the child must reside with you except in the case of a court order.

Durable Medical Equipment means items which are designed for and able to withstand repeated use by more than one person, customarily serve a medical purpose, generally are not useful in the absence of Injury or Sickness, are appropriate for use in the home, and are not disposable. Such equipment includes, but is not limited to: crutches, Hospital beds, wheel chairs, respirators, and dialysis machines.

Effective Date means May 1, 2023.

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

Emergency Services means, with respect to an Emergency Medical Condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the patient.

Employee means a full-time or part-time employee of the Employer who is currently in Active Service. Full-time employees are those working not less than forty (40) hours per week. Part-time employees must work at least thirty (30) hours per week. It also includes the Mayor, a City Council Member or the City Controller. An Employee who meets the requirements above will remain eligible while on an Employer approved leave of absence for a period of time not to exceed twelve (12) months.

Employer means the City of Houston as the plan sponsor self-insuring the benefits described in Plan, on whose behalf CIGNA is providing claim administration services.

Expense Incurred is when the service or the supply is provided.

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

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

Home Health Care Services mean those skilled health care services that can be provided during intermittent visits of two hours or less by Other Health Care Professionals. Necessary consumable medical supplies, home infusion therapy, and Durable Medical Equipment administered or used by Other Health Care Professionals in providing Home Health Care Services are covered. Home Health Care Services do not include 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. Physical, occupational, and speech therapy provided in the home are subject to the benefit limitations described under "Short-Term Rehabilitative Therapy."

Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or

inpatient care during the illness;

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

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

Hospice Facility means an institution or part of it which:

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

Hospital means:

- an institution licensed as a hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: specializes in treatment of Mental Health and Substance Abuse 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 will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

Hospital Confinement or Confined in a Hospital means that a person will be considered Confined in a Hospital if he is:

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

Initial Enrollment Period means the period of at least thirty-one (31) consecutive days duration prior to Effective Date of this Plan as designated by Employer during which eligible persons may seek to enroll in the Plan and Participants may terminate their enrollment in the Plan.

Injury means an accidental bodily injury.

Late Enrollee means an enrollee other than a Special Late Enrollee who is either:

- An eligible Employee who could have enrolled in this Plan when he or she first became eligible to enroll in the Plan (either (i) during the Initial Enrollment Period in which he or she became eligible to enroll in the Plan or (ii) if he or she first met the requirements to be an eligible Employee outside a Subsequent Enrollment Period then within thirty-one (31) days of when he or she first met such requirements), but did not do so and instead later applied for Plan coverage under B. Eligibility, Enrollment and Effective Date of Coverage.

- An eligible Dependent on behalf of whom enrollment could have been completed when he or she first became eligible to be enrolled in the Plan (either (i) during the Initial Enrollment Period in which he or she first became eligible to enroll in the Plan or (ii) if he or she first met the requirements to be an eligible Dependent outside a Subsequent Enrollment Period, then within thirty-one (31) days of when he or she first met such requirements), but was not so enrolled and instead when enrollment was completed by the Subscriber under B. Eligibility, Enrollment and Effective Date of Coverage.

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

Medically Necessary/Medical Necessity is Covered Services and supplies that are determined to be:

- 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 care provider; and
- rendered in the least intensive setting that is appropriate for delivery of services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

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

Necessary Services and Supplies include any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement, any charges, by whoever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.

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

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

Nurse Midwife means an individual who is licensed and certified as Certified Nurse-Midwife (CNM), Certified Professional Midwife (CPM) or Licensed Midwife (LM), and works under the direct supervision of a Participating Provider. Covered Services by a Nurse Midwife must be delivered in a Participating Provider Hospital or birthing center. Home delivery is not a Covered Expense.

Opt-Out Retiree means an individual who meets the definition of Retiree in this Plan and who opts to not continue coverage in the Plan for himself/herself and his/her then covered Dependents at the time when such person assumed Retiree status, provided that, between the time when such person assumed Retiree status and opts out of the Plan, such person and his or her Dependents were continuously enrolled in the Plan or an Alternative Health Benefits Plan. Not withstanding the foregoing, new Dependents of such Retiree, acquired after such Retiree opted out and after Retiree opts to re-enroll as a Subscriber in the Plan, shall be permitted to enroll in accordance with the Eligibility requirements outlined later in this section of the Plan.

Opt-Out Retirees are eligible to re-enroll themselves, their newly acquired Dependents and their previously covered

Dependents in the Plan at a later date in accordance with normal enrollment guidelines.

- An Opt-Out Retiree may apply for enrollment in the Plan by completing the enrollment method defined by the Employer during a subsequent enrollment period. The Participant Effective Date shall be the Anniversary Date next following.
- An Opt-Out Retiree who loses other health coverage may enroll himself/herself and any previously covered Dependents within thirty-one (31) days after such termination of such other coverage or of his or her COBRA continuation coverage by completing the enrollment method defined by Employer. The Participant Effective Date for the Opt-Out Retiree and any re-enrolled Dependents shall be the first or sixteen day of the month following the completion of the enrollment and payment of any Contribution required by Employer.

Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities. The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies.

Other Health Professional includes, but is 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.

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan because of any:

- medical Coinsurance;
- inpatient hospital facility Copayments;
- outpatient facility Copayments; or
- MRI/MRA/CAT/PET Scan Copayments.

When the Out-of-Pocket Maximum shown in **Section 2 – What is Covered** is reached, benefits for Covered Services are payable at 100% except for:

- office visit copayments;
- prescription drug copayments and coinsurance

Participant means any Subscriber or Dependent.

Participant Effective Date means the effective date of as outlined in the Eligibility, Enrollment and Effective Date of Coverage subsection of **Section 1 – Requirements**.

Participating Provider

The term Participating Provider means a Hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with CIGNA to provide Covered Services under the Plan.

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

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

Plan Year means the 12 month period beginning on the Effective Date and, thereafter, each subsequent 12 month period.

Preventative Care means:

(1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;

(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;

(3) for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

(4) for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Additional detailed information is available at (healthcare.gov/center/regulations/prevention/recommendations.html).

Primary Care Physician means a Participating Provider who is engaged in the practice of family practice, general medicine, internal medicine or pediatrics.

Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is operating within the scope of his license and performing a service for which benefits are provided under this plan when performed by a Psychologist.

Retiree is an individual retired from service of the Employer and is receiving retirement benefit payments under one of the several pension plans offered by the Employer. A Retiree or Participant who is eligible to receive or is receiving Medicare coverage, and who is eligible to participate in one of the various federally-sponsored Medicare Advantage Plans and Medicare Supplement Plans ("Alternate Health Benefits Plan") offered by Employer, must elect coverage under one of the Alternate Benefits Plans, rather than through the Plan.

Retired Disabled Following Catastrophic Injury on Duty means an individual who meets the requirements of an Employee and who is catastrophically injured in the course and scope of performing their job; and, as a result is totally and permanently disabled; and is receiving retirement benefit payments under one of the several pension plans offered by Employer; and, is receiving or is eligible to receive Lifetime Income Benefits according to provisions §408.161 of the Texas Labor Code, provided that between the time such person and his or her Dependents were continuously enrolled in the Plan or an Alternative Health Benefits Plan. Notwithstanding the foregoing, new Dependents of such Retiree, acquired after such Retiree enrolled as a Subscriber in the Plan, shall be permitted to enroll according to the Eligibility, Enrollment and Effective Date of Coverage subsection of **Section 1 – Requirements**.

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

Service Area means the geographical area served by the CIGNA Open Access Plan. The Service Area includes the area show in Exhibit C of the Administration Services Agreement between CIGNA and Employer.

Sickness means a physical or mental illness. It also includes pregnancy. Covered 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.

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

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

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

Special Late Enrollee means an eligible Employee and/or the Employee's eligible Dependent whose enrollment in the Plan is completed under one of the following four circumstances:

- Upon termination of coverage under any other group health plan other than COBRA:
    - The eligible Employee and/or his or her eligible Dependent could have enrolled or been enrolled for Plan coverage during a Subsequent Enrollment Period or within thirty-one (31) days of when such Employee and/or Dependent, as applicable, first satisfied the applicable eligibility requirements under B. Eligibility, Enrollment and Effective Date of Coverage, but was not so enrolled because the Employee and/or Dependent, as applicable was covered under another group health plan (other than COBRA continuation coverage) at the time the Employee declined enrollment;
    - The Employee signed a Waiver of Coverage stating that coverage under another group health plan was the reason for declining enrollment in the Plan. (This applies only if the Employer provided the Employee with notice of this requirement and the consequences of his or her failure to fulfill such requirement at the time the Employee declined enrollment); and
    - Coverage of such eligible Employee and/or eligible Dependents, as applicable, under another group health plan terminated due to termination of the group contract or loss of eligibility for any reason, including without limitation termination of employment; death of a spouse; termination of coverage under a spouse's health plan; divorce or separation; reduction in the number of hours of employment; a termination of employer contributions; the other group health plan no longer offering any benefits to the class of similarly situated individuals; in the case of coverage offered through an HMO, no longer residing, living, or working in the Service Area of the HMO and no other benefit option is available; or attainment of the maximum age to be eligible as a dependent child under the other group health plan, but not including loss of eligibility because he or she failed to pay premiums on a timely basis or was terminated for cause (including without limitation, termination due to fraud or material misrepresentation).
- Upon termination of coverage under COBRA:
    - The eligible Employee and/or his or her eligible Dependent could have enrolled or been enrolled for Plan coverage during a Subsequent Enrollment Period or within thirty-one (31) days of when the Employee and/or Dependent, as applicable, first satisfied the applicable eligibility requirements under B. Eligibility, Enrollment and Effective Date of Coverage of the Plan, but was not so enrolled because the Employee and/or Dependent had COBRA continuation coverage under another group health care plan at the time the Employee declined enrollment;
    - The Employee signed a Waiver of Coverage stating another group health plan coverage under COBRA

was the reason for declining enrollment in the Plan. (This applies only if the Employer provided the Employee with notice of this requirement and the consequences or his or her failure to fulfill this requirement at the time the Employee declined enrollment); and

- The COBRA continuation coverage of the enrollee(s) has since been exhausted. (Exhaustion of COBRA coverage means than an individual's coverage ceases for any reason other than his or her failure to pay premiums on a timely basis or for fraud or material misrepresentation of other cause. An individual is considered to have exhausted COBRA coverage if such coverage ceases (a) due to the group's failure to pay premiums on a timely basis; or (b) because he or she no longer resides or works in the Service Area (whether or not by choice) and there is no other COBRA continuation coverage available to the individual.

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

Subscriber means an Employee, Survivor, Retiree, Opt-Out Retiree, Retired Disabled Following Catastrophic Injury on Duty or Deferred Retired Employee. Throughout this document, Subscriber may also be referred to as "you" or "your".

Subsequent Enrollment Period means the period of at least thirty-one (31) consecutive days duration per Plan Year as designated by Employer during which eligible persons may seek to enroll in the Plan and Participants may terminate their enrollment in the Plan.

Survivor means a Dependent whose coverage is continued in the event of the death of an Employee. The spouse, or in the absence of a spouse, the eldest Dependent child, will be deemed to be the Employee in terms of determining contributions that are to be paid for continued coverage. Coverage for Survivors will end on the earliest of the following dates:

- the last day of the month in which any Survivor who was a Dependent child ceases to be a Dependent child as defined by this Plan;
- the last day of the month in which a Survivor becomes eligible for coverage as an Employee or becomes eligible for coverage under any employer-sponsored policy, plan or program of group health coverage; or
- upon the termination date of this Plan.

Coverage under this definition is limited to Dependents who were covered at the time of the covered Employee's death, except that coverage will be extended to any newborn natural child of the deceased Employee. If Revised Civil Statutes of Texas would entitle a Survivor under this definition to expanded eligibility under the Plan, then such Survivor shall be eligible in accordance with that Article for so long as it applies to that Survivor.

Telemedicine means telehealth or e-health and allows health care professionals to evaluate, diagnose and treat patients using telecommunications technology. Telemedicine allows patients to access medical expertise quickly, efficiently and without travel for certain minor health conditions.

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

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by CIGNA, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the

immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

Urgent Care Facility means a non-hospital center that provides ambulatory medical, surgical and/or urgent care.

Waiting Period means the period of time that must expire before an individual becomes eligible to enroll in the Plan. The Waiting Period begins on the first day of an eligible Employee's employment with Employer and runs until the sixteenth (16^{th}) day of the month or the first day of the following month (whichever is sooner) following a period of thirty (30) calendar days.

Waiver of Coverage means the method of acknowledgement, as defined by Employer, that you are required to complete under the Plan if you choose to decline enrollment in the Plan for you or any eligible Dependents.

B. Eligibility, Enrollment and Effective Date of Coverage

1. Eligibility

To be eligible to enroll as a Subscriber in the Plan, a person must be within one of the following categories:

- An Employee
- A Deferred Retired Employee;
- An Opt-Out Retiree;
- A Retired Disabled Following Catastrophic Injury on Duty;
- A Retiree (under age 65); or
- A Survivor.

a. Maternity care benefits will be extended to a Subscriber's unmarried Dependent who is a child.
b. Notwithstanding the foregoing, an eligible Employee may elect to be covered only as a Subscriber or a Dependent, but not both simultaneously. If and when a person terminates coverage under the Plan as either a Subscriber or Dependent, such person shall have the right to continue coverage under either definition that continues to apply, if any.
c. A person who is on active military duty shall not be eligible to enroll in the Plan.
d. Coverage of Survivors shall be limited to Dependents who were covered at the time of the Subscriber's death, except that coverage may also be extended to any newborn child of the deceased Subscriber in accordance with the provisions of this Agreement that pertain to newborn children.

Notwithstanding the foregoing, if the Revised Civil Statutes of Texas would entitle a Survivor under this definition to expanded eligibility under the Plan, then such survivor shall be eligible in accordance with said section for so long as it applies to said Survivor.

2. Subscriber Enrollment and Effective Dates

a. Initial Enrollment Period. An Employee may enroll for coverage in the Plan by completing enrollment using the method as required by Employer during the Initial Enrollment Period. If the Employee does so, his or her Participant Effective Date shall be the same as the Effective Date of this Plan.
b. Subsequent Enrollment Period. An Employee may enroll for coverage in the Plan by completing enrollment using the method as required by Employer during a Subsequent Enrollment Period. If the Employee does so, his or her Participant Effective Date shall be the Anniversary Date next following.
c. Newly eligible Employee outside of Initial or Subsequent Enrollment Period. An Employee who first becomes an eligible for coverage at a time that is not during the Initial Enrollment Period or a Subsequent Enrollment Period

may enroll for coverage within thirty-one (31) days of becoming an eligible Employee by completing the enrollment in the method as required by Employer during that thirty-one (31) day period. The Participant Effective Date of such eligible Employee shall be the sixteenth day of the month or the first day of the following month (whichever is sooner) following expiration of the Waiting Period.

d. Eligible Employee Who Previously Declined EnrollmentLate Enrollee. An eligible Employee who meets the applicable criteria to be a Late Enrollee may either:

- Enroll during the next Subsequent Enrollment Period, in which case his or her coverage shall become effective as provided as provided in B.2.b.; or
- Enroll outside of a Subsequent Enrollment Period, in which case the Eligible Employee's Effective Date shall be the sixteenth day of the month or the first day of the following month (whichever is sooner) following thirty (30) days after completing enrollment in the method required by Employer and payment of any contribution required by Employer.

- Special Late Enrollees. An eligible Employee who meets the applicable criteria to be a Special Late Enrollee may enroll and become covered as provided below.
  - An eligible Employee who becomes a Special Late Enrollee under the circumstances described in either subsection a or b of the definition of "Special Late Enrollee" may submit an Application to Administrator within thirty-one (31) days after termination of coverage under the Prior Plan or of his or her COBRA continuation coverage. The Special Late Enrollee's Effective Date shall be the first or sixteenth day of the month following Administrator's receipt of the Application and any required premium, subject to any applicable Waiting Period.
  - An eligible Employee who becomes a Special Late Enrollee under the circumstances described in subsection c. of the definition of "Special Late Enrollee" may submit an Application to Administrator within thirty-one (31) days after the date of the marriage, birth, adoption, Placement for Adoption, or court order to provide coverage for an Eligible Dependent, as applicable. The Special Late Enrollee's Effective Date shall be, as applicable: (i) the first day of the month following Administrator's receipt of the Application and payment of any required premium, in the case of an Eligible Employee whose Eligible Dependent was newly acquired through marriage; or (ii) the Eligible Dependent's date of birth, adoption, or Placement for Adoption, as applicable, in the case of an Eligible Employee whose Eligible Dependent was newly acquired through birth, adoption or Placement for Adoption; or (iii) the date the Employer receives notification of the court order in the case of an Eligible Employee whose Eligible Dependent was newly acquired through court order to provide coverage for such Eligible Dependent. Documentation of the events creating the Eligible Employee's status as a Special Late Enrollee must be attached to the Application.

e. Re-enrollment after Termination of Coverage. A Subscriber who discontinues his or her coverage under the Plan while on a leave of absence from employment by the Employer pursuant to, and in accordance with the terms of, the Family and Medical Leave Act of 1993 ("FMLA Leave") may, at the end of the FMLA Lave, re-enroll in the Plan (whether inside or outside of an Employer Enrollment Period), provided that he or she is still otherwise eligible to enroll in the Plan. (Such a Subscriber may also re-enroll any Dependents who were covered at the point during the FMLA Leave when coverage was discontinued, provided that they are still otherwise eligible for coverage.)

However, a Subscriber whose coverage terminates under any other circumstances may only re-enroll as provided in B.2.d, and the Subscriber's Dependents may only be re-enrolled as provided in B.3.a.

3. Dependent Enrollment and Effective Dates

An eligible Dependent may only become a Dependent under the Plan in one of the following ways:

a. An eligible Dependent can be enrolled at the same time as an eligible Employee enrolls as a Subscriber. Both shall

have the same Participant Effective Date. No eligible Dependent can become covered before the eligible Employee becomes covered as a Subscriber.

b. A Subscriber's newly acquired spouse who meets the requirements to be an eligible Dependent, on whose behalf Subscriber completed enrollment in the manner required by Employer within thirty-one (31) days of the marriage, shall become covered as of the date of the marriage. If, as a result of the marriage, the Subscriber acquires a stepchild who meets the requirements to be an eligible Dependent, and that stepchild is included in the enrollment completed by Subscriber with the new spouse and any required contributions paid, the stepchild shall also become covered as of the date of the marriage. The date of the marriage shall be the Participant Effective Date for both the spouse and the stepchild, if any.

   If the enrollment and any required contribution premium for the newly acquired eligible Dependents is not completed by Subscriber within the thirty-one (31) day period, it may be submitted either: (a) during a Subsequent Enrollment Period, in which case the eligible Dependent shall become covered as outlined in Subsequent Enrollment Period as set forth in B.3.c; or (b) outside of a Subsequent Enrollment Period, in which case the eligible Dependent shall become covered as provided in B.3.d.

   A child who meets the requirements to be a Special Late Enrollee shall become covered as provided in B.3.e.

c. A Subscriber may enroll a newborn child who satisfies the requirements to be an eligible Dependent by completing the enrollment in the method required by Employer prior to the end of the thirty-one (31) day period beginning on the date of birth. The Participant Effective Date of such a child shall be the date of birth.

   If the enrollment for such child is not completed by Subscriber within the thirty-one (31) day period, enrollment may be completed either: (a) during a Subsequent Enrollment Period, in which case the child shall become covered as outlined in the Subsequent Enrollment Period as set forth in B.3.c; or (b) outside of a Subsequent Enrollment Period, in which case the child shall become covered as provided in B.3.d below.

   A child who meets the requirements to be a Special Late Enrollee shall become covered as provided in B.3.e.

d. A Subscriber's child who is a foster or adoptive child who satisfies the requirements to be an eligible Dependent is eligible for coverage on the same basis as a newborn child, except that the Participant Effective Date shall be the following date and not the child's date of birth:
   - for a foster child, the date the child was placed in the Subscriber's home, and
   - for an adoptive child, at the option of the Subscriber the date the Subscriber becomes a party in a suit in which the adoption of the child by the Subscriber is sought or the date the adoption is final.

e. Dependent children for whom the Subscriber has received a court order requiring the Subscriber to provide health coverage will be covered for an initial period of thirty-one (31) days from the date the Employer receives notification of the court order. Coverage will continue beyond the thirty-one (31) days only if the Subscriber completes enrollment in the manner required by Employer within thirty-one (31) days of the date of receipt of the court order and makes or agrees to make additional contribution payments required by Employer. Coverage for court ordered Dependents will be effective as of the date the court order is received by the Employer.

   Coverage for a Dependent spouse for whom the Subscriber has received a court order requiring the Subscriber to provide health coverage will be effective on the first day of the month after the completion of enrollment by the Subscriber and payment of applicable contributions within thirty-one (31) days after issuance of the court order.

f. The Subscriber may enroll an eligible Dependent in the Plan during any Initial Enrollment Period or Subsequent Enrollment Period by completing the enrollment using the method required by Employer. If the eligible Dependent is added during the Initial Enrollment Period, his or her Participant Effective Date shall be the Effective Date of this Plan. If the eligible Dependent is added during a Subsequent Enrollment Period, the eligible Dependent's Participant Effective Date shall be the next Anniversary Date.

g. An eligible Dependent, other than a Special Late Enrollee, who first becomes eligible to enroll in the Plan outside of a Subsequent Enrollment Period may not be enrolled, unless the enrollment is completed by the Subscriber on his or her behalf within thirty-one (31) days of when he or she first satisfied the requirements to be an eligible Dependent.

   An eligible Dependent, other than a Special Late enrollee, who meets the requirements to be a Late Enrollee, may be enrolled outside of a Subsequent Enrollment Period. In that case, the eligible Dependent's Participant Effective Date shall be the sixteenth day of the month or the first day of the following month (whichever is sooner) following ninety (90) days after the enrollment is completed in the method required by the Employer and any required contribution is paid.

h. An eligible Dependent who meets the requirements to be a Special Late Enrollee and on behalf of whom the Subscriber completes enrollment in the method required by the Employer shall become covered under the Plan as specified below:

   - The Participant Effective Date of an eligible Dependent who is enrolled in the Plan under the circumstances described the definition of "Special Late Enrollee" shall be the first day of the month following completion of the enrollment and payment any required contribution, subject to an applicable Waiting Period, provided that such enrollment is completed within thirty-one (31) days after termination of the eligible Dependent's coverage under his or her prior group health care coverage.
   - An eligible Dependent who is enrolled in the Plan at the same time as an Eligible Employee who enrolls under the circumstances described in the definition of "Special Late Enrollee" shall have the same Participant Effective Date as such eligible Employee, as determined in accordance with B.2.d; provided that the eligible Employee completes enrollment for such eligible Dependent within thirty-one (31) days after the date of the marriage, birth, adoption, suit for adoption, placement for adoption, or receipt of notice of a court order for medical support by the Employer, as applicable.
   - The Participant Effective Date of an eligible Dependent child who is enrolled in the Plan under the circumstances described in the definition of "Special Late Enrollee" shall be the date of such child's loss of coverage under Title XIX of the Social Security Act, or CHIP, provided that (i) enrollment is completed by Subscriber on his or her behalf with Employer within thirty-one (31) days after such child's loss of coverage; (ii) the Subscriber declined coverage for the child in writing, stating that coverage under Medicaid or CHIP was reason for declining coverage; (iii) the child has lost coverage under Medicaid or CHIP; and (iv) the request for enrollment is made not later than the 31st day after the date on which coverage under Medicaid or CHIP terminates.

C. Cigna Open Access Plan and CIGNA Care Network (CCN)

This Plan provides coverage for Covered Services when using Participating Providers only. For Emergency Services, you can access the nearest provider. You and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Deductible or Coinsurance.

In order to receive a higher level of benefits, you should be sure to verify that your Specialist Physician has been designated a CIGNA Care Network (CCN) Provider.

Provider designations are assessed and may change annually. You have access to a list of all providers who participate in the network by visiting www.cigna.com; mycigna.com; or by calling the toll-free telephone number on your ID card. CIGNA Care Network (CCN) providers are specifically identified in this listing.

D. Participating Providers

Participating Providers include Physicians, Hospitals and Other Health Care Professionals and Other Health Care Facilities. Consult your Physician Guide or visit the CIGNA website at www.mycigna.com for a list of Participating Providers in your area. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

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

E. Prior Authorization/Pre-Authorized

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

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

- inpatient Hospital services;
- inpatient services at any participating Other Health Care Facility;
- residential treatment;
- outpatient facility services;
- intensive outpatient programs;
- advanced radiological imaging;
- non-emergency ambulance; or
- transplant services.

F. Covered Expenses

Covered Expenses include:

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.
- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their

administration.

- charges made for an annual prostate-specific antigen test (PSA).
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies but not the surgery itself if specifically excluded in Section 3 – What is not covered (tubal ligations, vasectomies, and elective abortions).
- Charges made for the following Preventive Care services for men and women. For women, this includes Well Women doctor office visits, screening for gestational diabetes, HPV testing, counseling for sexually transmitted diseases, counseling and screening for human immune-deficiency virus, contraceptive methods and counseling, breastfeeding support, supplies and counseling, screening and counseling for interpersonal and domestic violence.
- Plan will cover routine patient costs for qualified individuals participating in clinical trials (defined as a phase I, phase II, phase III or phase IV clinical trial conducted in relation to the prevention , detection or treatment of cancer or other life-threatening disease or condition). "Routine patient costs" are generally defined as items and services that typically would be covered under the plan for an individual not enrolled in a clinical trial. An individual may qualify to participate in a clinical trial based on a referral from a health care professional participating in the trial or by providing medical and scientific information establishing that participation would be appropriate.

G. Special Provisions

This section addresses Covered Services that often require clarification.

1. Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed 20 percent of the surgeon's allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts).

Co-Surgeon

The maximum amount payable will be limited to charges made by co-surgeons that do not exceed 20 percent of the surgeon's allowable charge plus 20 percent. (For purposes of this limitation, allowable charge means the amount payable to the surgeons prior to any reductions due to coinsurance or deductible amounts.)

2. 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.

3. Clinical Trials

Charges made for routine patient services associated with cancer clinical trials approved and sponsored by the federal government. In addition the following criteria must be met:

- the cancer clinical trial is listed on the NIH web site www.clinicaltrials.gov as being sponsored by the federal government;
- the trial investigates a treatment for terminal cancer and: the person has failed standard therapies for the disease;

cannot tolerate standard therapies for the disease; or no effective nonexperimental treatment for the disease exists;

- the person meets all inclusion criteria for the clinical trial and is not treated "off-protocol";
- the trial is approved by the Institutional Review Board of the institution administering the treatment.

Routine patient services do not include, and reimbursement will not be provided for:

- the investigational service or supply itself;
- services or supplies listed herein as Exclusions;
- services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs);
- services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

4. Genetic Testing

Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:

- a person has symptoms or signs of a genetically-linked inheritable disease;
- it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
- the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per calendar year for both pre- and post-genetic testing.

5. Internal Prosthetic/Medical Appliances

Charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered. Hearing aids are covered to a maximum of one (1) pair per Participant every thirty-six (36) calendar months.

6. Orthognathic Surgery

Charges made for orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone can not correct are covered, provided:

- the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
- the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease or;
- the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the Physician.

7. Breast Reconstruction and Breast Prostheses

Charges made for reconstructive surgery following a mastectomy, if the insured chooses to have surgery, and in the manner chosen by the insured and Physician. Services and benefits include:

- surgical services for reconstruction of the breast on which surgery was performed;
- surgical services for reconstruction of the nondiseased breast to produce symmetrical appearance;
- postoperative breast prostheses; and
- mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs.

During all stages of mastectomy, treatment of physical complications, including lymphedema therapy are covered.

8. Reconstructive/Cosmetic Surgery

Charges made for reconstructive or cosmetic surgery or therapy to repair or correct severe facial disfigurements or severe physical deformities that are congenital or result from developmental abnormalities (other than abnormalities of the jaw or TMJ disorder), tumors, trauma, disease or the complications of Medically Necessary non-cosmetic surgery.

Reconstructive surgery for correction of congenital birth defects or developmental abnormalities must be performed prior to your attainment of age 19. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement, as determined by CIGNA.

9. Transplant Services

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

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

All Transplant services, other than cornea, are covered at 100% when received at CIGNA LIFESOURCE Transplant Network® facilities. Cornea transplants are not covered at CIGNA LIFESOURCE Transplant Network® facilities. Transplant services, including cornea, received at participating facilities specifically contracted with CIGNA for those Transplant services, other than CIGNA LIFESOURCE Transplant Network® facilities, are payable at the In-Network level. Transplant services received at any other facilities, including Non-Participating Providers and Participating Providers not specifically contracted with CIGNA for Transplant services, are not covered.

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

10. Transplant 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 travel benefits are not available for cornea transplants. Benefits for transportation and lodging are available to you only if you are the recipient of a preapproved organ/tissue transplant 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 transplant site (including charges for a rental car used during a period of care at the transplant facility); and lodging while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered

covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age. The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits 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 benefits are available when the covered person is a donor.

11. Tobacco User Premiums

Tobacco user premium is $35 per month per tobacco user that is a Participant under this Plan. The employee will be held responsible for payment of the tobacco premium through payroll deduction for all Participants in their household that elect a "Smoker status" during Annual Open Enrollment. The above monthly premium is subject to increase at the discretion of Plan Sponsor.

12. Gender Dysphoria

The treatment is unique to each person. Coverage generally includes Behavioral Health Services, Hormonal Therapy, Gender reassignment and related Surgery (age 18+). Pre-requisites may apply. Services not covered include treatment considered cosmetic and/or not medically necessary and fertility preservation treatments.

13. Bariatric Surgery

Bariatric surgery for morbid obesity is generally covered based on medical necessity as defined by specific clinical criteria. Pre-requisites may apply. Coverage is available with in-network providers only and limited to a lifetime maximum of $10,000.

14. Medical Pharmaceuticals

Benefits under this section are provided only for Medical Pharmaceuticals which, due to their characteristics (as determined by the Plan Administrator), are required to be administered, or the administration of which must be directly supervised, by a qualified Physician. Benefits payable under this section include Medical Pharmaceuticals whose administration may initially, or typically, require Physician 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.

The Plan Administrator Business Decision Team (P&T Committee) determines whether utilization management requirements or other coverage conditions should apply to a Medical Pharmaceutical by considering a number of factors, including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, the P&T Committee's evaluations of the place in therapy, relative safety or relative efficacy of Medical Pharmaceuticals as well as whether 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. When considering a Medical Pharmaceutical for a coverage status, the Business Decision Team reviews clinical and economic factors regarding enrollees as a general population across its book-of-business. Regardless of its eligibility for coverage under your plan, whether a particular Prescription Drug Product is appropriate for you or any of your Dependents is a determination that is made by you (or your Dependent) and the prescribing Physician.

The coverage criteria for a Medical Pharmaceutical may change periodically for various reasons. For example, a Medical Pharmaceutical may be removed from the market, a new Medical Pharmaceutical in the same therapeutic class as a Medical Pharmaceutical may become available, or other market events may occur. Market events that may affect the

coverage status of a Medical Pharmaceutical include, but are not limited to, an increase in the cost of a Medical Pharmaceutical.

15. 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 the Plan Administrator for the specific gene therapy service. Gene therapy products and their administration received at other facilities are not covered.

Charges made for non-taxable travel expenses incurred by you in connection with a prior authorized gene therapy procedure may be covered subject to certain conditions and limitations as allowed by the Plan Administrator.

H. Additional Services Available in Conjunction with your CIGNA Open Access Plan

This section describes helpful services available in conjunction with your medical plan. You can access these services by calling the toll-free number shown on the back of your ID card.

1. Case Management

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

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

- You, your dependent or an attending Physician can request Case Management services by calling the **toll-free number** shown on your ID card during normal business hours, Monday through Friday. In addition, your employer 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.

2. 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.

I. How To File Your Claim

Your Plan provides coverage when care is received only from Participating Providers and Pharmacies, however you may still have claims (for example, when Emergency Services are received from a non-Participating Provider) and should follow the claim submission instructions for those claims. Claims can be submitted by the provider if the provider is able and willing to file on your behalf. If the provider is not submitting on your behalf, you must send your completed claim form and itemized bills to the claims address listed on the claim form.

You may get the required claim forms from the www.mycigna.com website or by calling customer service using the toll-free number on your identification card.

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT 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 NUMBER IS THE 7-DIGIT POLICY NUMBER SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

Timely Filing Of Claims

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

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 or write us at the toll-free number 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 that 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 which cannot be managed without the requested services.

If you request that your appeal, be expedited, in urgent care situations 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. See Section 4(L) below for additional information about external Independent Reviews.

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

J. Coordination of Benefits

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

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

1. **Plan** means any of the following that provides benefits or services for medical care or treatment**:**
   - Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
   - Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.
   - Medical benefits coverage of group, group-type, and individual automobile contracts.

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

2. **Closed Panel Plan** means 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.
3. **Primary Plan** means the Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.
4. **Secondary Plan** means a Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.
5. **Allowable Expense** means a necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

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

   - An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
   - If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
   - If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
   - If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
   - If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.
6. **Claim Determination Period** is a Plan Year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.
7. **Reasonable Cash Value** is an amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

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

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

knowledge;

- then, the Plan of the parent with custody of the child;
- then, the Plan of the spouse of the parent with custody of the child;
- then, the Plan of the parent not having custody of the child, and
- finally, the Plan of the spouse of the parent not having custody of the child.

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

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

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

Effect on the Benefits of This Plan

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

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

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

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

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

Recovery of Excess Benefits

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

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

Right to Receive and Release Information

CIGNA, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

K. Special Requirements for Persons Covered Under Medicare

- The Plan shall be the primary payor, as compared to Medicare, when an Employee age 65 or older is enrolled in Medicare. The Plan shall also be the primary payor, as compared to Medicare, when an Employee's Dependent age 65 or older is enrolled in Medicare.
- The Plan shall be the primary payor, as compared to Medicare, for a period of thirty (30) months, for covered persons who have become entitled to Medicare solely on the basis of end stage renal disease. The thirty (30) month period begins the first month in which the individual became entitled to Medicare coverage.
- When a covered person is covered under Part A and/or Part B of Medicare and Medicare is primary payor as compared to this Plan, CIGNA shall pay on behalf of that covered person all Medicare deductible and coinsurance payments applicable to services covered by Medicare that would also be Covered Services. The covered person shall remain liable, however, for the Copayments, Coinsurance and Deductibles set forth in What is Covered. If that covered person is eligible for Medicare Part A and or Part B but has not enrolled in such coverage, his/her claims shall be treated by CIGNA as though the covered person had enrolled in such Medicare coverage.
- When any benefits are available as primary benefits to a covered person under Medicare, Medicare shall be determined first and benefits available under this Plan, if any, will be adjusted accordingly.

L. 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 or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

Subrogation/Right of Reimbursement

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

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

Lien of the Plan

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether

or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;

- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- 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.

M. Payment of Benefits

To Whom Payable

Medical Benefits are assignable to the provider. When you assign benefits to a provider, you have assigned the entire amount of the benefits due on that claim. If the provider is overpaid because of accepting a patient's payment on the charge, it is the provider's responsibility to reimburse the patient. Because of CIGNA's contracts with providers, all claims from contracted providers should be assigned.

CIGNA may, at its option, make payment to you for the cost of any Covered Expenses from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependents are responsible for reimbursing the provider.

If any person to whom benefits are payable is a minor or, in the opinion of CIGNA is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal

guardian, CIGNA may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

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

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

Recovery of Overpayment

When an overpayment has been made by CIGNA, CIGNA will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment.

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.

N. Termination of Coverage

1. Employees

Your coverage will end on the earliest date below:

- the date this Plan is terminated;
- the last day of the bi-weekly period for which you have made any required contribution for the coverage;
- the last day of the bi-weekly period coinciding with or next following the day on which you are no longer eligible as an Employee under this Plan;
- the last day of the bi-weekly period coinciding with or next following the date on which you are no longer employed by the Employer, unless you qualify for and continue coverage as a Deferred Retired Employee or Retiree. For this purpose, if you are on a leave of absence, not to exceed twelve (12) months, that has been approved by the Employer, you have not ended employment with the Employer;
- the date of termination if you are terminated by CIGNA for fraud, misrepresentation or misconduct as provided in N. 5. below;
- the end of a bi-weekly period at your request.

You may have rights to continue coverage under certain circumstances, including reinstatement of coverage under provisions set out in the Employer's A-P 3-4 (Revised).

2. Deferred Retired Employee

The coverage of Deferred Retired Employee will end on the earliest of the dates below:

- the date this Plan is terminated;
- the end of the last month for which the Deferred Retired Employee has made the required contribution;
- the last day of the month coinciding with or next following the day on which the Deferred Retired Employee ceases to be eligible for coverage under this Plan as a Deferred Retired Employee, by attaining the age necessary to become eligible for pension benefits or otherwise, unless the Deferred Retired Employee qualifies for and continues coverage hereunder as a Retiree;
- the date of termination of the Deferred Retired Employee by CIGNA for fraud, misrepresentation or misconduct as provided in N.5. below;

- the end of a month at the request of the Deferred Retired Employee.

3. Retirees

The coverage of any Retirees will end on the earliest of the dates below:

- the date this Plan is terminated;
- the end of the last month for which the Retiree has made the required contribution;
- the date of termination of the Retiree by CIGNA for fraud, misrepresentation or misconduct as provided in N.5. below;
- the end of a month at the request of the Retiree.

Retirees may have rights to continue coverage under certain circumstances, including circumstances where Retiree has not more than two (2) required payments. Retiree will be required to pay total amount of missed premiums to reinstate coverage within two (2) months.

4. Dependents

Coverage for any Dependents will end on the earliest date below:

- the date your coverage ends, except that coverage may be continued as a Survivor in the event that you die.
- the date of termination of the Plan;
- the date of discontinuation of coverage for all Dependents under the Plan;
- the date the Dependent becomes covered as an Employee under the Plan;
- the last day of the month in which the Dependent turns age 26 or next day following the day on which the Dependent ceases to be eligible for coverage under the Plan;
- the last day of the bi-weekly period for which you have made any required contribution for the Dependent coverage;
- if CIGNA or Employers makes a request to you to furnish proof of eligibility of any Dependent enrolled in the plan and you fail to furnish the required proof within thirty(30) days after receipt of the request, the Dependent's coverage shall terminate upon further written notice from CIGNA or Employer to you, provided that the termination shall not take effect until at least fifteen (15) days after the further notice is mailed to your last known address;
- the date of termination of the Dependent by CIGNA for fraud, misrepresentation or misconduct as provided in N.5. below.

5. Termination by CIGNA

The coverage of any covered person (Employee, Survivor, Deferred Retired Employee, Retiree, Retired Disabled Following Catastrophic Injury on Duty or Dependent) may be terminated by CIGNA under the following conditions:

- In the case of fraud or material misrepresentation by a covered person in connection with the Plan, coverage may be terminated retroactively as of the time when the fraud or misrepresentation occurred, after not less than fifteen (15) days written notice from CIGNA to the covered person.
- In the case of fraud by a covered person in the use of Covered Services, including without limitation permitting the improper use of a Plan identification card, coverage may be terminated retroactively as of the time when the fraud occurred, after not less than fifteen (15) days written notice from CIGNA to the covered person.
- In the case of misconduct by a covered person detrimental to safe Plan operations and the delivery of Covered Services, coverage may be terminated immediately, upon written notice from CIGNA to the covered person.

- In the absence of fraud, all statements or affirmations made by you when enrolling for coverage under this Plan will be deemed representations and not warranties. Coverage can be voided for fraud or intentional misrepresentations made as part of the enrollment process as required by the Employer.

EXHIBIT A-2
CIGNA OPEN ACCESS PLAN DOCUMENT
Updated with Plan Changes Effective 05/01/2023

Section 2 – What is Covered

The information in the chart on the following pages outlines how the Plan will provide coverage for Covered Services received by Participants through Participating Providers. Additional information, including Exclusions and Limitations for any Covered Services and Covered Expenses, may be found in **Section 1 – Requirements** and **Section 3 – What is Not Covered.**

BENEFIT HIGHLIGHTS	COVERAGE UNDER THIS PLAN
Lifetime Maximum	Unlimited
Coinsurance Level	70%
Plan Year Deductible Individual Family Maximum Family Maximum Calculation: The Family Maximum is met when Covered Expenses for all covered family members reach $1,500, except that no single family member shall meet more than $750.	 $850 per person $1,700 per family
Out-of-Pocket Maximum The Out-of-Pocket Maximum will change based on the annual Patient Protection and Affordable Care Act (PPACA) maximum changes.	
Primary Care Physician's Services Primary Care Physician (PCP)'s Office visit (or Telemedicine Visit if offered by PCP) Surgery Performed In the Physician's Office Second Opinion Consultations Allergy Treatment/Injections Allergy Serum (dispensed by the Physician in the office) Cigna TeleHealth Connection Visit* *Specific copayment Rate published annually	 100% after $40 per office visit Copayment 100% after the $40 PCP per office visit Copayment 100% after the $40 PCP per office visit Copayment 100% after either the $40 PCP per office visit Copayment or 50% of the Charge for the injection if no PCP is seen, whichever is less 100% 100% after $40 per visit Copayment
Specialty Care Physician Services – no referral is required; see explanation of Cigna Care Network (CCN) in Section 2.B.	

EXHIBIT A-2
CIGNA OPEN ACCESS PLAN DOCUMENT
Updated with Plan Changes Effective 05/01/2023

BENEFIT HIGHLIGHTS	COVERAGE UNDER THIS PLAN
Note: OB/GYN provider is a Specialist.	
Office Visits Consultant and Referral Physician's Services (or Telemedicine Visit if offered by Specialist)	100% after the $65 CCN or $80 Non-CCN Specialist per office visit Copayment
Surgery Performed by a Specialist in the Physician's Office	100% after the $65 CCN or $80 Non-CCN Specialist per office visit Copayment
Second Opinion Consultations performed by a Specialist	100% after the $65 CCN or $80Non-CCN Specialist per office visit Copayment
Allergy Treatment/Injections performed by a Specialist	100% after the $65 CCN or $80 Non-CCN Specialist office visit Copayment or 50% of the Charge for the injection if no Specialist is seen, whichever is less
Allergy Serum (dispensed by the Specialist in the office)	100%
Cigna TeleHealth Connection Visit* *Specific copayment Rate published annually	100% after the $65 CCN or $80 Non-CCN Specialist per visit Copayment
Preventive Care (see Explanation of Terms)	
Routine Preventive Care for children	100%
Immunizations	100%
Well-woman and well-man exam	100%
Colorectal Cancer Screenings	100%
Mammograms, PSA, PAP Smear, Colonoscopy	
Preventive Care Related Services (i.e. "routine" services)	100%
Diagnostic Related Services (i.e. "non-routine" services)	100%
Inpatient Hospital - Facility Services Coverage limited to Semi-Private room rates unless specified in Exclusion R. Necessary Services and Supplies are included under this benefit.	70% after Plan Year Deductible
Outpatient Facility Services Outpatient surgery performed in a Free-Standing Surgical Facility and same-day inpatient surgery performed in a hospital without an overnight stay (including invasive diagnostic procedures such as cardiac catheterization).	70% after Plan Year Deductible

EXHIBIT A-2
CIGNA OPEN ACCESS PLAN DOCUMENT
Updated with Plan Changes Effective 05/01/2023

Inpatient Hospital Physician's Visits/Consultations/Services including but not limited to surgeons, radiologists, pathologists and anesthesiologists.	70% after Plan Year Deductible
Outpatient Professional Services including but not limited to Physicians, surgeons, radiologists, pathologists and anesthesiologists	70% after Plan Year Deductible
Emergency and Urgent Care Services	
Physician's Office Visit	100% after the $40 PCP or applicable $65 CCN or $80Non-CCN Specialist per office visit copayment
Hospital Emergency Room	70% after Plan Year Deductible
Outpatient Professional services (including but not limited to radiology, pathology and ER Physician)	70% after Plan Year Deductible
Urgent Care Facility	100% after $75 per visit copayment
X-ray and/or Lab performed at the Emergency Room (billed by the facility as part of the ER visit)	70% after Plan Year Deductible
X-ray and/or Lab performed at the Urgent Care Facility (billed by the facility as part of the UC visit)	100%
Independent x-ray and/or Lab Facility in conjunction with an ER visit	70% after Plan Year Deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CT Scans, PET Scans etc.) The scan copayment applies per type of scan per day	70% after Plan Year Deductible
Ambulance	70% after Plan Year Deductible
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Plan Year Maximum: 60 days combined	70% after Plan Year Deductible
Laboratory and Radiology Services (includes pre-admission testing)	
Physician's Office Visit	100% after the $40 PCP or applicable $65 CCN or $80 Non-CCN Specialist per office visit Copayment
Outpatient Hospital Facility	70% after Plan Year Deductible
Independent X-ray and/or Lab Facility	70% after Plan Year Deductible
Advanced Radiological Imaging (i.e. MRIs, MRAs, CT Scans and PET Scans)	

Physician's Office Visit Inpatient Facility Outpatient Facility	70% after Plan Year Deductible 70% after Plan Year Deductible 70% after Plan Year Deductible
Outpatient Short-Term Rehabilitative Therapy and Chiropractic Services Charges made for Short-term Rehabilitative Therapy which is a part of a rehabilitative program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate inpatient or outpatient setting. Also included are services that are provided by a Chiropractic Physician when provided in an outpatient setting. Services of a Chiropractic Physician include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment that is rendered to restore motion, reduce pain and improve function. 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 discharge. The Phase II program must be Physician directed with active treatment and EKG monitoring. Phase III and Phase IV cardiac rehabilitation is not covered. Phase III follows Phase II and is generally conducted at a recreational facility primarily to maintain the patient's status achieved through Phases I and II. Phase IV is an advancement of Phase III which includes more active participation and weight training. Plan Year Maximum: Unlimited Includes: Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy Chiropractic Therapy (includes Chiropractors) Cardiac Rehabilitation	100% after the $40 PCP or applicable $65 CCN or $80 Non-CCN Specialist per office visit Copayment

Home Health Care Charges made for Home Health Care Services when you: • require skilled care; • are unable to obtain the required care as an ambulatory outpatient; and • do not require confinement in a Hospital or Other Health Care Facility. Home Health Care Services are provided under the terms of a Home Health Care plan for the person named in that plan. If you are a minor or an adult who is dependent upon others for nonskilled care (e.g. bathing, eating, toileting), Home Health Care Services will only be provided for you during times when there is a family member or care giver present in the home to meet your nonskilled care needs. Plan Year Maximum: 60 days (includes outpatient private nursing when approved as medically necessary)	70% after Plan Year Deductible
Hospice (See Section 3 – What is Not Covered, subsection B) Charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program: • by a Hospice Facility for Bed and Board and Services and Supplies; • by a Hospice Facility for services provided on an outpatient basis; • by a Physician for professional services; • by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling; • for pain relief treatment, including drugs, medicines and medical supplies; • by an Other Health Care Facility for: o part-time or intermittent nursing care by or under the supervision of a Nurse; o part-time or intermittent services of an Other Health Care Professional; • physical, occupational and speech therapy; • medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.	
Inpatient Services	70% not subject to the Plan Year Deductible
Outpatient Services (same coinsurance level as Home Health Care)	70% not subject to the Plan Year Deductible
Bereavement Counseling Services provided as part of Hospice Care	

Inpatient	70% not subject to the Plan Year Deductible
Outpatient	70% not subject to the Plan Year Deductible
Services Provided by Mental Health Professional	Covered under Mental Health benefit
Maternity Care Services	
Initial Visit to Confirm Pregnancy **Note:** OB/GYN provider is a Specialist. Nurse Midwife is covered, see **Section 1 – Requirements**, A. Explanation of Terms for more information.	100% after the $40 PCP or applicable $65 CCN or $80 Non-CCN Specialist per office visit Copayment
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	70% after Plan Year Deductible
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	100% after the $40 PCP or applicable $65 CCN or $80 Non-CCN Specialist per office visit Copayment
Delivery - Facility (Inpatient Hospital, Birthing Center)	70% after Plan Year Deductible
Abortion	
Covers non-elective procedures only	
Physician's Office Visit	100% after the $40 PCP or applicable $65 CCN or $80 Non-CCN Specialist per office visit Copayment
Inpatient Facility	70% after Plan Year Deductible
Outpatient Facility	70% after Plan Year Deductible
Physician's Services	70% after Plan Year Deductible
Family Planning Services	
Office Visits, Lab and Radiology Tests and Counseling **Note:** The standard benefit will include coverage for contraceptive devices (e.g. Depo-Provera and Intrauterine Devices (IUDs). Diaphragms will also be covered when services are provided in the physician's office.	100% after the $40 PCP or applicable $65 CCN or $80 Non-CCN Specialist per office visit Copayment
Surgical Sterilization Procedure for Vasectomy/Tubal Ligation (excludes reversals)	
Physician's Office Visit	100% after the $40 PCP or applicable $65 CCN or $80 Non-CCN Specialist per office visit Copayment
Inpatient Facility	70% after Plan Year Deductible
Outpatient Facility	70% after Plan Year Deductible

Physician's Services	70% after Plan Year Deductible
Infertility Treatment **See Section 3 – What is Not Covered, subsection A.1.j)** 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). • Artificial Insemination	100% after the $40 PCP or applicable $65 CCN or $80 Non-CCN Specialist per office visit Copayment
Office Visit (Lab and Radiology Tests, Counseling)	70% after Plan Year Deductible
Inpatient Facility	70% after Plan Year Deductible
Outpatient Facility	70% after Plan Year Deductible
Physician's Services	
Organ Transplants (see Section 1 – Requirements, subsection G. Special Provision 9 and 10.) Includes all medically appropriate, non-experimental transplants	
Physician's Office Visit	100% after the $40 PCP or applicable $65 CCN or $80 Non-CCN Specialist per office visit Copayment
Inpatient Facility	100% at Lifesource center, otherwise 70% after Plan Year Deductible
Physician's Services	100% at Lifesource center, otherwise 70% after Plan Year Deductible
Lifetime Travel Maximum: $10,000 per transplant	100% (only when using Lifesource facility)

Durable Medical Equipment (See Section 3 – What is Not Covered, subsection D) Charges made for the purchase or rental of Durable Medical Equipment which is ordered or prescribed by a provider and provided by a vendor approved by CIGNA. Coverage for the repair, replacement or duplicate equipment is not covered except when replacement or revision is necessary due to growth or a change in medical condition. Wigs will be covered, following chemotherapy and/or radiation treatment for patients with cancer, to a maximum of $300. Plan Year Maximum: Unlimited	70% after Plan Year Deductible
External Prosthetic Appliances Charges made for the initial purchase and fitting of external prosthetic devices which are used as replacements or substitutes for missing body parts and are necessary to alleviate or correct Sickness, Injury or congenital defect; including only artificial arms and legs and terminal devices such as hands or hooks. Replacement of such prostheses is covered only if needed due to normal anatomical growth. Plan Year Maximum: Unlimited	70% after Plan Year Deductible
Nutritional Evaluation Charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease. Plan Year Maximum: 3 visits per person	
Physician's Office Visit	100% after the $40 PCP or applicable $65 CCN or $80 Non-CCN Specialist per office visit Copayment
Inpatient Facility	70% after Plan Year Deductible
Outpatient Facility	70% after Plan Year Deductible
Physician's Services	70% after Plan Year Deductible
Dental Care (Accidental injury to sound, natural teeth) Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.	
Physician's Office Visit	100% after the $40 PCP or applicable $65 CCN or $80 Non-CCN Specialist per office visit Copayment
Inpatient Facility	70% after Plan Year Deductible
Outpatient Facility	70% after Plan Year Deductible
Physician's Services	70% after Plan Year Deductible

Routine Foot Disorders	Not covered except for services associated with foot care for diabetes and peripheral vascular disease.
Treatment Resulting From Life Threatening Emergencies Medical treatment required as a result of an Emergency Medical Condition will be considered a Covered Expense even if not performed by a Participating Provider until the medical condition is stabilized. Once the Emergency Medical Condition is stabilized, CIGNA and the Participating Provider (Primary Care Physician or Specialist) will work to transfer your care to a Participating Provider.	
Mental Health 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. **Inpatient** Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Partial Hospitalization and Mental Health Residential Treatment Services. Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period. Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions. Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center. A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.	70% after Plan Year Deductible

Outpatient (Includes Individual, Group and Intensive Outpatient) 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 Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment. 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. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.	
Physician's Office Visit (or Cigna Behavioral TeleHealth)	100% after $40 per visit Copayment
Outpatient Facility	70% after Plan Year Deductible
Substance Abuse 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 Abuse.	

Inpatient 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 Abuse Services include Partial Hospitalization sessions and Residential Treatment services. Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period. Substance Abuse 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 Abuse conditions. Substance Abuse Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of Substance Abuse; 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 Abuse Residential Treatment Center when she/he is a registered bed patient in a Substance Abuse Residential Treatment Center upon the recommendation of a Physician.	70% after Plan Year Deductible
Outpatient (Includes Individual and Intensive Outpatient) Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Abuse Intensive Outpatient Therapy Program. A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week. Substance Abuse Detoxification Services 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.	
Physician's Office Visit (or Cigna Behavioral TeleHealth)	100% after $40 per visit Copayment
Outpatient Facility	70% after Plan Year Deductible

Vision Benefit - NO VISION BENEFIT

EXHIBIT A-2
CIGNA OPEN ACCESS PLAN DOCUMENT
Updated with Plan Changes Effective 05/01/2023

Section 3 – What is Not Covered

A. General

1. Exclusions (specific exclusions are not appealable for medical necessity)

a. 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.
- treatment of Injury if Participant was under the influence of illegal drugs or alcohol at the time of the Injury.
- if the Injury occurred in connection, in whole or in part, with the commission of a felony by the Participant.
- if the Participant intentionally inflicted the Injury upon himself/herself, unless such action resulted from a mental illness or disorder included in the edition of the American Psychiatric Association's Diagnostic and Statistic Manual of Mental Disorders that is current at the time the Injury occurs.
- 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, riot or insurrection.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- 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.

b. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:

- 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;
- not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
- 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 as provided in the "Clinical Trials" section of this plan.

c. Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.

d. The following services are excluded from coverage regardless of clinical indications: Abdominoplasty; Panniculectomy; Rhinoplasty; Blepharoplasty; Redundant skin surgery; Removal of skin tags; Acupressure; Craniosacral/cranial therapy; Dance therapy, Movement therapy; Applied kinesiology; Rolfing; Prolotherapy; and Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.

e. Elective, non-therapeutic abortions.

f. 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 sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.

g. Intentionally left blank.

h. Unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.

i. Court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.

j. Infertility services services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs and all medical care and services related to pregnancy, delivery (including care for postdelivery complications related thereto) and newborn care for the purpose of surrogacy are also excluded from coverage.

k. Reversal of male or female voluntary sterilization procedures.

l. (Intentionally left blank)

m. 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.

n. Medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.

o. Nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back-to-school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, or mental retardation.

p. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.

q. 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 except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.

r. Private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision or as required for isolation due to infectious disease or immune problem.

s. Personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.

t. Artificial aids including, but not limited to, corrective orthopedic shoes, orthotic inserts, arch supports, elastic stockings, garter belts, corsets, and dentures.

u. For or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.

v. Aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille

typewriters, visual alert systems for the deaf and memory books.

w. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).

x. Routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.

y. Treatment by acupuncture.

z. Massage therapy.

aa. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.

ab. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.

ac. 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.

ad. Dental implants for any condition.

ae. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.

af. Blood administration for the purpose of general improvement in physical condition.

ag. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.

ah. Cosmetics, dietary supplements and health and beauty aids.

ai. Nutritional supplements (except for Ensure as prescribed by a Participating Provider) and formulae except for infant formula needed for the treatment of inborn errors of metabolism, including formulas for treatment of Phenylkenetonuria (PKU) for other Heritable Diseases.

aj. Medical treatment for a Retiree age 65 or older, who is enrolled in Medicare and is eligible to participate in one of the various federally sponsored Medicare Advantage Plans offered by Employer.

2. Limitations

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

- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicare or Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- for charges which would not have been made if the person had no insurance.
- to the extent that they are more than Maximum Reimbursable Charges applicable to care, if any received out-of-network (for example, emergency care).
- 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 made 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.

B. Hospice Care Services

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

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

C. Mental Health and Substance Abuse Services

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

- any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement.
- treatment of disorders which 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.

D. Durable Medical Equipment

Unless covered in connection with the services described in another section of this certificate, the following are specifically excluded:

- Hygienic or self-help items or equipment;
- Items or equipment that are primarily used for comfort or convenience, such as bathtub chairs, safety grab bars, stair gliders or elevators, over-the-bed tables, saunas or exercise equipment;
- Environmental control equipment, such as air purifiers, humidifiers and electrostatic machines;
- Institutional equipment, such as air fluidized beds and diathermy machines;
- Elastic stockings;
- Equipment used for the purpose of participation in sports or other recreational activities including, but not limited to, orthotics, braces and splints;

- Items, such as auto tilt chairs, paraffin bath units and whirlpool baths, which are not generally accepted by the medical profession as being therapeutically effective;
- Items which under normal use would constitute a fixture to real property, such as ramps, railings, and grab bars.

E. Short-Term Rehabilitative Therapy and Chiropractic Care Services

The following limitations apply to Short-Term Rehabilitative Therapy and Chiropractic Care:

- occupational therapy is provided only for purposes of training members to perform the activities of daily living;
- speech therapy is not covered when used to improve speech skills that have not fully developed; considered custodial or educational; intended to maintain speech communication; or not restorative in nature;
- multiple services provided on the same day constitute one visit, but a separate Copayment will apply to the services provided by each Physician.

EXHIBIT A-2
CIGNA OPEN ACCESS PLAN DOCUMENT
Updated with Plan Changes Effective 05/01/2023

Section 4 - Notices

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

A. Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

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

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

Qualified Medical Child Support Order Defined

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

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

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

Payment of Benefits

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

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

If you or your eligible Dependent(s) experience a special enrollment event as described below, you or your eligible Dependent(s) may be entitled to enroll in the Plan outside of a designated enrollment period upon the occurrence of one of the special enrollment events listed below. If you are already enrolled in the Plan, you may request enrollment for you and your eligible Dependent(s) under a different option offered by the Employer for which you are currently eligible. If you are not already enrolled in the Plan, you must request special enrollment for yourself in addition to your eligible Dependent(s). You and all of your eligible Dependent(s) must be covered under the same option. The special enrollment events include:

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; spouse only; Employee and spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, spouse and Dependent child(ren). Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage. Dependent children who were already Dependents of the Employee but not currently enrolled in the Plan are not entitled to special enrollment.
- **Loss of eligibility for State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.
- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan. If required by the Plan, when enrollment in this Plan was previously declined, it must have been declined in writing with a statement that the reason for declining enrollment was due to other health coverage. This provision applies to loss of eligibility as a result of any of the following:
    - divorce or legal separation;
    - cessation of Dependent status (such as reaching the limiting age);
    - death of the Employee;
    - termination of employment;
    - reduction in work hours to below the minimum required for eligibility;
    - you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
    - ; 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; and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.
- **Eligibility for employment assistance under State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

Except as stated above, special enrollment must be requested within 30 days after the occurrence of the special enrollment event. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption. Coverage with regard to any other

special enrollment event will be effective on the first day of the calendar month following receipt of the request for special enrollment.

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

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

C. Effect of Section 125 Tax Regulations on This Plan

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

1. **Coverage Elections**

   Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if your Employer agrees and you enroll for or change coverage within 30 days of the following:

   - the date you meet the Special Enrollment criteria described above; or
   - the date you meet the criteria shown in the following Sections B through F.

2. **Change of Status**

   A change in status is defined as:

   - change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;
   - change in number of Dependents due to birth, adoption, placement for adoption, or death of a Dependent;
   - change in employment status of Employee, spouse or Dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
   - changes in employment status of Employee, spouse or Dependent resulting in eligibility or ineligibility for coverage;
   - change in residence of Employee, spouse or Dependent to a location outside of the Employer's network service area; and
   - changes which cause a Dependent to become eligible or ineligible for coverage.

3. **Court Order**

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

4. **Medicare or Medicaid Eligibility/Entitlement**

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

5. **Change in Cost of Coverage**

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

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

6. **Changes in Coverage of Spouse or Dependent Under Another Employer's Plan**

   You may make a coverage election change if the plan of your spouse or Dependent: incurs a change such as adding or deleting a benefit option; allows election changes due to Special Enrollment, Change in Status, Court Order or

Medicare or Medicaid Eligibility/Entitlement; or this Plan and the other plan have different periods of coverage or open enrollment periods.

D. Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

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

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

E. Federal Tax Implications for Dependent Coverage

Premium payments for Dependent health insurance are usually exempt from federal income tax. Generally, if you can claim an individual as a Dependent for purposes of federal income tax, then the premium for that Dependent's health insurance coverage will not be taxable to you as income. However, in the rare instance that you cover an individual under your health insurance who does not meet the federal definition of a Dependent, the premium may be taxable to you as income. If you have questions concerning your specific situation, you should consult your own tax consultant or attorney.

F. Coverage for Maternity Hospital Stay

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (*e.g.*, your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

G. Women's Health and Cancer Rights Act (WHCRA)

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

H. 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.

I. Obtaining a Certificate of Creditable Coverage Under This Plan

Upon loss of coverage under this Plan, a Certificate of Creditable Coverage will be mailed to each terminating individual at

the last address on file. You or your dependent may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Plan and for 24 months following termination of coverage. to help you get special enrollment in another plan, or to obtain certain types of individual health coverage even if you have health problems. To obtain a Certificate of Creditable Coverage, contact the Plan Administrator or call the toll-free customer service number on the back of your ID card.

J. Requirements of Medical Leave Act of 1993 (as amended) (FMLA)

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

Continuation of Health Insurance During Leave

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

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

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

Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, as amended, any canceled insurance (health, life or disability) will be reinstated as of the date of your return, if you apply for coverage within thirty-one (31) days after you return to work.

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

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

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

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

Continuation of Coverage

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

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

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

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

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

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

Reinstatement of Benefits (applicable to all coverages)

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

military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a Waiting Period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

Any 63-day break in coverage rule regarding credit for time accrued toward a Waiting Period will be waived.

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

L. When You Have a Complaint or an Appeal

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

"Physician Reviewers" are licensed Physicians depending on the care, service or treatment under review.

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

Start With Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you may call the toll-free number on your Benefit Identification card, explanation of benefits, or claim form and explain your concern to one of our Member Services 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.

Appeals Procedure

CIGNA has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing to CIGNA within 365 days of receipt of a denial notice. 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 or write us at the toll-free number on your Benefit Identification card, explanation of benefits, or claim form.

Level-One Appeal

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

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

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

Level-Two Appeal

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

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

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

You may request that the appeal 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 Physician, would cause you severe pain which cannot be managed without the requested services; or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. CIGNA's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CIGNA will respond orally with a decision within 72 hours, followed up in writing.

Independent Review Process

(a) Administrator shall make available to a Participant, a person acting on behalf of a Participant, or the Participant's provider of record an independent review process only for cases involving an adverse utilization review determination or when required by law. Administrator shall inform Participants of the availability of the independent review process in all initial medical necessity denial letters and all Adverse Determination Appeal or Expedited Adverse Determination Appeal denial letters.

(b) To request an independent review, a Participant must complete the TX "Request for Review by an Independent Review Organization" form and return it to the Administrator. The Administrator shall submit such form, along with the completed "Request from a Utilization Review Agent For Assignment of an Independent Review Organization" form, to the Texas Department of Insurance (TDI) along with copies of the initial adverse medical necessity determination letter and the Adverse Determination Appeal denial letter.

c) The TDI will randomly assign an independent review organization for each matter within one business day of the receipt of the request.

(d) The Administrator must comply with the determination of the independent review regarding the medical necessity or appropriateness of the health care items and services reviewed. Administrator shall pay for the full cost for the independent review and such cost is passed through to the Plan Sponsor.

(e) An expedited independent review is available for life-threatening conditions.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the; upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

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

Legal Action

In most instances, you may not initiate a legal action against CIGNA until you have completed the Level-One and Level-Two appeal processes.

M. COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

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

When is COBRA Continuation Available?

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

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

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

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

Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary is an individual who was covered under this Plan on the day before a qualifying event occurred and who is either an Employee ("you"), the Employee's spouse, or former spouse, or the Employee's Dependent. In addition, any child born to or placed for adoption with a Covered Employee during a period of continuation coverage is automatically considered a qualified beneficiary. 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.

If you elect COBRA continuation coverage for yourself, you may also cover your Dependents even if they are not considered qualified beneficiaries under COBRA. However, such individuals' coverage will terminate when your COBRA continuation

coverage terminates. The sections titled "Secondary Qualifying Events" and "Medicare Extension For Your Dependents" are not applicable to these individuals.

Secondary Qualifying Events

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

Disability Extension

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

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

- SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
- A copy of the written SSA determination must be provided to the Plan Administrator within 60 calendar days after the date the SSA determination is made AND before the end of the initial 18-month continuation period.

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

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

Medicare Extension for Your Dependents

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

Termination of COBRA Continuation

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

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- cancellation of the Employer's policy with CIGNA;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan;
- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

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

If you and/or your Dependents move out of the Employer's service area or the Employer eliminates a service area in your location, your COBRA continuation coverage under the plan will be limited to emergency services only. Because the Plan

does not provide out-of-network coverage, nonemergency services will not be covered under the plan outside of the Employer's service area. If the Employer offers another benefit option through CIGNA or another carrier which can provide coverage in your location, you may elect COBRA continuation coverage under that option.

Employer's Notification Requirements

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

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

How to Elect COBRA Continuation Coverage

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

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

How Much Does COBRA Continuation Coverage Cost?

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

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

When and How to Pay COBRA Premiums

First payment for COBRA continuation

If you elect COBRA continuation coverage, you do not have to send any payment with the election form. However, you must

make your first payment no later than 45 calendar days after the date of your election. (This is the date the Election Notice is postmarked, if mailed.) If you do not make your first payment within 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 that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a payment before the end of the grace period for that coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

You Must Give Notice of Certain Qualifying Events

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

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

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

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

Newly Acquired Dependents

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

COBRA Continuation for Retirees Following Employer's Bankruptcy

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

Interaction With Other Continuation Benefits

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