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CDHP PHARMACY PLAN DOCUMENT
Updated with Plan Changes Effective 05/01/2023

This document, known as the "Pharmacy Plan Document," describes the benefits available to the Participants in the City of Houston's CDHP 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. In Network versus Out of Network Benefits
- D. Participating Providers
- E. Prior Authorization/Pre-Authorized
- F. Certification Requirements – Out of Network
- G. Covered Expenses
- H. Special Provisions
- 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
- O. CIGNA ChoiceFund – Health Reimbursement Account

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. Notice of Provider Directory/Networks
- B. Qualified Medical Child Support Order (QMSCO)
- C. Special Enrollment Rights Under the Health Insurance Portability & Accountability Act
- D. Effect of Section 125 Tax Regulations on This Plan
- E. Eligibility for Coverage of Adopted Children

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SECTION 1 - REQUIREMENTS

A. Explanation of Terms – Refer to Administrative Services Agreement for Third Party Administrator Pharmacy Benefits Management Services (ASA) for Definitions of applicable terms not listed below.

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 Pharmacy Benefits Plan means any pharmacy benefit plan, other than the Plan, that is offered by Employer.

Anniversary Date means the annual anniversary of the Effective Date.

Charges means the Fixed Administrative Charges, and Charges and fees for Additional Services described in Exhibit G to the ASA.

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.

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

Covered Services means medically necessary pharmaceutical products, services and supplies, specified as covered in the Schedule of Benefits, that are received by Participants in accordance with the terms and procedures of the Plan.

Deductible means expenses to be paid by you and your Dependents. 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.

Effective Date means May 1, 2023.

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.

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.

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.

Medicare Part D means the Medicare prescription drug benefit, an optional United States federal-government program to help Medicare beneficiaries pay for self-administered prescription drugs through prescription drug insurance premiums.

Necessary Services and Supplies include prescription drugs and pharmaceutical services and supplies.

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.

Out-of-Pocket Expenses are Covered Expenses incurred for charges that are not paid by the benefit plan prior to reaching Out of Pocket Maximum including Copayment. When the Out-of-Pocket Maximum shown in Section 2 (What is Covered) is reached, benefits for Covered Services are payable at 100%.

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 Pharmacy means a retail Pharmacy with which Administrator has contracted to provide prescription services to Participants, or designated home delivery Pharmacy or Specialty Pharmacy with which Administrator has contracted to provide home delivery prescription services to Participants. A home delivery Pharmacy or Specialty Pharmacy is a Pharmacy that provides Prescription Drugs through mail order.

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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.

Pharmacy means a retail Pharmacy, or a home delivery Pharmacy.

Pharmacy & Therapeutics (P & T) Committee is a committee of Participating Providers, medical directors and Pharmacy directors which regularly reviews Prescription Drugs and related supplies for safety and efficacy. The P&T Committee evaluates Prescription Drugs and related supplies for potential addition to or deletion from the Prescription Drug List and may also set dosage and/or dispensing limits on Prescription Drugs and related supplies.

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

Prescription Drug means: a drug which has been approved by the Food and Drug Administration for safety and efficacy; certain drugs approved under the Drug Efficacy Study Implementation review; or drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

Prescription Drug List means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

Prescription Order means the lawful authorization for a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of such Physician's professional practice or each authorized refill thereof.

Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

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. As of the Effective Date of this Plan, a Retiree who is eligible to receive or is receiving Medicare coverage, and who is eligible to participate in any 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 Administratoror another entity to which Administrator 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 Administrator Open Access Plan and CDHP Plan. The Service Area includes the area show in Exhibit C of the Administration Services Agreement between Administrator and Employer.

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 pharmacy 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 pharmacy 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 pharmacy 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 pharmacy care plan at the time the Employee declined enrollment;
    - The Employee signed a Waiver of Coverage stating another pharmacy 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.

Specialty Drug means a pharmaceutical product that is reasonably determined by Administrator to be a specialty drug in accordance with industry practice. Specialty Drugs generally are (i) derived from biotechnology processes which use tissue culture, living cells, or cellular enzymes) small molecule oral drugs which are organic compounds; (ii) and binds to a protein, nucleic acid, or polysaccharide; (iii) targets the underlying disease pathology rather than treating symptoms; (iv) manages complications of disease; (v) targets conditions that are rare, chronic, and costly; (vi) requires a special distribution channel (e.g. restricted access, REMS, etc.); (vii) requires close supervision and monitoring of therapy for safety and effectiveness; and (viii) requires close supervision or handling related to the dispensing and fulfillment process**.**

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.

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.

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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 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 or a spouse who is legally separated from the Subscriber 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 Enrollment.
    - Late 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 ninety (90) 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. In-Network versus Out-of-Network Benefits

This Plan provides coverage for care In-Network and Out-of-Network. To receive benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Deductible and/or Coinsurance.

When you select a Participating Provider (In-Network), this Plan pays a greater share of the costs than if you select a non-Participating Provider (Out-of-Network).

D. Participating Pharmacy Providers

Participating Pharmacy Providers are included on the Pharmacy Providers list. Consult your Provider Guide or visit the Administrator's website at www.mycigna.com for a list of Participating Pharmacies in your area, call the number on the back of your I.D. card. Participating Pharmacies are committed to providing you and your Dependents appropriate pharmaceutical services while lowering Pharmacy costs.

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E. Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to certain prescriptions being filled and covered under this policy.

G. Covered Expenses

Covered Expenses include all medications on the approved formulary.

H. Special Provisions

This section addresses Prescription Drugs Covered Services that often require clarification.

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, CIGNA will provide coverage for those expenses as shown in the Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a Dependent is issued a prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by CIGNA, as if filled by a Participating Pharmacy.

Coverage for certain Prescription Drugs and Related Supplies requires your Physician to obtain authorization prior to prescribing. Prior authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If your Physician wishes to request coverage for Prescription Drugs or Related Supplies for which prior authorization is required, your Physician may call or complete the appropriate prior authorization form and fax it to CIGNA to request a prior authorization for coverage of the Prescription Drugs or Related Supplies. Your Physician should make this request before writing the prescription.

If the request is approved, your Physician will receive confirmation. The authorization will be processed in our claim system to allow you to have coverage for those Prescription Drugs or Related Supplies. The length of the authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When your Physician advises you that coverage for the Prescription Drugs or Related Supplies has been approved, you should contact the Pharmacy to fill the prescription(s).

If the request is denied, your Physician and you will be notified that coverage for the Prescription Drugs or Related Supplies is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

If you have questions about a specific prior authorization request, you should call Member Services at the toll-free number on the ID card.

All drugs newly approved by the Food Drug Administration (FDA) are designated as either non-Preferred or non-Prescription Drug List drugs until the P&T Committee clinically evaluates the Prescription Drug for a different designation. Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

EXHIBIT A-3

CDHP PHARMACY PLAN DOCUMENT
Updated with Plan Changes Effective 05/01/2023

I. How To File Your Claim

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

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

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 Administrator's contracts with providers, all claims from contracted providers should be assigned.

Administrator 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 Administrator 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, Administratormay, 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, Administrator 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 Administrator from all liability to the extent of any payment made.

Recovery of Overpayment

When an overpayment has been made by Administrator, Administrator 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

Administrator, 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 Administratorfor fraud, misrepresentation or misconduct as provided in O. 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 Administratorfor fraud, misrepresentation or misconduct as provided in N.5. below;
- the end of a month at the request of the Deferred Retiree.

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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 Administratorfor 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 Administrator or Employer 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 Administrator 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 Administratorfor fraud, misrepresentation or misconduct as provided in N.5. below.

5. Termination by Administrator

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 Administrator 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 Administrator 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 Administrator 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 Administrator 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.

O. CIGNA ChoiceFund® - Health Reimbursement Account

The Basics

How does it work?

The Health Reimbursement Arrangement combines traditional medical coverage with a fund that includes contributions only from your employer.

1. **Employer contribution** — Your Employer establishes a health fund that can be used to pay for qualified health care expenses during that year. The services you receive and where you get them are up to you. Amounts paid by the fund for covered services count toward the annual deductible. For a list of qualified expenses, please visit CIGNA.com, subject to limits set by your employer.

2. **Your contribution** — Once you've used the dollars in your health fund, you pay your expenses up to the deductible.
3. **Your Employer and you** — After your deductible is met, you use a traditional medical plan for covered services. Depending on your plan, you pay pre-determined coinsurance or copayments for certain services.

Which services are covered by my Health Reimbursement Arrangement?

According to federal law, HRA funds can be used to cover only qualified medical expenses for you and your dependents. However, your employer may choose not to allow coverage for certain qualified expenses. Please refer to myCIGNA.com for information on the services for which you may use your HRA funds. If you use your HRA for expenses not allowed under federal tax law, your contributions will be subject to taxes.

Which services are covered by my medical plan, and which will I have to pay out of my own pocket?

Covered services vary depending on your plan, so visit myCIGNA.com or check your plan materials in this booklet for specific information. In addition to your premiums deducted from your paycheck, you'll be responsible for paying:

- Costs for any services needed after you've spent your health fund, if you haven't met your deductible.
- Your coinsurance or copayments after you meet the deductible and your medical plan coverage begins.

If all of your medical expenses are covered services and the total cost doesn't exceed the amount in your health fund, you may not have additional out-of-pocket costs.

Your plan may also include a Flexible Spending Account (FSA). If you are eligible to enroll in this account, you can contribute pre-tax dollars from each paycheck — then use the funds to reimburse yourself for eligible health care expenses, such as certain vision, hearing, or orthodontic care, even if they're not covered by your medical/pharmacy plan. Your employer determines which health care expenses are eligible for reimbursement. Your employer also decides whether money for expenses is deducted first from your HRA or FSA. In addition, your employer may allow you to use FSA funds remaining at the end of the plan year to pay for claims incurred during the 2½ months after your plan year ends. Please check with your employer to determine if this option is available to you.

EXHIBIT A-3

CDHP PHARMACY PLAN DOCUMENT
Updated with Plan Changes Effective 05/01/2023

Are services covered if I use out-of-network doctors?

You can use the dollars in your HRA to visit any licensed doctor or facility. However, if you choose a provider who participates with Administrator, your costs will be lower.

Tools and Resources at Your Fingertips

To help you understand your benefits, we've created a suite of information and tools that you can access confidentially through our member website, **myCIGNA.com**.

You have a right to know the cost of services you receive. You have the power to make a difference in the type and quality of those services. You have unique health care needs.

And that's why you have myCIGNA.com – to find value in your health plan. myCIGNA.com includes helpful resources specifically for members who have CIGNA Choice Fund.

- Online access to your current fund balance, past transactions and claim status, as well as your Explanation of Benefits.
- Your own savings account calculator, with account balance tracking and transaction worksheets to estimate your out-of-pocket expenses.
- Medical cost and drug cost information, including average costs for your state.
- Explanations of other CIGNA products and services – what they are and how you can use them.
- Frequently asked questions – about health care in general and CIGNA specifically.
- A number of convenient, helpful tools that let you:

Compare costs

Use tools to compare costs and help you decide where to get care. You can get average price ranges for certain ambulatory surgical procedures and radiology services. You can also find estimated costs in your region for common medical services and conditions.

Find out more about your local hospitals

Learn how hospitals rank by number of procedures performed, patients' average length of stay, and cost. Go to our online provider directory for estimated average cost ranges for certain procedures, including total charges and your out-of-pocket expense, based on a CIGNA benefit plan. You can also find hospitals that earn the "Centers of Excellence" designation based on effectiveness in treating selected procedures/conditions and cost.

Get the facts about your medication, cost, treatment options and side effects

Use the pharmacy tools to: check your prescription drug costs, listed by specific pharmacy and location (including CIGNA Home Delivery); and review your claims history for the past 16 months. Click "WebMD Drug Comparison Tool" under **Related Health Resources** to look at condition-specific drug treatments and compare characteristics of more than 200 common medications. Evaluate up to 10 medications at once to better understand side effects, drug interactions and alternatives.

Take control of your health

Take the health assessment, an online questionnaire that can help you identify and monitor your health status. You also can find out how your family history may affect you, learn about preventive care and check your progress toward healthy goals. And if your results show that you may benefit from other services, you can learn about related CIGNA programs on the same site.

Explore topics on medicine, health and wellness

Get information on more than 5,000 health conditions, health and wellness, first aid and medical exams through **Healthwise**®, an interactive library. Research articles on clinical findings through **Condition Centers**®.

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Keep track of your personal health information

Health Record is your central, secure location for your medical conditions, medications, allergies, surgeries, immunizations, and emergency contacts. You can add your health risk assessment results to **Health Record**, so you can easily print and share the information with your doctor. Your lab results from certain facilities can be automatically entered into your Personal Health Record.

Chart progress of important health indicators

Input key data such as blood pressure, blood sugar, cholesterol (Total/LDL/HDL), height and weight, and exercise regimen. **Health Tracker** makes it easy to chart the results and share them with your doctor.

On the Phone

Call the toll-free number on your CIGNA ID card to reach the CIGNA 24-Hour Health Information Line[SM]. You can speak to a trained nurse for guidance on appropriate care or directions to the nearest facility. You also can listen to audio tapes on a variety of health topics. It's easy, reassuring, convenient and confidential.

CIGNA Health Advisor®/Personal Health Team

You now have access to health specialists – including individuals trained as nurses, coaches, nutritionists and clinicians – who will listen, understand your needs and help you find solutions, even when you're not sure where to begin. Partner with a health coach and get help to maintain good eating and exercise habits; support and encouragement to set and reach health improvement goals; and guidance to better manage conditions, including coronary artery disease, low back pain, osteoarthritis, high blood pressure, high cholesterol and more. From quick answers to health questions to assistance with managing more serious health needs, call the toll-free number on your CIGNA ID card or visit mycigna.com. See your benefits administrator for more details about all of the services you have access to through your plan.

Getting the Most from Your HRA

As a consumer, you make decisions every day – from buying the family car to choosing the breakfast cereal. Make yourself a more educated health care consumer and you'll find that you, too, can make a difference in the health care services you receive and what you ultimately pay.

Fast Facts

If you choose to see a CIGNA participating provider, the cost is based on discounted rates, so your costs will be lower. If you visit a provider not in the network, you may still use CIGNA Choice Fund to pay for the cost of those services, but you will pay a higher rate, and you may have to file claims.

If you need hospital care, there are several tools to help you make informed decisions about quality and cost.

- With the Select Quality Care[TM] hospital comparison tool on myCIGNA.com, you can learn how hospitals rank by number of procedures performed, patients' average length of stay, and cost.
- Visit our provider directory for CIGNA "Centers of Excellence," providing hospital scores for specific procedures/conditions, such as cardiac care, hip and knee replacement, and bariatric surgery. Scores are based on cost and effectiveness in treating the procedure/condition, based on publicly available data.
- www.cigna.com also includes a Provider Excellence Recognition Directory. This directory includes information on:
- Participating physicians who have achieved recognition from the National Committee for Quality Assurance (NCQA) for diabetes and/or heart and stroke care.
- Hospitals that fully meet The Leapfrog Group patient safety standards.

Wherever you go in the U.S., you take the CIGNA 24-Hour Health Information Line[SM] with you.

Whether it's late at night, and your child has a fever, or you're traveling and you're not sure where to get care, or you don't feel well and you're unsure about the symptoms, you can call the CIGNA 24-Hour Health Information Line whenever you have a question. Call the toll-free number on your CIGNA ID card and you will speak to a nurse who will help direct you to the appropriate care.

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A little knowledge goes a long way.

Getting the facts about your care, such as treatment options and health risks is important to your health and well-being — and your pocketbook. For instance:

- Getting appropriate preventive care is key to staying healthy. Your CIGNA Participating Provider can provide a wide variety of tests and exams that are covered by your CIGNA plan. Visit myCIGNA.com to learn more about proper Preventive Care and what's covered under your plan. You can also find ways to stay healthy by calling the CIGNA 24-Hour Health Information Line, which includes audio tapes on preventive health, exercise and fitness, nutrition and weight control, and more.
- When it comes to medications, talk to your doctor about whether generic drugs are right for you. The brand name drugs you are prescribed may have generic alternatives that could lower your costs. If a generic version of your brand name drug is not available, other generic drugs with the same treatment effect may meet your needs.
- The health care cost estimator tool on myCIGNA.com can help you use the plan effectively. When planning and budgeting, consider:
- Your medical and prescription drug expenses from last year.
- Any expected changes in your medical spending in the coming year.

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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 Pharmacy 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	
	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	
Healthcare Reimbursement Account Employer Contribution (See Section 1 – Requirements, subsection O)	**Employee - $500** **Family - $1,000**	
Coinsurance Level	80% of CIGNA's discounted rate	60% of the Maximum Reimbursable Charge
Maximum Reimbursable Charge Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or A percentage (110%) of a schedule developed by CIGNA that is based upon a methodology similar to a methodology utilized by Medicare to determine the allowable fee for the same or similar service within the geographic area. **Note:** Out-of-Network providers may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles and coinsurance.	Not Applicable	110%
Plan Year Deductible (Medical and Pharmacy combined)	The amount you pay for out-of-network services counts toward both your in-network and out-of-network deductibles. The amount you pay for in-network services counts only toward your in-network deductible. Medical and Pharmacy costs contribute to one combined Plan Deductible amount, within the available medical Individual and Family ranges.	
Individual	$1,750 per person	$3,500 per person
Family Maximum	$3,500 per family	$7,000 per family
Example Family Maximum Calculation for In-Network:		

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BENEFIT HIGHLIGHTS	COVERAGE UNDER THIS PLAN	
	IN-NETWORK	OUT-OF-NETWORK
The Family Maximum is met when Covered Expenses for all covered family members reach $3,500 except that no single family member shall meet more than $1,750.		
Out-of-Pocket Maximum (includes Plan Year Deductible) (Medical and Pharmacy Combined) The Out-of-Pocket Maximum will change based on the annual Patient Protection and Affordable Care Act (PPACA) maximum changes.		

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BENEFIT HIGHLIGHTS	COVERAGE UNDER THIS PLAN
Prescription Drugs (see additional information in Section 1 – Requirements, subsection H and Section 3 – What is Not Covered)	
Retail – For In-Network benefits, prescriptions must be obtained from retail pharmacies contracted with Cigna's national Pharmacy network 1. Retail pharmacies for 30-day supply include Walgreen's, Wal-Mart, H-E-B, Kelsey-Seybold Clinics, CVS/Target, and Kroger as well as participating independent pharmacies. 2. Retail Narrow Network pharmacy for 90-day supply include Wal-Mart, CVS/Target, and Kroger. Visit mycigna.com or call 1-800-997-1406 for more information.	**The amount you pay for up to a 30-day supply**
Tier 1 – Generic drugs on the Prescription Drug List	**Tier 1** In-Network - 20% after Plan Year Deductible** Out-of-Network 60% coinsurance/prescription after Plan Year Deductible** **Exception: Generic Statins (cholesterol medication) for ages 40-75: $0 cost share**
Tier 2* – Brand-Name drugs designated as preferred on the Prescription Drug List with no Generic equivalent	**Tier 2*** In-Network - 20% after Plan Year Deductible** Out-of-Network 60% coinsurance/prescription after Plan Year Deductible**
Tier 3* – Brand-Name drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	**Tier 3*** In-Network - 20% after Plan Year Deductible** Out-of-Network 60% coinsurance/prescription after Plan Year Deductible**
Tier 4 - Specialty Medications administered via injection or infusion by a health care professional, customer, or caregiver and certain oral medications given in the home (e.g. injectable drugs used to treat rheumatoid arthritis, hepatitis C, multiple sclerosis, asthma). Limited to a 30-day supply. *If it does not indicate "Dispense as Written" on the prescription and generic substitution is allowed, but the customer insists on the brand drug, the customer pays the brand tier copay plus the difference in cost between the brand drug and the generic.	**Tier 4** In-Network - 20% after Plan Year Deductible** Out-of-Network 60% coinsurance/prescription after Plan Year Deductible**

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Tobacco Cessation Medications Over-the-counter (OTC) and Generic Prescription Medications* Generic Oral Contraceptive Medications* * Not subject to deductible	 $0 Copayment
Home Delivery - Prescriptions must be filled by CIGNA Home Delivery Pharmacy. To get an order form, go to the Pharmacy tab on myCIGNA.com or call 1-800-997-1406 for more information.	**The amount you pay for up to a 90-day supply:**
Tier 1 - Generic drugs on the Prescription Drug List	20% after Plan Year Deductible*
• Generic Diabetes related (drugs and supplies) * • Generic Cholesterol related* • Generic Asthma related* • Generic Blood Pressure related* • Generic Blood Thinner related* • Generic Anxiety/Depression/Bipolar disorder related* • Generic Osteoporosis related* • Generic Prenatal Vitamins*	$0 Copayment $0 Copayment $0 Copayment $0 Copayment $0 Copayment $0 Copayment $0 Copayment $0 Copayment
* Not subject to deductible	
Tier 2 - Brand-Name drugs designated as preferred on the Prescription Drug List with no Generic equivalent	20% after Plan Year Deducible
• Preferred Brand Diabetes related (drugs and supplies) * • Preferred Brand Asthma related* • Preferred Brand Blood Pressure related* • Preferred Brand Blood Thinner related* • Preferred Brand Cholesterol related* • Preferred Brand Osteoporosis related* • Preferred Brand Prenatal Vitamins*	$0 Copayment $0 Copayment $0 Copayment $0 Copayment $0 Copayment $0 Copayment $0 Copayment
* Not subject to deductible	
Tier 3 - Brand-Name drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	20% after Plan Year Deductible**
Tier 4 – Specialty - Medications administered via injection or infusion by a health care professional, customer, or caregiver and certain oral medications given in the home (e.g. injectable drugs used to treat rheumatoid arthritis, hepatitis C, multiple sclerosis, asthma)	20% after Plan Year Deducible**; limited to 30 day supply

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****Preventive Drugs are not subject to the Plan Year Deductible.**

Preventive Drug Classes and Examples:

Antihyperlipidemic: lovastatin, simvastatin, pravastatin sodium
Antihypertensive: lisinopril, losartan potassium, ramipril
Antidiabetic Agent: glyburide,metformin, acarbose, glimipiride
Antiasthmatics: zafirlukast, albuterol sulfate, metaproterenol sulfate
Anticoagulants: warfarin, enoxaparin sodium, Fragmin
Bone resorption: alendronate sodium, etidronate disodium, calcitonin-salmon
Nutritional supplements: Ensure

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Section 3 – What is Not Covered

Prescription Drugs

No payment will be made for the following expenses:

- drugs available over the counter that do not require a prescription by federal or state law;
- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- injectable infertility drugs;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in the standard reference compendia (AHFS or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in peer-reviewed English-language bio-medical journals;
- prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- implantable contraceptive products;
- any fertility drug;
- prescription vitamins (other than prenatal vitamins), pediatric multivitamins containing fluoride, and dietary supplements;
- diet pills or appetite suppressants (anorectics);
- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance;
- drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- prescriptions more than one year from the original date of issue;
- all Prescription and over-the-counter non-sedating antihistamine drugs, including, but not limited to, cetirizine (Zyrtec), desloratadine (Clarinex), fexofenadine (Allegra), loratadine (Claritin), loratadine & pseudoephedrine (Claritin-D) and fexofenadine & pseudoephedrine (Allegra-D). This includes drugs with the same or similar chemical compound or make-up with the identical mode of action or outcome.
- All prescription drugs for the treatment of heartburn/ulcer/somach acid conditions (Proton Pump Inhibiors) and for which there are over-the-counter (OTC) equivalents or alternatives. This includes drugs with the same or similar chemical compound or make-up with the identical mode of action or outcome. Over-the-Counter drugs and medications for the treatment of heart burn/ulcer/stomach acid conditions (Proton Pump Inhibitors).

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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. Notice of Provider Pharmacy Directory/Networks

Notice Regarding Provider Pharmacy Directories and Provider Pharmacy Networks

Your Plan utilizes a network of Pharmacies, a separate listing of Participating Pharmacies who participate in the network is available to you without charge by visiting www.cigna.com; mycigna.com or by calling the toll-free telephone number on your ID card.

B. 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.

C. 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.

D. 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.

E. 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.

F. 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.

G. 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.

H. 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.

I. 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.

J. 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.

K. 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 qualit4y 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 plan; 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. If your appeal is expedited, there is no need to complete the Level-Two process prior to bringing legal action.

L. 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.

EXHIBIT A-3

CDHP PHARMACY PLAN DOCUMENT
Updated with Plan Changes Effective 05/01/2023

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.

EXHIBIT A-3

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Updated with Plan Changes Effective 05/01/2023

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.