Participating Sponsor/Group:
SANTA MONICA
COLLEGE

MEDICAL BENEFITS (OPEN ACCESS PLUS)

VISION BENEFITS

DENTAL BENEFITS

EFFECTIVE DATE: August 25, 2025

CN001
10548A
1758915

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

Printed in U.S.A.

These materials are being made available electronically for your convenience. Cigna has provided the final documents to your group. Care should be taken to ensure you are reviewing the most complete, accurate and up to date version. Any questions regarding content may be directed to your group or Cigna.

Table of Contents

Address: P.O. Box 155
Mill Court
La Charroterie
St Peter Port Guernsey GY1 4ET

CIGNA GLOBAL INSURANCE COMPANY LIMITED

(herein called Cigna) certifies that it insures certain Members for the benefits provided by the following policy(s):

POLICYHOLDER: CIGNA GLOBAL WELLBEING SOLUTIONS LIMITED
PARTICIPATING SPONSOR/GROUP: SANTA MONICA COLLEGE

GROUP POLICY(S) — COVERAGE

10548A – MEDICAL BENEFITS (OPEN ACCESS PLUS)
10548A – VISION BENEFITS
10548A – DENTAL BENEFITS

EFFECTIVE DATE: August 25, 2025

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.

This certificate takes the place of any other issued to you on a prior date which described the insurance.

All benefits payable under this Policy will be made in United States Dollars.

Jennifer Laydon
Financial Analysis Director

Explanation of Terms

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

The Schedule

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

Special Plan Provisions

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

Services Available in Conjunction with Your Medical Plan

The following pages describe helpful services available in conjunction with your medical plan. You can access these services by calling the toll-free number shown on the back of your ID card.

Case Management

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

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

- You, your Dependent or an attending Physician can request Case Management services by calling the toll-free number shown on your ID card. In addition, the Group, a claim office or a utilization review program (see the Pre-Admission Certification (PAC)/Continued Stay Review (CSR) section of your certificate) may refer an individual for Case Management.
- The Review Organization assesses each case to determine whether Case Management is appropriate.
- You or your Dependent are contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.
- Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
- The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
- The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
- Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

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

Additional Programs

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

Important Information

Continuity of Care

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

- undergoing a course of treatment for a serious and complex condition from the provider or facility.
- pregnant and undergoing treatment for the pregnancy from the provider or facility.
- undergoing a course of institutional or inpatient care from the provider or facility.
- scheduled to undergo non-elective surgery, including receipt of post-operative care with respect to such a surgery.
- determined to be terminally ill and is receiving treatment for such illness from the provider or facility.

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

Provider Directories and Provider Networks

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

How To File Your Claim

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

You may get the required claim forms at www.cignaenvoy.com.

CLAIM REMINDERS

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

Timely Filing of Out-of-Network and International Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within one year (365 days) for Out-of-Network benefits or for International benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within one year for Out-of-Network benefits or for International benefits , the claim will not be considered valid and will be denied.

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

Eligibility - Effective Date

Member Insurance

This plan is offered to you as a Member.

Eligibility for Member Insurance

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

- you are in a Class of Eligible Members as determined by the Group;
- you pay any required contribution; and
- you're traveling outside your country of residence for study abroad program

If you were previously insured and your insurance ceased, you must satisfy the New Member Group Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Members, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Members within one year after your insurance ceased.

Initial Member Group: You are in the Initial Member Group if you are employed in a class of Members on the date that class of Members becomes a Class of Eligible Members as determined by the Group.

New Member Group: You are in the New Member Group if you are not in the Initial Member Group.

Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of;

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Waiting Period

Initial Member Group: A period of time as determined by the Group.

New Member Group: A period of time as determined by the Group.

Classes of Eligible Members

- Students: each member identified as a student by the Participating Group.

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

Effective Date of Member Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction or enrollment form, as applicable, but no earlier than the date you become eligible.

You will become insured on your first day of eligibility, following your election, if you are in Active Service on that date, or if you are not in Active Service on that date due to your health status.

Dependent Insurance

For your Dependents to be insured, you will have to pay the required contribution, if any, toward the cost of Dependent Insurance.

Effective Date of Dependent Insurance

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

All of your Dependents as defined will be included.

Your Dependents will be insured only if you are insured.

Exception for Newborns

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

Important Information About Your Medical Plan U.S.

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

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician:

This medical plan does not require that you select a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available to you under this medical plan. Notwithstanding, a Primary Care Physician may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependents. For this reason, we encourage the use of Primary Care Physicians and provide you with the opportunity to select a Primary Care Physician from a list provided by Cigna for yourself and your Dependents. If you choose to select a Primary Care Physician, the Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

Open Access Plus Medical Benefits

The Schedule

For You and Your Dependents

Open Access Plus Medical Benefits provide coverage for care inside the United States (in-network and out-of-network) and internationally (outside the United States). To receive Open Access Plus Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance, if any.

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

Coinsurance

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

Copayments/Deductibles

Copayments are amounts to be paid by you or your Dependent for covered services. Deductibles are Covered Expenses to be paid by you or your Dependent before benefits are payable under this plan. Deductible amounts are separate from and not reduced by Copayments. Copayments and Deductibles are in addition to any Coinsurance.

Once the Deductible maximum in The Schedule has been reached, you and your family need not satisfy any further medical Deductible for the rest of that plan year.

Contract Year

Contract Year means a twelve month period beginning on each 08/25.

Out-of-Pocket-Expenses

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

- Coinsurance, if any

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

- Non-compliance penalties
- Plan Deductible
- Copayments
- Benefit Deductible
- Provider charges in excess of the Maximum Reimbursable Charge

Open Access Plus Medical Benefits

The Schedule

Accumulation of Plan Deductibles and Out-of-Pocket Maximums

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

Multiple Surgical Reduction

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

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

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

Co-Surgeon

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

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Lifetime Maximum	$1,000,000		
Annual Maximum	$500,000		
The Percentage of Covered Expenses the Plan Pays See Definitions section for an explanation of Maximum Reimbursable Charge	100%	70% of the Maximum Reimbursable Charge	100% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Contract Year Deductible Individual Family **Family Calculation** **Individual Calculation** Family members must meet only their individual Deductible and then their claims will be covered under the plan Coinsurance; if the family Deductible has been met prior to their individual Deductible being met, their claims will be paid at the plan Coinsurance.	 $200 per person $600 per family	 $200 per person $600 per family	 $200 per person $600 per family
Combined Medical/Pharmacy Contract Year Deductible	No	Yes	Yes
Contract Year Out-of-Pocket Maximum Individual Family Maximum **Family Maximum Calculation** **Individual Calculation:** Family members must meet only their individual Out-of-Pocket and then their claims will be covered at 100%; if the family Out-of-Pocket has been met prior to their individual Out-of-Pocket being met, their claims will be paid at 100%.	 $5,000 $15,000 per family	 $5,000 per person $15,000 per family	 $5,000 per person $15,000 per family
Combined Medical/Pharmacy Out-of-Pocket Maximum Combined Medical/Pharmacy Out-of-Pocket: includes retail and home delivery drugs	Yes	Yes	Yes

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Combined Medical/Vision Out-of-Pocket Maximum	Yes	Yes	Yes
Physician's Services			
Physician Office Visit	$25 per visit Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Consultant and Referral Physician's Services	$25 per visit Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Surgery Performed In the Physician's Office			
Physician Office Visit	$25 per visit Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Second Opinion Consultations (provided on a voluntary basis)			
Physician Office Visit	$25 per visit Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Allergy Treatment/Injections			
Physician Office Visit	$25 per visit Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Student Health Center	100%	100% of the Maximum Reimbursable Charge	Not Covered
Preventive Care Routine Preventive Care – birth through age 2 Physician Office Visit Contract Year Maximum: Unlimited	100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	100%
Routine Preventive Care – ages 3 and over Physician Office Visit Contract Year Maximum: Unlimited	100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	100%
Immunizations – birth through age 17 Contract Year Maximum: Unlimited	100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	100%
Immunizations – ages 18 and over Contract Year Maximum: Unlimited	100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	100%
Travel Immunizations	100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	100%
Cancer Screenings Preventive Care Related Services (i.e. “routine” services)	100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	100%
Diagnostic Related Services (i.e. “non-routine” services)	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Inpatient Hospital - Facility Services	$75 per admission Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	100%
Semi-Private Room and Board	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate	Limited to the semi-private room rate
Private Room	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate	Limited to the semi-private room rate. (Private room covered outside the United States only if no semi-private room equivalent is available).
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate	Limited to the ICU/CCU daily room rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Inpatient Hospital Physician's Visits/Consultations	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Inpatient Professional Services			
Surgeon	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Radiologist	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Pathologist	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Anesthesiologist	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Outpatient Professional Services			
Surgeon	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Radiologist	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Pathologist	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Anesthesiologist	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Emergency Services and Urgent Care			
Urgent Care Services			
Urgent Care Facility Includes Outpatient Professional Services X-ray and/or Lab performed at the Urgent Care Facility (billed by the facility as part of the UC visit) Services billed as Emergency Services by an Urgent Care provider will be payable at the In-Network level.	$50 per visit Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Advanced Radiological Imaging (i.e., MRIs, MRAs, CAT Scans, PET Scans, etc.) billed by the facility as part of the UC visit	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Emergency Services			
Hospital Emergency Room Includes Outpatient Professional Services and X-ray and/or Lab performed at the Emergency Room (billed by the facility as part of the ER visit)	$100 per visit Copay (waived if admitted), then 100%	$100 per visit Copay (waived if admitted), then 100%	Plan Deductible, then 100%
Advanced Radiological Imaging (i.e., MRIs, MRAs, CAT Scans, PET Scans, etc.) billed by the facility as part of the ER visit	100%	100%	Plan Deductible, then 100%
Ambulance	Plan Deductible, then 100%	Plan Deductible, then 100% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Contract Year Maximum: 120 days combined	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Laboratory Services			
Physician Office Visit	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Outpatient Facility	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Laboratory Services at an Independent Lab facility	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Radiology Services			
Physician Office Visit	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Outpatient Facility	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Advanced Radiological Imaging (i.e. , MRIs, MRAs, CAT Scans and PET Scans)			
Physician Office Visit	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Inpatient Facility	Plan Deductible, then $75 per admission Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	100%
Outpatient Facility	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Outpatient Therapy Services			
Physician Office Visit	$25 per visit Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Outpatient Hospital Facility	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Contract Year Maximum: 20 days for all therapies combined			
Includes: Cardiac Rehab Physical / Physio Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy Applied Behavior Analysis (ABA Therapy)			

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Chiropractic Care Physician Office Visit Contract Year Maximum: 20 days	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Home Health Care Services Contract Year Maximum: 120 days (includes outpatient private nursing when approved as Medically Necessary)	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Gene Therapy Includes prior authorized gene therapy products and services directly related to their administration, when Medically Necessary. Gene Therapy is only covered in the United States when received at a provider contracted with Cigna for the specific gene therapy product and related services.			
Gene Therapy Product	Covered same as Medical Pharmaceuticals	In-Network Coverage Only	Covered same as Medical Pharmaceuticals
Inpatient Facility	$75 per admission Copay, then 100%	In-Network Coverage Only	100%
Outpatient Facility	Plan Deductible, then 100%	In-Network Coverage Only	Plan Deductible, then 100%
Travel Maximum $10,000 per episode of gene therapy	100% (available only for travel when prior authorized to receive gene therapy at a participating In-Network facility specifically contracted with Cigna to provide the specific gene therapy)	In-Network Coverage Only	In-Network Coverage Only

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Advanced Cellular Therapy Includes prior authorized advanced cellular therapy products and related services when Medically Necessary. Advanced cellular therapy is only covered in the United States when received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services.			
Advanced Cellular Therapy Product	Covered same as Medical Pharmaceuticals	In-Network Coverage Only	Covered same as Medical Pharmaceuticals
Inpatient Facility	$75 per admission Copay, then 100%	In-Network Coverage Only	100%
Outpatient Facility	Plan Deductible, then 100%	In-Network Coverage Only	Plan Deductible, then 100%
Advanced Cellular Therapy Travel Maximum: $10,000 per episode of advanced cellular therapy (Available only for travel when prior authorized to receive advanced cellular therapy from a provider located more than 60 miles of your primary residence and is contracted with Cigna for the specific advanced cellular therapy product and related services.)	100%	In-Network Coverage Only	In-Network Coverage Only

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Maternity Care Services			
Initial Visit to Confirm Pregnancy Physician Office Visit	$25 per visit Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	$25 per visit Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Delivery - Facility			
Inpatient Hospital	$75 per admission Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	100%
Birthing Center	$75 per admission Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	100%
Abortion Includes elective and non-elective procedures			
Physician Office Visit	$25 per visit Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Inpatient Facility	$75 per admission Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	100%
Outpatient Facility	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Family Planning Services			
Office Visits Tests and Counseling			
Physician Office Visit	$25 per visit Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Lab and Radiology Tests	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Surgical Sterilization Procedure for Tubal Ligation (excludes reversals)			
Surgical Sterilization Procedures for Vasectomy (excludes reversals)			
Physician Office Visit	$25 per visit Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Inpatient Facility	$75 per admission Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	100%
Outpatient Facility	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Infertility, Fertility and Conception Services	Not Covered	Not Covered	Not Covered

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Transplant Services and Related Specialty Care Includes all medically appropriate, non-experimental transplants			
Physician Office Visit	$25 per visit Copay, then 100%	In-Network Coverage Only	Plan Deductible, then 100%
Inpatient Facility	$75 per admission Copay, then 100%	In-Network Coverage Only	100%
Travel Maximum: $10,000 per transplant	100% (only available when using Cigna LifeSOURCE Transplant Network® facilities)	In-Network Coverage Only	In-Network Coverage Only
Durable Medical Equipment Contract Year Maximum: $1,000	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Hearing Exam Includes hearing exams, diagnosis, testing and fitting of hearing aid devices One examination per 24 month period	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Hearing Aids One hearing aid necessary for each hearing impaired ear up to $1,000 per hearing aid every 3 years	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Insulin Pumps Contract Year Maximum: Unlimited	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Blood Glucose Meters Contract Year Maximum: Unlimited	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Diabetic Supplies	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Wigs (for hair loss due to alopecia areata) Contract Year Maximum: $500	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Nutritional Counseling Contract Year Maximum: 3 visits; the visit limit does not apply to treatment of diabetes			
Physician Office Visit	$25 per visit Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Inpatient Facility	$75 per admission Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	100%
Outpatient Facility	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Nutritional Formulas Unlimited	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Genetic Counseling Contract Year Maximum: 3 visits; for counseling, pre- and post-genetic testing			
Physician Office Visit	$25 per visit Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Inpatient Facility	$75 per admission Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	100%
Outpatient Facility	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an Injury to teeth.			
Physician Office Visit Contract Year Maximum: $500	$25 per visit Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Inpatient Facility	$75 per admission Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	100%
Outpatient Facility	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Acupuncture Medically Necessary treatment of pain or disease by acupuncture provided on an outpatient basis Contract Year Maximum: 10 days	$25 per visit Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%
Alternative Therapies and Non-traditional Medical Services Herbalist, Massage Therapist, Naturopath,			
Physician Office Visit Combined Contract Year Maximum: $1,000	Not Covered	Not Covered	Plan Deductible, then 100%
Routine Foot Disorders Not covered except for services associated with foot care for diabetes, peripheral neuropathies and peripheral vascular disease when Medically Necessary.			

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Mental Health			
Inpatient Includes Acute Inpatient and Residential Treatment Contract Year Maximum: $10,000 (The Inpatient maximum is combined for Mental Health and Substance Abuse.)	$75 per admission Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	$75 per admission Copay, then 100%
Outpatient Outpatient – Office Visits Includes individual, family and group psychotherapy; medication management Contract Year Maximum: $10,000	$25 per visit Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	$25 per visit Copay, then 100%
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, Transcranial Magnetic Stimulation (TMS), etc. Contract Year Maximum: $10,000 (The Outpatient maximum is combined for Mental Health and Substance Abuse.)	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Substance Use Disorder			
Inpatient Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment Contract Year Maximum: $10,000 (The Inpatient maximum is combined for Mental Health and Substance Abuse.)	$75 per admission Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	$75 per admission Copay, then 100%
Outpatient Outpatient – Office Visits Includes individual, family and group psychotherapy, medication management Contract Year Maximum: $10,000	$25 per visit Copay, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	$25 per visit Copay, then 100%
Outpatient - All Other Services Includes Outpatient Detoxification, Partial Hospitalization, Intensive Outpatient Services, etc. Contract Year Maximum: $10,000 (The Outpatient maximum is combined for Mental Health and Substance Abuse.)	Plan Deductible, then 100%	Plan Deductible, then 70% of the Maximum Reimbursable Charge	Plan Deductible, then 100%

Certification Requirements U.S. Out-of-Network

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

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

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

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

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

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

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

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

Outpatient Certification Requirements - U.S. Out of Network

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

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

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

Outpatient Diagnostic Testing, and Outpatient Procedures

Including, but not limited to:

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

Prior Authorization/Pre-Authorized U.S.

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

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

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

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

overdose reversal that are otherwise covered under the health benefit plan.

Covered Expenses

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

- preventive care services, and
- services or supplies that are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Cigna and that are not otherwise excluded from coverage by the terms of this policy, and
- as determined by Cigna, Medically Necessary Covered Expenses may also include charges for generally accepted medical standards of care and practice.

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

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

Covered Expenses

- charges for inpatient Room and Board and other Necessary Services and Supplies made by a Hospital, subject to the limits as shown in The Schedule.
- charges for licensed Ambulance service to the nearest Hospital where the needed medical care and treatment can be provided.
- charges for outpatient medical care and treatment received at a Hospital.
- charges for outpatient medical care and treatment received at a Free-Standing Surgical Facility.
- charges for inpatient Room and Board and other Necessary Services and Supplies made by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility as shown in The Schedule.
- charges for Emergency Services.
- charges for Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse for professional nursing service.
- charges made for anesthetics, including, but not limited to supplies and their administration.
- charges for diagnostic x-ray.
- charges for advanced radiological imaging, including for example CT Scans, MRI, MRA and PET scans and laboratory examinations, x-ray, radiation therapy and radium and radioactive isotope treatment and other therapeutic radiological procedures.
- charges for chemotherapy.
- charges for blood transfusions.
- charges for oxygen and other gases and their administration.
- charges made for Medically Necessary foot care for diabetes, peripheral neuropathies, and peripheral vascular disease.
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for family planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception; injected contraceptives; insertion, removal and Medically Necessary examination for the use of implanted contraceptives; and after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
- charges made for preventive care services as defined by recommendations from the following:
  - the U.S. Preventive Services Task Force (A and B recommendations);
  - the Advisory Committee on Immunization Practices (ACIP) for immunizations;
  - the American Academy of Pediatrics' Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care;
  - the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children; and
  - with respect to women, evidence-informed preventive care and screening guidelines supported by the Health Resources and Services Administration.

Detailed information is available at www.healthcare.gov. For additional information on immunizations, visit the immunization schedule section of www.cdc.gov.

- charges for developmental screenings at ages 9 months, 18 months and 30 months. Developmental screenings are any developmental screening tool favorably mentioned in the American Academy of Pediatrics Committee on Children with Disabilities paper on "Developmental Surveillance and Screening of Infants and Young Children" or any other program judged by the Department of Health and Social Services to be an equivalent program.

- charges for newborn screenings.
- charges made for or in connection with baseline lead poison screening or testing, or in connection with lead poison screening, testing, diagnostic evaluation, screening and testing supplies, and home visits for children who are at high risk for lead poisoning according to guidelines set by the Division of Public Health.
- charges for treatment of pediatric autoimmune disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome, including the use of intravenous immunoglobulin therapy is required.
- charges for hearing loss screening tests of newborns and infants provided by a Hospital before discharge.
- charges for the treatment of diabetes as recommended in writing or prescribed by a Physician or Other Health Professional, including:
  - insulin pumps, blood glucose meters and diabetes self-management training;
  - alcohol pads, swabs, wipes, Glucagon/Glucagen, injection aids, insulin pump accessories, needles including pen needles, syringes, test strips, lancets, urine glucose and ketone strips; and
  - insulin and pharmacological agents for controlling blood sugar.
- scalp hair prostheses and wigs worn due to alopecia areata.
- charges for smoking cessation treatment.
- charges for chronic care management services.
- charges made for Medically Necessary treatment of pain or disease by acupuncture provided on an outpatient basis. Acupuncture services that are not covered include but are not limited to maintenance or treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status.
- charges made for hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound and delivers speech and other sounds at levels equivalent to that of normal speech and conversation
- charges made for routine hearing exams as shown in The Schedule.
- charges made for or in connection with travel immunizations for Members and their Dependents.
- charges for treatment of autism spectrum disorder including the following care and assistive communication devices prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed Physician or a licensed Psychologist: behavioral health treatment; pharmacy care; psychiatric care; psychological care; therapeutic care; items and equipment necessary to provide, receive, or advance in the above listed services, including those necessary for applied behavioral analysis; and any care for individuals with autism spectrum disorders that is determined by the Secretary of the Department of Health and Social Services, based upon their review of best practices and/or evidence-based research, to be Medically Necessary.
- Medically Necessary orthognathic surgery to repair or correct a severe facial deformity or disfigurement.
- charges for Medically Necessary specialized treatment and support to secure access to dental care for children under age 21 with severe disabilities due to significant mental or physical condition, illness or disease.
- charges for the delivery of telehealth services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient's health care by a health care provider legally allowed to practice in the state or country and practicing within the health care provider's scope of practice as would be practiced in-person with a patient, while such patient is at an originating site and the health care provider is at a distant site.
  - **Distant site** means a site at which a health care provider legally allowed to practice in the state or country is located while providing health care services by means of telemedicine or telehealth.
  - **Originating site** means a site at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth.
  - **Store and forward transfer** means the synchronous or asynchronous transmission of a patient's medical information either to or from an originating site or to or from the provider at the distant site, but does not require the patient being present nor must it be in real time.

Cancer Screenings

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

diagnostic or screening mammography exam using a low-dose X-ray to produce an image of the breast.

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

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

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

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

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

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

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

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

  At risk for ovarian cancer means any of the following:

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

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

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

Genetic Counseling

Charges for genetic counseling for an individual who is undergoing genetic testing or is a potential candidate for

genetic testing. May be performed prior to and/or following the genetic test.

Nutritional Counseling

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

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

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

Internal Prosthetic/Medical Appliances

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

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

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

Home Health Care Services

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

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

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

Covered services include:

- Skilled nursing services provided by a Registered Nurse (RN); Licensed Practical Nurse (LPN); Licensed Vocational Nurse (LVN) and an Advanced Practice Registered Nurse o(APRN).
- Services provided by health care providers such as physical therapist; occupational therapist and speech therapist.
- Services of a home health aide when provided in direct support of those nurses and health care providers.
- Necessary consumable medical supplies and home infusion therapy administered or used by a health care provider.
- Private duty nursing services when determined to be medically necessary.

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

The following are excluded from coverage:

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

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

Hospice Care Services

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

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

- by a Hospice Facility for Room and Board and Services and Supplies;
- by a Hospice Facility for services provided on an outpatient basis;

- by a Physician for professional services;
- by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
- for pain relief treatment, including drugs, medicines and medical supplies.

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

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

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

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

- services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- services for any period when you or your Dependent is not under the care of a Physician;
- services or supplies not listed in the Hospice Care Program;
- to the extent that any other benefits are payable for those expenses under the policy;
- services or supplies that are primarily to aid you or your Dependent in daily living.

Mental Health and Substance Use Disorder Services

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

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

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

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

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

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

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

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

Mental Health Residential Treatment Center means an institution which specializes in the treatment of psychological and social disturbances that are the result of a Mental Health Disorder; provides a subacute, structured, psychotherapeutic

treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a Mental Health Residential Treatment Center.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Durable Medical Equipment

- charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by the Cigna for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable

wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, ventilators, insulin pumps and wheel chairs.

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

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

External Prosthetic Appliances and Devices

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

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

Prostheses/Prosthetic Appliances and Devices

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

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

Orthoses and Orthotic Devices

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

- Nonfoot orthoses – only the following nonfoot orthoses are covered:
  - rigid and semirigid custom fabricated orthoses,
  - semirigid prefabricated and flexible orthoses; and
  - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
  - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
  - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
  - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- non-foot orthoses primarily used for cosmetic rather than functional reasons; and
- non-foot orthoses primarily for improved athletic performance or sports participation.

Braces

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

The following braces are specifically excluded: Copes scoliosis braces.

Splints

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

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

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

Coverage for replacement is limited as follows:

- no more than once every 24 months for persons 19 years of age and older;
- no more than once every 12 months for persons 18 years of age and under;
- replacement due to a surgical alteration or revision of the impacted site.

The following are specifically excluded external prosthetic appliances and devices:

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

Outpatient Therapy Services

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

Cardiac Rehabilitation

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

Phase III and Phase IV cardiac rehabilitation are not covered. Phase III follows Phase II and is generally conducted at a recreational facility primarily to maintain the patient's status achieved through Phases I and II. Phase IV is an advancement of Phase III which includes more active participation and weight training.

Chiropractic Care Services

- Charges for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function. For these services you have direct access to qualified chiropractic Physicians.

Coverage is provided when Medically Necessary in the most medically appropriate setting to:

- Restore function (called “rehabilitative”):
  - To restore function that has been impaired or lost.
  - To reduce pain as a result of Sickness, Injury, or loss of a body part.
- Improve, adapt or attain function (sometimes called “habilitative”):
  - To improve, adapt or attain function that has been impaired or was never achieved as a result of congenital abnormality (birth defect).
  - To improve, adapt or attain function that has been impaired or was never achieved because of mental health and substance use disorder conditions. Includes conditions such as autism and intellectual disability, or mental health and substance use disorder conditions that result in a developmental delay.

Coverage is provided as part of a program of treatment when the following criteria are met:

- The individual’s condition has the potential to improve or is improving in response to therapy, and maximum improvement is yet to be attained.
- There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.
- The therapy is provided by, or under the direct supervision of, a licensed health care professional acting within the scope of the license.
- The therapy is Medically Necessary and medically appropriate for the diagnosed condition.

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

Therapy services that are not covered include:

- sensory integration therapy.
- treatment of dyslexia.

- maintenance treatment for therapy (other than physical therapy or Chiropractic Care) or preventive treatment provided to prevent recurrence or to maintain the patient's current status.
- charges for Chiropractic Care not provided in an office setting.
- vitamin therapy.

Coverage is administered according to the following:

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

Breast Reconstruction and Breast Prostheses

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

Reconstructive Surgery

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

Transplant Services and Related Specialty Care

- charges approved by medical management for human organ and tissue transplant services including solid organ and bone marrow/stem cell procedures are covered subject to the following conditions and limitations.

Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral. Implantation procedures for artificial heart, percutaneous ventricular assist device (PVAD), extracorporeal membrane oxygenation (ECMO), ventricular assist device (VAD), and intra-aortic balloon pump (IABP) are also covered.

- All transplant services and related specialty care services, other than cornea transplants, are covered at the U.S. In-Network level when received at Cigna LifeSOURCE Transplant Network® facilities.
- Transplant services and related specialty care services received at Participating Provider facilities in the United States specifically contracted with Cigna for the requested transplant services and related specialty care services are payable at the U.S. In-Network level.
- Transplant services and related specialty care services received outside the United States are covered at the International level.
- Transplant services and related specialty care services received at any other facility, including non-Participating Provider facilities and Participating Provider facilities in the United States not specifically contracted with Cigna for the requested transplant services and related specialty care services, are not covered.
- Cornea transplants received at a facility in the United States, that is specifically contracted with Cigna for this type of transplant are payable at the U.S. In-Network level.

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

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

Transplant and Related Specialty Care Travel Services In-Network coverage only

Charges made for non-taxable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations:

- Transplant and related specialty care travel benefits are not available for cornea transplants.
- Benefits for transportation and lodging are available to the recipient of a preapproved organ/tissue transplant and/or related specialty care from a designated Cigna LifeSOURCE Transplant Network® facility.
- The term recipient is defined to include a person receiving authorized transplant related services during any of the following: evaluation, candidacy transplant event, or post-transplant care.
- Travel expenses for the person receiving the transplant will include charges for: transportation to and from the designated Cigna LifeSOURCE Transplant Network® facility (including charges for a rental car used during a period of care at the designated Cigna LifeSOURCE Transplant Network® facility); and lodging while at, or traveling to and from the designated Cigna LifeSOURCE Transplant Network® facility.
- In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.
- The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income; travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits for Transplant and Related Specialty Care Services and for Transplant and Related Specialty Care Travel Services are only available when the covered person is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above. Charges for the expenses of a donor companion are not covered. No transplant and related specialty care services or travel benefits are available when the covered person is the donor for an organ/tissue transplant; the transplant recipient's plan would cover all donors costs.

Advanced Cellular Therapy

Charges for advanced cellular therapy products and services directly related to their administration are covered when Medically Necessary. Coverage includes the cost of the advanced cellular therapy product; medical, surgical, and facility services directly related to administration of the advanced cellular therapy product, and professional services.

Cigna determines which U.S. Food and Drug Administration (FDA) approved products are in the category of advanced cellular therapy, based on the nature of the treatment and how it is manufactured, distributed and administered. An example of advanced cellular therapy is chimeric antigen receptor (CAR) T-cell therapy that redirects a person's T cells to recognize and kill a specific type of cancer cell.

Advanced cellular therapy products and their administration are covered at the U. S. In-Network benefit level when prior authorized to be received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services. Advanced cellular therapy products and their administration received from a provider in the United States that is not contracted with Cigna for the specific advanced cellular therapy product and related services are not covered.

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

Advanced Cellular Therapy Travel Services

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

Benefits for transportation and lodging are available to you only when:

- you are the recipient of a prior authorized advanced cellular therapy product;
- the term recipient is defined to include a person receiving prior authorized advanced cellular therapy related services during any of the following: evaluation, candidacy, event, or post care;
- the advanced cellular therapy products and services directly related to their administration are received at a provider contracted with Cigna for the specific advanced cellular therapy product and related services; and
- the provider is not available within a 60 mile radius of your primary home residence.

Travel expenses for the person receiving the advanced cellular therapy include charges for: transportation to and from the advanced cellular therapy site (including charges for a rental car used during a period of care at the facility); and lodging while at, or traveling to and from, the site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.

The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within a 60 mile radius of your primary home residence; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

Medical Pharmaceuticals

The plan covers charges made for Medical Pharmaceuticals that are administered in an inpatient setting, outpatient setting, Physician's office, or in a covered person's home.

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

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

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

The coverage criteria for a Medical Pharmaceutical may change periodically for various reasons. For example, a Medical Pharmaceutical may be removed from the market, a new Medical Pharmaceutical in the same therapeutic class as a Medical Pharmaceutical may become available, or other market events may occur. Market events that may affect the coverage status of a Medical Pharmaceutical include, but are not limited to, an increase in the cost of a Medical Pharmaceutical.

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

Gene Therapy

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

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

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

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

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

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

Gene Therapy Travel Services

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

Benefits for transportation and lodging are available to you only when you are the recipient of a prior authorized gene therapy; and when the gene therapy products and services directly related to their administration are received at a participating In-Network facility specifically contracted with Cigna for the specific gene therapy service. The term recipient is defined to include a person receiving prior authorized gene

therapy related services during any of the following: evaluation, candidacy, event, or post care.

Travel expenses for the person receiving the gene therapy include charges for: transportation to and from the gene therapy site (including charges for a rental car used during a period of care at the facility); and lodging while at, or traveling to and from, the site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver who is at least 18 years of age.

The following are specifically excluded travel expenses: any expenses that if reimbursed would be taxable income, travel costs incurred due to travel within 60 miles of your home; food and meals; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

Clinical Trials

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

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

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

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

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

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

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

Examples of routine patient care costs and services include:

- radiological services.
- laboratory services.

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

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

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

Prescription Drug Benefits

Inside the United States

The Schedule

For You and your Dependents

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

Supplemental Discount Programs

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

Coinsurance

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

Copayments (Copay)

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

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

BENEFIT HIGHLIGHTS	NETWORK PHARMACY United States	NON-NETWORK PHARMACY United States
Maintenance Drug Products Maintenance Drug Products may be filled in an amount up to a consecutive 90 day supply per Prescription Order or Refill at a retail Network Pharmacy or home delivery Network Pharmacy.		
Immunizations and Contraceptives Note: Certain Immunizations and Contraceptives are payable at 100% when purchased from a Network US Pharmacy. Note: Oral Contraceptives 100% INUS. Policy Year Combined $3,000 INUS Maximum for Retail and Home Delivery.		
Prescription Drug Products at Retail Pharmacies	**The amount you pay for up to a consecutive 30-day supply at a Network Pharmacy**	**The amount you pay for up to a consecutive 30-day supply at a non-Network Pharmacy**
Tier 1 Generic Drugs on the Prescription Drug List	No charge after $10 Copay	50% after plan Deductible
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after $25 Copay	50% after plan Deductible
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after $50 Copay	50% after plan Deductible
Prescription Drug Products at Retail Pharmacies	**The amount you pay for up to a consecutive 90-day supply at a Network Pharmacy**	**The amount you pay for up to a consecutive 90-day supply at a non-Network Pharmacy**
Specialty Prescription Drug Products are limited to up to a consecutive 30-day supply per Prescription Order or Refill.		
Tier 1 Generic Drugs on the Prescription Drug List	No charge after $30 Copay	50% after plan Deductible
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after $75 Copay	50% after plan Deductible
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after $150 Copay	50% after plan Deductible

BENEFIT HIGHLIGHTS	NETWORK PHARMACY United States	NON-NETWORK PHARMACY United States
Prescription Drug Products at Home Delivery Pharmacies	**The amount you pay for up to a consecutive 90-day supply at a Network Pharmacy**	**The amount you pay for up to a consecutive 90-day supply at a non-Network Pharmacy**
Specialty Prescription Drug Products are limited to up to a consecutive 30-day supply per Prescription Order or Refill and are subject to the same Copayment or Coinsurance that applies to retail Network Pharmacies.		
Tier 1 Generic Drugs on the Prescription Drug List	No charge after $30 Copay	In-network coverage only
Tier 2 Brand Drugs designated as preferred on the Prescription Drug List	No charge after $75 Copay	In-network coverage only
Tier 3 Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after $150 Copay	In-network coverage only

Prescription Drug Benefits - U.S.

Covered Expenses

Your plan provides benefits for Prescription Drug Products on the Prescription Drug List that are dispensed by a Pharmacy. Details regarding your plan's Covered Expenses, which for the purposes of the Prescription Drug Benefit include Medically Necessary Prescription Drug Products ordered by a Physician, Limitations and Exclusions are provided below and are shown in The Schedule.

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

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

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

Prescription Drug List Management

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

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

Limitations

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

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

Prior Authorization Requirements

Coverage for certain Prescription Drug Products prescribed to you requires your Physician to obtain prior authorization from Cigna or its Review Organization. The reason for obtaining prior authorization from Cigna is to determine whether the Prescription Drug Product is Medically Necessary in accordance with Cigna's coverage criteria. It is not necessary to obtain prior authorization in an emergency situation for a 72 hour supply of a non-controlled substance. Coverage criteria for a Prescription Drug Product may vary based on the clinical use for which the Prescription Order or Refill is submitted, and may change periodically based on changes in, without limitation, clinical guidelines or practice standards, or market factors.

If Cigna or its Review Organization reviews the documentation provided and determines that the Prescription Drug Product is not Medically Necessary or otherwise excluded, your plan will not cover the Prescription Drug Product. Cigna, or its Review Organization, will not review claims for excluded Prescription Drug Products or other services to determine if they are Medically Necessary, unless required by law.

When Prescription Drug Products that require prior authorization are dispensed at a Pharmacy, you or your prescribing Physician are responsible for obtaining prior authorization from Cigna. If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed by the Pharmacy, you can ask us to consider reimbursement after you pay for and receive the Prescription Drug Product. You will need to pay for the Prescription Drug Product at the Pharmacy prior to submitting a reimbursement request.

When you submit a claim on this basis, you will need to submit a paper claim using the form that appears on the website shown on your ID card.

If a prior authorization request is approved, your Physician will receive confirmation. The authorization will be processed in the claim system to allow you to have coverage for the Prescription Drug Product. If a prescriber indicates on the prior authorization form that the prescription medication is for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient, a reauthorization for the same prescription medication will not be required more frequently than every 12 months. The authorization will at all times be subject to the plan’s terms of coverage for the Prescription Drug Product, which may change from time to time. When your Physician advises you that coverage for the Prescription Drug Product has been approved, you can contact a Pharmacy to fill the covered Prescription Order or Refill.

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

Emergency Supplies of Prescription Drug Products

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

Contraceptives

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

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

Step Therapy

Certain Prescription Drug Products are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products you are required to try a different Prescription Drug Product(s) first unless you satisfy the plan's exception criteria. You may identify whether a particular Prescription Drug Product is subject to step therapy requirements at the website shown on your ID card or by calling member services at the telephone number on your ID card.

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

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

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

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

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in The Schedule. For a single Prescription Order or Refill, you may receive a Prescription Drug Product up to the stated supply limit.

Some products are subject to additional supply limits, quantity limits or dosage limits based on coverage criteria that have been approved based on consideration of the P&T Committee's clinical findings. Coverage criteria are subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a dispensing supply limit or similar limit or requirement at the website shown on your ID card or by calling member services at the telephone number on your ID card.

Specialty Prescription Drug Products

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

Designated Pharmacies

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

New Prescription Drug Products

New Prescription Drug Products may or may not be placed on a Prescription Drug List tier upon market entry. Cigna will use reasonable efforts to make a tier placement decision for a New Prescription Drug Product within six months of its market availability. Cigna's tier placement decision shall be based on consideration of, without limitation, the P&T Committee's clinical review of the New Prescription Drug Product and economic factors. If a New Prescription Drug Product not listed on the Prescription Drug List is approved by Cigna or its Review Organization as Medically Necessary in the interim, the New Prescription Drug Product shall be covered at the applicable coverage tier as set forth in The Schedule.

Your Payments

Covered Prescription Drug Products purchased at a Pharmacy are subject to any applicable Deductible, Copayments or Coinsurance shown in The Schedule, as well as any limitations or exclusions set forth in this plan. Please refer to The Schedule for any required Copayments, Coinsurance, Deductibles or Out-of-Pocket Maximums.

Deductible

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

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

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

Copayment

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

- the Copayment for the Prescription Drug Product set forth in The Schedule; or
- the Prescription Drug Charge; or
- the Network Pharmacy's submitted Usual and Customary (U&C) Charge, if any.

Coinsurance

Your plan requires that you pay a Coinsurance amount for covered Prescription Drug Products as set forth in The Schedule, if any. After satisfying any applicable annual Deductible set forth in The Schedule, your costs under the plan for a covered Prescription Drug Product dispensed by a

Network Pharmacy and that is subject to a Coinsurance requirement will be the lowest of the following amounts:

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

Payments at Non-Network Pharmacies

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

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

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

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

Exclusions

Coverage exclusions listed under the "Exclusions, Expenses Not Covered and General Limitations" section also apply to benefits for Prescription Drug Products. In addition, the exclusions listed below apply to benefits for Prescription Drug Products. When an exclusion or limitation applies to only certain Prescription Drug Products, you can access the Prescription Drug List through the website shown on your ID card or call member services at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

- coverage for Prescription Drug Products for the amount dispensed (days' supply) which exceeds the applicable supply limit, or is less than any applicable supply minimum set forth in The Schedule, or which exceeds quantity limit(s) or dosage limit(s) set by the P&T Committee.
- more than one Prescription Order or Refill for a given prescription supply period for the same Prescription Drug Product prescribed by one or more Physicians and dispensed by one or more Pharmacies.
- Prescription Drug Products which are prescribed, dispensed or intended to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home, rehabilitation facility, or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceutical products.
- Prescription Drug Products furnished by the local, state or federal government (except for a Network Pharmacy owned or operated by a local, state or federal government).
- any product dispensed for the purpose of appetite suppression (anorectics) or weight loss.
- Prescription and non-prescription supplies other than supplies covered as Prescription Drug Products.
- vitamins, except prenatal vitamins that require a Prescription Order or Refill, unless coverage for such product(s) is required by federal or state law.
- medications used for cosmetic or anti-aging purposes, including, without limitation, medications used to reduce wrinkles, medications used to promote hair growth, and fade cream products.
- Prescription Drug Products used for the treatment of infertility.
- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
- Medical Pharmaceuticals covered solely under the plan's medical benefits.
- any ingredient(s) in a compounded Prescription Drug Product that has not been approved by the U.S. Food and Drug Administration (FDA).
- medications available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless state or federal law requires coverage of such medications or the over-the-counter medication has been designated as eligible for coverage as if it were a Prescription Drug Product.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to an over-the-counter drug(s), or are available in over-the-counter form. Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
- any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of

disease, even when used for the treatment of Sickness or Injury, unless coverage for such product(s) is required by federal or state law.

- medications used for travel prophylaxis unless specifically identified on the Prescription Drug List.
- immunization agents, virus detection testing, virus antibody testing, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions unless specifically identified on the Prescription Drug List.
- certain Prescription Drug Products that are a Therapeutic Equivalent or Therapeutic Alternative to another covered Prescription Drug Product(s). Such coverage determinations may be made periodically, and benefits for a Prescription Drug Product that was previously excluded under this provision may be reinstated at any time.
- medications that are not FDA-approved for any indication.
- Prescription Drug Products classified as gene therapy.

Reimbursement/Filing a Claim

When you or your Dependents purchase your Prescription Drug Products through a Network Pharmacy, you pay any applicable Copayment, Coinsurance, or Deductible shown in The Schedule at the time of purchase. You do not need to file a claim form for a Prescription Drug Product obtained at a Network Pharmacy unless you pay the full cost of a Prescription Drug Product at a Network Pharmacy and later seek reimbursement for the Prescription Drug Product under the plan or wish to dispute the amount you were charged. For example, if you must pay the full cost of a Prescription Drug Product to the retail Network Pharmacy because you did not have your ID card, then you must submit a claim to Cigna for any reimbursement or benefit you believe is due to you under this plan. If, under this example, your payment to the retail Network Pharmacy for the covered Prescription Drug Product exceeds any applicable copay, then you will be reimbursed the difference, if any, between the applicable copay and the Prescription Drug Charge for the Prescription Drug Product. If you believe that the amount of any applicable Copayment, Coinsurance and/or Deductible you were charged was incorrect, to dispute the accuracy of the amount you were charged you must submit a claim for reimbursement according to the applicable claim filing procedures for postservice claims.

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

Prescription Drug Benefits

International

Outside the United States

The Schedule

For You and your Dependents

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

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

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

BENEFIT HIGHLIGHTS	INTERNATIONAL PHARMACY Outside the United States
Lifetime Maximum	Refer to the Medical Benefits Schedule
Contract Year Deductible	
Individual	Refer to the Medical Benefits Schedule
Family	Refer to the Medical Benefits Schedule
Contract Year Out-of-Pocket Maximum	
Individual	Refer to the Medical Benefits Schedule
Family	Refer to the Medical Benefits Schedule
Prescription Drug Products at Pharmacies Outside the United States	**The amount you are required to pay** No charge after plan Deductible

Prescription Drug Benefits - International

Covered Expenses

Your plan provides benefits for Prescription Drug Products dispensed by a Pharmacy outside the United States. Details regarding your plan's Covered Expenses, which for the purposes of the Prescription Drug Benefit include Medically Necessary Prescription Drug Products ordered by a Physician, Limitations, and Exclusions are provided below and/or are shown in The Schedule.

If you or any one of your Dependents, while insured for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy outside the United States for Medically Necessary Prescription Drug Products ordered by a Physician, your plan provides coverage for those expenses as shown in The Schedule.

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

Emergency Supplies of Prescription Drug Products

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

Contraceptives

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

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

Your Payments

Covered Prescription Drug Products purchased at a Pharmacy are subject to any applicable Deductible, Copayments or Coinsurance shown in The Schedule, as well as any limitations or exclusions set forth in this plan. Please refer to The Schedule for any required Copayments, Coinsurance, Deductibles or Out-of-Pocket Maximums.

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

Exclusions

Coverage exclusions listed under the "Exclusions, Expenses Not Covered and General Limitations" section also apply to benefits for Prescription Drug Products. In addition, the exclusions listed below apply to benefits for Prescription Drug Products purchased outside the United States:

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

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

Reimbursement/Filing a Claim

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

Vision Benefits

The Schedule

For You and Your Dependents

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

Coinsurance

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

BENEFIT HIGHLIGHTS	UNITED STATES	INTERNATIONAL Outside the United States
Contract Year Deductible		
Individual	$0	$0
Family	$0	$0
Contract Year Out-of-Pocket Maximum		
Individual	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Family Maximum	Refer to the Medical Benefits Schedule	Refer to the Medical Benefits Schedule
Examinations	**This Plan Will Pay:**	**This Plan Will Pay:**
Once every 12 consecutive months	100%	100%
Lenses and Frames or Contact Lenses	Not Covered	Not Covered

Vision Benefits

For You and Your Dependents

Covered Expenses

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

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

Expenses Not Covered

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

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

Cigna Dental Preferred Provider Benefits

The Schedule

For You and Your Dependents

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

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

Deductibles

Deductibles are expenses to be paid by you or your Dependent. Deductibles are in addition to any Coinsurance. Once the Deductible maximum in The Schedule has been reached you and your family need not satisfy any further dental deductible for the rest of that plan year.

Participating Provider Payment

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

Non-Participating Provider Payment

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

Simultaneous Accumulation of Amounts

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

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

BENEFIT HIGHLIGHTS	IN-NETWORK United States	OUT-OF-NETWORK United States	INTERNATIONAL Outside the United States
Classes I, II Combined Contract Year Maximum	$750		
Classes II Contract Year Deductible			
Individual	$0 per person		
Family	$0 per family		
Class I			
Preventive Care	100%	100%	100%
Class II			
Basic Restorative	80%	80%	80%

Dental Benefits

Covered Dental Expense

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

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

Teledentistry

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

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

Alternate Benefit Provision

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

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

Predetermination of Benefits

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

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

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

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

Covered Services

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

Participating and Non-Participating Provider

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

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

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

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

Class I Services – Diagnostic and Preventive

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

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

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

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

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

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

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

Space Maintainers, fixed unilateral – Limited to nonorthodontic treatment.

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

Amalgam Filling.

Composite/Resin Filling.

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

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

Periodontal Scaling and Root Planing – Entire Mouth.

Adjustments – Complete Denture

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

Recement Bridge.

Routine Extractions.

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

Removal of Impacted Tooth, Soft Tissue

Removal of Impacted Tooth, Partially Bony

Removal of Impacted Tooth, Completely Bony.

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

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

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

Dental Expenses Not Covered

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

- services performed solely for cosmetic reasons;
- replacement of a lost or stolen appliance;
- replacement of a bridge, crown or denture.
- procedures, appliances or restorations whose main purpose is to: change vertical dimension; diagnose or treat conditions or dysfunction of the temporomandibular joint; stabilize periodontally involved teeth; or restore occlusion;
- porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second and third molars;
- bite registrations; precision or semiprecision attachments; or splinting;
- instruction for plaque control, oral hygiene and diet;
- dental services that do not meet common dental standards;
- services that are deemed to be medical services;
- services and supplies received from a Hospital;
- orthodontic treatment;
- the surgical placement of an implant body or framework of any type; surgical procedures in anticipation of implant placement; any device, index, or surgical template guide used for implant surgery; treatment or repair of an existing implant; prefabricated or custom implant abutments; removal of an existing implant;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society;
- services for which benefits are not payable according to the "General Limitations" section.

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

Additional coverage limitations determined by plan or provider type are shown in The Schedule. Payment for the following is specifically excluded from this plan:

- care for health conditions that are required by state or local law to be treated in a public facility.
- care required by state or federal law to be supplied by a public school system or school district.
- care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Injury or Sickness caused by war, or an act of war, whether declared or undeclared, riot, civil commotion or police action which occurs in the Member's Country of Citizenship.
- Injury or Sickness that results, directly or indirectly from: nuclear fission, fusion or radioactivity; nuclear, biological and chemical weapons and/or devices; or attacks on, or sabotage of, facilities and storage depots, which lead to the release of radioactivity or nuclear, biological or chemical warfare agents which occurs in the Member's Country of Citizenship.
- charges which you are not obligated to pay and/or for which you are not billed or for which you would not have been billed. This exclusion includes, but is not limited to:
  - any instance where Cigna determines that a provider or pharmacy did not bill you for, or has waived, reduced, or forgiven any portion of its charges and/or any portion of any Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for an otherwise Covered Expense (as shown on The Schedule) without Cigna's express consent.
  - charges of a non-Participating Provider who has agreed to charge you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.

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

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

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician relies on the coverage policies maintained by Cigna or the Review Organization. Coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.

  The plan or policy shall not deny coverage for a drug therapy or device as experimental, investigational and unproven if the drug therapy or device is otherwise approved by the FDA to be lawfully marketed and is recognized for treatment of the prescribed indication in a prescription drug reference compendium approved by the Insurance Commissioner or substantially accepted peer reviewed medical literature and is considered under the Centers for Medicare and Medicaid’s National Coverage Determination List.

- charges for health care services, supplies, or medications when billed for conditions or diagnoses that are not covered or reimbursable under the coverage policies maintained by Cigna or the Review Organization.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- the following services are excluded from coverage regardless of clinical indications except as may be covered under the “Reconstructive Surgery” benefits: macromastia surgery; gynecomastia surgery; abdominoplasty; panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ) disorders.
- for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations, unless otherwise covered under this plan.
- court-ordered treatment or hospitalization, unless treatment is prescribed by a Physician and is a covered service or supply under this plan.
- infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- reversal of male and female voluntary sterilization procedures.
- any services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- medical and Hospital care and costs for the child of your Dependent child, unless the child is otherwise eligible under this plan.
- non-medical counseling and/or ancillary services including, but not limited to, Custodial Services, educational services, vocational counseling, training and rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs, and driver safety courses.
- non-medical living arrangements, including but not limited to, health resorts, recreational programs, outdoor skills programs, relaxation or lifestyle programs, or supportive living programs.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Care Services" or “Breast Reconstruction and Breast Prostheses” sections of this plan.
- private Hospital rooms and/or private duty nursing except as provided under the Home Health Care Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs, except as covered under this plan as shown in the Covered Expenses section.
- aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books, except as shown in the Covered Expenses section for treatment of autism.
- corrective lenses, eyeglass lenses and frames, contact lenses and associated services (exams and fitting), except the initial prescribed set or pair after treatment of keratoconus or following cataract surgery.
- eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.

- all non-injectable prescription drugs, unless Physician administration or oversight is required, injectable prescription drugs to the extent they do not require Physician supervision and are typically considered self-administered drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses and toenail maintenance. However, foot care services for diabetes, peripheral neuropathies and peripheral vascular disease are covered when Medically Necessary.
- membership costs and fees associated with health clubs and weight loss programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection, storage or donation of blood or blood products, except for autologous donation in anticipation of scheduled services when medical management review determines the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- health and beauty aids, cosmetics and dietary supplements.
- enteral feedings, supplies and specially formulated medical foods, whether prescribed or not, except as specifically provided in the "Enteral Nutrition" benefit.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- charges related to an Injury or Sickness payable under worker's compensation or similar laws.
- the cost of treatment or services that are provided without charge by a Student Health Center or rendered by a person employed by the Participating Sponsor/Group, including, but not limited to team doctors and trainers, or other services performed at no cost.

General Limitations

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

- to the extent that payment is unlawful or prohibited by applicable sanctions rules.
- for elective or pre-scheduled treatment in sanctioned countries.
- for any person whom Cigna considers to be "ordinarily resident" in a sanctioned country. A person is considered "ordinarily resident" if she/he visits a sanctioned country for a period of longer than 6 weeks over the course of any 12 month period.
- for charges made for any service that is not covered by the terms of this policy or for coverage declined, or otherwise not elected by you, at enrollment.
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- any charges related to care provided through a public program.
- to the extent that payment is prohibited by applicable law including but not limited to sanctions rules imposed by the United Nations, the European Commission, the United States, and Canada.
- for charges which would not have been made if the person did not have coverage.
- to the extent that they are more than Maximum Reimbursable Charges.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.
- for expenses for services, supplies, care, treatment, drugs, or surgery that are not Medically Necessary.
- for charges made by any Physician or Other Health Professional who is a member of your family or your Dependent's Family.
- for claim payments that are illegal under applicable law.

Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan. For claims incurred within the United States, you should file all claims under each Plan. For claims incurred outside the United States, if you file claims with more than one Plan, you must indicate at the time of filing a claim under this Plan, that you also have or will be filing your claim under another Plan.

Definitions

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

Plan

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

- Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- Coverage under any government health insurance plan.
- Medical benefits coverage of group, group-type, and individual automobile contracts.

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

Closed Panel Plan

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

Primary Plan

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

Secondary Plan

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

Allowable Expense

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.

Reasonable Cash Value

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

Order of Benefit Determination Rules

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

- The Plan that covers you as an enrollee or a member shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or member;
- If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - then, the Plan of the parent with custody of the child;
  - then, the Plan of the spouse of the parent with custody of the child;
  - then, the Plan of the parent not having custody of the child, and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active member (or as that member’s Dependent) shall be the Primary Plan and the Plan that covers you as laid-off or retired member (or as that member's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result,

the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

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

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 are not more than 100% of the total of all Allowable Expenses.

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.

Domestic Partners

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

Expenses for Which a Third Party May be Responsible

This plan does not cover:

- Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
- Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), occupational disease law, any employers's liability insurance or similar type of insurance or coverage. The coverage under this plan is secondary to any automobile no-fault or similar coverage.

Subrogation/Right of Reimbursement

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

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

Lien of the Plan

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- The plan hereby disavows all equitable defenses in pursuit of its right of recovery. The plan's subrogation or recovery rights are neither affected nor diminished by equitable defenses.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.
- Participants must assist the plan in pursuing any subrogation or recovery rights by providing requested information.

Payment of Benefits

Medical, Dental and Vision

Assignment and Payment of Benefits

You may authorize Cigna to pay any healthcare benefits under this policy to a Participating or non-Participating Provider. When you authorize the payment of your healthcare benefits to a Participating or non-Participating Provider, you authorize the payment of the entire amount of the benefits due on that claim. If a provider is overpaid because of accepting duplicate payments from you and Cigna, it is the provider's responsibility to reimburse the overpayment to you. Cigna may pay all healthcare benefits for Covered Expenses directly to a Participating Provider without your authorization. You may not interpret or rely upon this discrete authorization or permission to pay any healthcare benefits to a Participating or non-Participating Provider as the authority to assign any other rights under this policy to any party, including, but not limited to, a provider of healthcare services/items.

Even if the payment of healthcare benefits to a non-Participating Provider has been authorized by you, Cigna may, at its option, make payment of benefits to you. When benefits are paid to you or your Dependents, you or your Dependents are responsible for reimbursing the non-Participating Provider.

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due him, such payment will be made to his legal

guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

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

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

Recovery of Overpayment

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

Calculation of Covered Expenses

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

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

Termination of Insurance – Members

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Members or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the date your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence

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

Injury or Sickness

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

Retirement

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

Termination of Insurance - Dependents

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

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

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

The Group may require you to pay the entire cost of the premium for you, if covered, during the continuation period.

Medical Benefits Extension During Hospital Confinement Upon Policy Cancellation

If the Medical Benefits under this plan cease for you or your Dependent due to cancellation of the policy (except if policy is canceled for nonpayment of premiums, and you or your Dependent is Confined in a Hospital on that date), Medical Benefits will be paid for Covered Expenses incurred in connection with that Hospital Confinement. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in The Schedule;
- the date a succeeding carrier agrees to provide coverage without limitation for the Hospital Confinement;
- the date you or your Dependent is no longer Hospital Confined; or
- 10 days from the date the policy is canceled.

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

Dental Benefits Extension

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

- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

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

When You Have an Appeal or Complaint

If you have questions, disagree with the determination of a claim, or have a complaint, you may contact Cigna at the address indicated below. A written request for a claim review must be sent in writing within 365 days of receipt of a denial notice to:

Cigna

Attn: Appeals & Complaints

P.O. Box 15800

Wilmington, DE 19850 USA

For a claim review, you should state the reason(s) why you feel your claim should have been approved. Send a copy of the denial along with any relevant additional information (e.g. benefit documents, clinical records) which helps to demonstrate that your claim is covered under the plan. For questions, please contact the **Cigna Service Center at 1-800-441-2668 (inside the United States and Canada) or 302-797-3100 (outside the United States, call collect).**

It is important to include your Name, Group Number, Member/Patient ID Number, Name of the patient and relationship, and "Attention: Appeals" on all supporting documents.

You are entitled to receive free upon request access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

You will be notified of the final decision in a timely manner, as described in your plan materials.

If you are still not satisfied with our final decision to your complaint or appeal, you can refer your complaint or appeal to the Channel Islands Financial Ombudsman Service at the address below:

The Channel Islands Financial Ombudsman (CIFO)

PO Box 114

Jersey, Channel Islands

JE4 9QG

Telephone: +44 (0)1534 748610

Fax: +44 (0)1534 747629

Email: enquiries@ci-fo.org

Website www.ci-fo.org

Definitions

Active Service/Enrollment

You will be considered in Active Service/Enrollment:

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

Ambulance

Licensed ambulance transportation services involve the use of specially designed and equipped vehicles for transporting ill or injured patients. It includes ground, air, or sea transportation when Medically Necessary and clinically appropriate.

Ancillary Charge

An additional cost, outside of plan cost sharing detailed in The Schedule of Prescription Drug Benefits, which may apply to some Prescription Drug Products when you request a more expensive Brand Drug when a lower cost, Therapeutic Equivalent, Generic Drug is available. The Ancillary Charge is the amount by which the cost of the requested Brand Drug exceeds the cost of the Generic Drug.

Biologic

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

Biosimilar

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

Brand Drug

A Prescription Drug Product that Cigna identifies as a Brand Drug product across its book-of-business, principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or Biologics as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, Pharmacy, or your Physician may be classified as a Brand Drug under the plan.

Business Decision Team

A committee comprised of voting and non-voting representatives across various Cigna business units such as clinical, medical and business leadership that is duly authorized by Cigna to effect changes regarding coverage treatment of Prescription Drug Products and Medical Pharmaceuticals based on clinical findings provided by the P&T Committee, including, but not limited to, changes regarding tier placement and application of utilization management to Prescription Drug Products and Medical Pharmaceuticals.

Charges

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

Chiropodist

See Podiatrist

Cigna LifeSOURCE Transplant Network®

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

Network®, the facility must be a designated program for the specific type of transplant requested.

Contracted Fee - Dental

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

Country of Citizenship

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

Custodial Services

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

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

Dentally Necessary

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

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

A diagnosis, treatment and service with respect to a dental condition or disease, is not Dentally Necessary if made, prescribed or delivered solely for convenience of the patient or provider.

Dentist

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

Dependent

Dependents are:

- your lawful spouse; or
- your Domestic Partner; and
- any child of yours who is:
  - less than 26 years old.
  - 26 or more years old, unmarried and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability, or intellectual disabilities or a physical handicap which arose while the child was covered as a Dependent under this Plan, or while covered as a dependent under a prior plan with no break in coverage.

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

The term child means a child born to you or a child legally adopted by you. It also includes a stepchild.

If your Domestic Partner has a child, that child will also be included as a Dependent.

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

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

Domestic Partner

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

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

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

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

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

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

Designated Pharmacy

A Network Pharmacy that has entered into an agreement with Cigna, or with an entity contracting on Cigna's behalf, to provide Prescription Drug Products or services, including, without limitation, specific Prescription Drug Products, to plan enrollees on a preferred basis. For example, a Designated Pharmacy may provide enrollees certain Specialty Prescription Drug Products that have limited distribution availability, provide enrollees with an extended days' supply of Prescription Drug Products or provide enrollees with Prescription Drug Products on a preferred cost share basis. A Pharmacy that is a Network Pharmacy is not necessarily a Designated Pharmacy.

Emergency Services

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

Expense Incurred

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

Free-Standing Surgical Facility

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

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

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

Generic Drug

A Prescription Drug Product that Cigna identifies as a Generic Drug product at a book-of-business level principally based on available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source, that classify drugs or Biologics (including Biosimilars) as either brand or generic based on a number of factors. Not

all products identified as a "generic" by the manufacturer, Pharmacy or your Physician may be classified as a Generic Drug under the plan. A Biosimilar may be classified as a Generic Drug for the purposes of benefits under the plan even if it is identified as a “brand name” drug by the manufacturer, Pharmacy or your Physician.

Group

The term Group means an eligible organization or plan sponsor.

Herbalist

The term Herbalist means a non-medical practitioner who specializes in treating disorders with natural remedies derived exclusively from plant materials.

Home Country

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

Hospice Care Program

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

Hospice Care Services

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

Hospice Facility

The term Hospice Facility means an institution or part of it which:

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

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: maintains, on the premises, all facilities necessary for medical and surgical treatment; provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, or is appropriately accredited where located as determined by Cigna; or
- an institution which: specializes in treatment of Mental Health and Substance Use Disorder or other related illness; provides residential treatment programs; and is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital does not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

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

Injury

The term Injury means an accidental bodily injury.

Maintenance Drug Product

A Prescription Drug Product that is prescribed for use over an extended period of time for the treatment of chronic or long-term conditions such as asthma, hypertension, diabetes and heart disease, and is identified principally based on consideration of available data resources, including, but not limited to, First DataBank or another nationally recognized drug indicator source and clinical factors. For the purposes of benefits, the list of your plan’s Maintenance Drug Products does not include compounded medications, Specialty Prescription Drug Products or Prescription Drug Products, such as certain narcotics that a Pharmacy cannot dispense above certain supply limits per Prescription Drug Order or

Refill under applicable federal or state law. You may determine whether a drug is a Maintenance Drug Product by calling member services at the telephone number on your ID card.

Massage Therapist

The term Massage Therapist means a person who is licensed to apply manipulation, methodical pressure, friction and kneading to the body.

Maximum Reimbursable Charge - Medical

Services in the United States

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

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

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

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

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

The Maximum Reimbursable Charge is subject to all other benefit limitations and exclusions and Cigna's applicable Coverage Policies, Reimbursement Policies, and other coding and payment methodologies. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.

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

Maximum Reimbursable Charge (MRC) – Dental and Vision

Services in the United States

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

- the provider's normal charge for a similar service or supply; or
- the percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna.

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

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

Maximum Reimbursable Charge – Medical, Dental, Vision and Pharmacy

Services Outside the United States

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

- the charges contracted or otherwise agreed between the provider and Cigna; or

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

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

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

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

Cigna is not obligated to pay excessive charges.

Medicaid – U.S.

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

Medical Pharmaceutical

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

Medically Necessary/Medical Necessity

Health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, condition, disease or its symptoms, that are all of the following as determined by a Medical Director or Review Organization:

- required to diagnose or treat an illness, Injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or Other Health Professional;
- not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your Sickness, Injury, condition, disease or its symptoms; and
- rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting.

In determining whether health care services, supplies, or medications are Medically Necessary, the Medical Director or Review Organization may rely on, the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia, peer-reviewed, evidence-based scientific literature or guidelines and generally accepted medical standards of care and practice.

Medicare - U.S.

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

Member

The term means faculty, chaperone, fellows, volunteer, and student of a school who is in study abroad program, who is currently enrolled and for whom premiums have been paid of the Group outside their country of residence.

Naturopath

The term Naturopath means a non-medical practitioner who specializes in treating conditions by making reforms to the diet and lifestyle of the patient.

Necessary Services and Supplies

The term Necessary Services and Supplies includes any charges, except charges for Room and Board, made by a Hospital for medical services and supplies actually used during Hospital Confinement.

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

Network Pharmacy

A retail or home delivery Pharmacy that has:

- entered into an agreement with Cigna or an entity contracting on Cigna's behalf to provide Prescription Drug Products to plan enrollees.
- agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- been designated as a Network Pharmacy for the purposes of coverage under the Group's plan.

This term may also include, as applicable, an entity that has directly or indirectly contracted with Cigna to arrange for the provision of any Prescription Drug Products the charges for which are Covered Expenses.

New Prescription Drug Product

A Prescription Drug Product, or new use or dosage form of a previously FDA-approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or newly-approved use or dosage form becomes available on the market following approval by the U.S. Food and Drug Administration (FDA) and ending on the date Cigna makes a Prescription Drug List coverage status decision.

Nurse

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

Ophthalmologist

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

Optometrist

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

Other Health Care Facility

The term Other Health Care Facility means a facility other than a Hospital or Hospice Facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities.

Other Health Professional

The term Other Health Professional means an individual other than a Physician who is appropriately licensed and/or certified by the appropriate authorizing agency to deliver Medically Necessary services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses. Other Health Professionals do not include providers such as Certified First Assistants, Certified Operating Room Technicians, Certified Surgical Assistants/Technicians, Licensed Certified Surgical Assistants/Technicians, Licensed Surgical Assistants, Orthopedic Physician Assistants and Surgical First Assistants.

Participating Provider – Dental

The term Participating Provider means a Dentist, or a professional corporation, professional association, partnership, or other entity which is entered into a contract with Cigna to provide dental services in the U.S. at predetermined fees. The providers qualifying as Participating Providers may change from time to time. A list of the current Participating Providers will be provided by the Group. Services received from Participating Providers are considered In-Network.

Participating Provider - Medical

The term Participating Provider means a person or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services and/or supplies in the U.S., the charges for which are Covered Expenses. It includes an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies, the charges for which are Covered Expenses. Covered services and/or supplies received from Participating Providers are considered In-Network.

Participating School

The term Participating School means a Higher Education participating in the Trust to which this policy is issued.

Pharmacy

A duly licensed Pharmacy that dispenses Prescription Drug Products in a retail setting or via home delivery. A home delivery Pharmacy is a Pharmacy that primarily provides Prescription Drug Products through mail order.

Pharmacy & Therapeutics (P&T) Committee

A committee comprised of physicians and an independent pharmacist that represent a range of clinical specialties. The committee regularly reviews Medical Pharmaceuticals or Prescription Drug Products, including New Prescription Drug Products, for safety and efficacy, the findings of which clinical reviews inform coverage determinations made by the Business Decision Team. The P&T Committee's review may be based on consideration of, without limitation, U.S. Food and Drug Administration-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.

Physician

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

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

Podiatrist

The term Podiatrist means a licensed practitioner responsible for the examination, diagnosis, prevention, treatment and care of conditions and functions of the human foot. A Podiatrist performs surgical procedures, prescribes corrective devices, drugs and physical therapy.

Prescription Drug Charge

The Prescription Drug Charge is the amount that, prior to application of the plan's cost-share requirement(s), is payable by Cigna to its Pharmacy Benefit Manager for a specific covered Prescription Drug Product dispensed at a Network Pharmacy, including any applicable dispensing fee and tax. The "Pharmacy Benefit Manager" is the business unit, affiliate, or other entity that manages the Prescription Drug Benefit for Cigna.

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

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

Prescription Drug Charge - U.S. Network Pharmacies

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

Prescription Drug List

A list that categorizes Prescription Drug Products covered under the plan's Prescription Drug Benefits into coverage tiers. This list is developed by Cigna based on clinical factors communicated by the P&T Committee and adopted by the Group as part of the plan. The list is subject to periodic review and change and is subject to the limitations and exclusions of the plan. You may determine to which tier a particular Prescription Drug Product has been assigned through the website shown on your ID card or by calling customer service at the telephone number on your ID card.

Prescription Drug Product

A drug, Biologic (including a Biosimilar), or other product that has been approved by the U.S. Food and Drug

Administration (FDA), certain products approved under the Drug Efficacy Study Implementation review, or products marketed prior to 1938 and not subject to review and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. For the purpose of benefits under the plan, this definition may also include products in the following categories if specifically identified on the Prescription Drug List:

- certain durable products and supplies that support drug therapy;
- certain diagnostic testing and screening services that support drug therapy;
- certain medication consultation and other medication administration services that support drug therapy; and
- certain digital products, applications, electronic devices, software and cloud based service solutions used to predict, detect and monitor health conditions in support of drug therapy.

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

Prescription Order or Refill

The lawful directive to dispense a Prescription Drug Product issued by a Physician whose scope of practice permits issuing such a directive.

Preventive Treatment

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

Primary Care Physician

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

Psychologist

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

Review Organization

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

Room and Board

The term Room and Board includes all charges made by a Hospital for room and meals and for all general services and activities needed for the care of registered bed patients.

Sickness – Medical

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

Skilled Nursing Facility

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

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

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

Specialty Prescription Drug Product

A Prescription Drug Product or Medical Pharmaceutical considered by Cigna to be a Specialty Prescription Drug Product based on consideration of the following factors, subject to applicable law: whether the Prescription Drug Product or Medical Pharmaceutical is prescribed and used for the treatment of a complex, chronic or rare condition; whether the Prescription Drug Product or Medical Pharmaceutical has a high acquisition cost; and, whether the Prescription Drug Product or Medical Pharmaceutical is subject to limited or

restricted distribution, requires special handling and/or requires enhanced patient education, provider coordination or clinical oversight. A Specialty Prescription Drug Product may not possess all or most of the foregoing characteristics, and the presence of any one such characteristic does not guarantee that a Prescription Drug Product or Medical Pharmaceutical will be considered a Specialty Prescription Drug Product. Specialty Prescription Drug Products may vary by plan benefit assignment based on factors such as method or site of clinical administration, or by tier assignment or utilization management requirements based on factors such as acquisition cost. You may determine whether a medication is a Specialty Prescription Drug Product through the website shown on your ID card or by calling member services at the telephone number on your ID card.

Student Health Center

The term means primary care clinics based on primary or secondary school campuses in the United States.

Terminal Illness

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

Therapeutic Alternative

A Prescription Drug Product or Medical Pharmaceutical that is of the same therapeutic or pharmacological class, and usually can be expected to have similar outcomes and adverse reaction profiles when administered in therapeutically equivalent doses as, another Prescription Drug Product, Medical Pharmaceutical or over-the-counter medication.

Therapeutic Equivalent

A Prescription Drug Product or Medical Pharmaceutical that is a pharmaceutical equivalent to another Prescription Drug Product, Medical Pharmaceutical or over-the-counter medication.

Urgent Care

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

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

The usual fee that a Pharmacy charges individuals for a Prescription Drug Product (and any services related to the dispensing thereof) without reference to reimbursement to the Pharmacy by third parties. The Usual and Customary (U&C) Charge includes a dispensing fee and any applicable sales tax.

Vision Provider

The term Vision Provider means: an optometrist, ophthalmologist, optician or a group partnership or other legally recognized aggregation of such professionals; duly licensed and in good standing with the relevant public licensing bodies to provide covered vision services within the scope of the Vision Providers' respective licenses.

CIGNA GLOBAL HEALTH BENEFIITS EUROPE DATA PROTECTON NOTICE

As a provider of quality healthcare around the world, our customers and clients expect us to carefully handle and protect the Personal Information (as defined below) they share with us.

You are receiving this Data Protection Notice either because your group has signed an agreement with us, as an insurance company, to provide you, directly or through our partners, with international health insurance cover and other additional covers and services as it may apply (referred to in this Data Protection Notice as the "Services"), or you otherwise benefit from our Services (for example, as a dependent).

In order to provide our Services to you, we will collect and use your Personal Information. This Data Protection Notice explains how and why we do this, and outlines your rights in relation to your Personal Information.

Depending on the specific terms and conditions of our insurance agreement with the group, your Personal Information may be collected by any of the following entities (including but not limited to):

- Cigna Life Insurance Company of Europe S.A.-N.V., with corporate address in Belgium at Plantin en Moretuslei 309, 2140 Antwerp, Brussels, and subject to the prudential supervision of the National Bank of Belgium and to the supervision of the Financial Services and Markets Authority in the field of consumer protection.

- Cigna Life Insurance Company of Europe S.A.-N.V., UK Branch, a foreign branch of Cigna Life Insurance Company of Europe, S.A. N.V., with corporate address at 5 Aldermanbury Square, 13th Floor, London, England, EC2V 7HR and authorized by the National Bank of Belgium and subject to limited regulation by the Financial Conduct Authority and Prudential Regulation Authority in the UK.

- Cigna Europe Insurance Company S.A.-N.V., with corporate address in Belgium at Plantin en Moretuslei 309, 2140 Antwerp, Belgium, and subject to the prudential supervision of the National Bank of Belgium and to the supervision of the Financial Services and Markets Authority in the field of consumer protection.

- Cigna Europe Insurance Company S.A.-N.V., Brussels, Zurich Branch, a foreign branch of Cigna Europe Insurance Company S.A.-N.V., with corporate address at Europaallee 41, 8004 Zurich, Switzerland, existing under the laws of Switzerland, and registered in the commercial register of Canton Zurich.

- Cigna Global Insurance Company Limited with corporate address in Guernsey at P.O. Box 155, Mill Court, La Charroterie, St Peter Port, Guernsey GY1 4ET 67, and subject to the prudential supervision of the Guernsey Financial Services Commission for the conduct of insurance business.

The company collecting your Personal Information depends on the insurance entity which provides your insurance cover and can be found in your member booklet or certificate of insurance. This company will be the data controller of the Personal Information collected to provide the Services to you.

In addition to this Data Protection Notice, some of our products and services may have their own notices (for example, the Cigna Online and Mobile Privacy Notice, which describes in more detail how your Personal Information is used in a particular context).

PERSONAL INFORMATION

"Personal Information" is the information that identifies and relates to you, or to other individuals which also benefit from our Services, such as your dependents. Your Personal Information may be provided to us by yourself or by a third party entitled to provide us with such information (e.g. your health care providers, your group, etc.).

Due to the nature of the Services you are entitled to, your Personal Information may contain sensitive data including, but not necessarily limited to, your medical condition and health status.

THE TYPES OF PERSONAL INFORMATION WE COLLECT

The Personal Information we collect includes:

> General information such as your name, address, contact details, date of birth, gender, relationship to the policyholder (where you are not the policyholder);

> Identification information such as your national identification number, passport number or driving license number;

> Information linked to the provision of the Services (for example, to review and pay your claims; to issue guarantee of payment/s when applicable);

> Information about your job including job title or any other that may be strictly required to provide the Services to you, provided that there is a connection between the access to the Services and your job or job title;

> Information relating to previous policies or claims;

> Financial information such as your bank or payment details;

> Telephone recordings and other logs of your correspondence with us; and

> Sensitive data including details of your current and past physical and/or mental health.

We collect the Personal Information outlined above from a number of different sources, including from:

> You directly, or from someone else on your behalf (such as a family member that you have formally authorized to do so);

> Healthcare providers and other medical providers, and other third parties that are required to provide the Services to you (for example loss adjusters, claims handlers, experts (including medical experts));

> Other third parties involved in the provision of the Services or linked to that provision such as a broker or another insurer, claimants, defendants;

> Your group (as it may be applicable);

> Medical reports and counsel opinions;

> Emergency assistance;

> Other companies within the Cigna corporate group as may be appropriate to provide the Services to you; and

> Insurance industry fraud prevention and detection databases and sanctions screening tools.

As we are required to collect your Personal Information as a consequence of a contractual agreement with the group failure to provide this information may prevent or delay the fulfilment of these obligations. For example, if you do not provide certain Personal Information, we will not be able to provide you with the Services.

PURPOSE AND USE OF PERSONAL INFORMATION

Your Personal Information is collected in order to provide the Services, administer your plan and, in general, conduct insurance business in line with the Services you are entitled to.

We use your Personal Information to:

> Provide insurance and assistance services including, for example, claim assessment, processing and settlement; and, where applicable, handle claim disputes;

> Communicate with you and others, including the group, as part of our Services;

> Send you important information regarding changes to our policies, other terms and conditions and other administrative information;

> Make non-automated decisions about whether to provide the Services to you;

> Provide improved quality, training and security (e.g. with respect to recorded or monitored phone calls to our contact numbers);

> Continuously improve and test the quality of our Services (for example, conducting satisfaction surveys, research and analysis related to the Services);

> Protect our business against fraud. This includes searching claims or fraud registers when dealing with insurance requests or claims in order to detect, prevent and investigate fraud;

> Manage our infrastructure and business operations, and comply with internal policies and procedures, including those relating to auditing; finance and accounting; billing and collections; IT systems; business continuity; and records, document and print management;

> Resolve complaints and handle requests;

> Comply with applicable laws and regulatory obligations, including those relating to anti-money laundering and anti-terrorism; and respond to requests from public and governmental authorities and ligation; and

> Establish and defend legal rights; protect our operations or those of any of our group companies or insurance business partners; safeguard our rights, privacy, safety or property, and/or that of our group companies, you or others; and pursue available remedies or limit our damages.

As outlined above, we may use your Personal Information for a number of different purposes that are always connected with the Services we provide. Consequently, we will rely on the following legal grounds to use your Personal Information:

> The use of your Personal Information is necessary for the performance of a contract to which you are a party;

> We have a legal or regulatory obligation to use your Personal Information. For example, we will rely on this ground to comply with anti-money laundering and anti-terrorism obligations; and

> We have a legitimate interest in using your Personal Information. We may rely on this legal ground for the purpose of providing improved quality, training and managing our infrastructure and operations. When collecting and processing your Personal Information under this ground we put in place robust safeguards to ensure that your privacy is protected and that our legitimate interests are not overridden by your interests or fundamental rights and freedoms.

Due to the nature of the Services you are entitled to, we may process sensitive data connected with the provision of such Services. In general, your consent is not required since we are permitted by applicable law to process such information as a healthcare insurance company. However we may collect your consent in specific situations where either the nature of the data to be disclosed and/or the requirements on the jurisdiction where you are on assignment or other applicable laws and regulations may require that consent.

DISCLOSURE OF YOUR PERSONAL INFORMATION

If necessary for providing you with the Services you are entitled to, or for any of the purposes described in this Data Protection Notice, we may disclose your Personal Information with other parties. Disclosing your Personal Information means that we will provide your Personal Information to and/or that your Personal Information will be accessed by:

> Cigna group companies. Access to Personal Information within Cigna is restricted to those individuals and entities who have a requirement to access the information for the purposes described in this Data Protection Notice;

> Other insurance and distribution parties, such as other insurers; reinsurers; brokers and other intermediaries and agents and appointed representatives;

> Healthcare providers and travel and medical assistance providers;

> External third-party service providers, such as IT systems, support and hosting service providers; document and records management providers; translators; and similar third-party vendors and outsourced service providers that assist us in carrying out business activities;

> External professional advisors and partners such as medical professionals, accountants, actuaries, auditors, experts, consultants, lawyers; banks and financial institutions that service our accounts; claim investigators, adjusters and others;

> Investigative firms we brief to look into claims on our behalf in relation to suspected fraud;

> Our regulators and other governmental or public authorities where necessary to comply with a legal or regulatory obligation;

> The police and other third parties or law enforcement agencies, court, regulator, government authority or other similar third parties where necessary for the prevention or detection of crime or to comply with a legal or regulatory obligation; or otherwise to protect our rights or the rights of a third party;

> Debt collection & Subrogation agencies;

> Selected third parties in connection with any sale, transfer or disposal of our business;

> Other third parties, such as emergency providers (fire, police and medical emergency services) and travel carriers;

> Your group or a company acting on your group's behalf to monitor, audit or otherwise administer the Services and fulfil contractual obligations in relation to the Services. Consequently, the Personal Information that may be shared will be the minimum necessary to perform the Services you are entitled to. Under no circumstances will Cigna provide any sensitive information (i.e. medical information related to you) to the group without asking for previous express consent from you;

> In addition to the above, we may need to share limited Personal Information with the group in case of an emergency medical evacuation or repatriation ("Emergency") to ensure that your health and safety and the best outcome for you, in case of an Emergency when outside your home country, is achieved. Please be aware that during an Emergency we will try to prevent the immediate and significant effects of illness, injury or conditions which if left untreated would result in a significant deterioration of health and represent a threat to your life. During the complexity of those situations the interaction with your group may be required to provide additional assistance to try to ensure the best possible outcome during an evacuation and/or assess whether to provide other assistance to you out-with the Cigna plan. The Personal Information that may be shared will be the minimum necessary to conduct the evacuation or repatriation in line with the Services you are entitled to. The information that will be shared may be: date of evacuation or repatriation; location where the patient will be evacuated or repatriated from or to; medical conditions which has resulted in the need for the evacuation or repatriation and the medical necessities of the patient during the Emergency. Once you are safely medically repatriated or evacuated that sharing of information will cease immediately; and

> Registers of claims which are shared with other insurers in order to check information to detect and prevent fraudulent claims. The Personal Information put on these registers may include details of injuries.

For any of the categories of the recipients listed above, it should be noted that some of them may be located in the European Economic Area, while others can process and access your Personal Information from outside the European Economic Area, as described in the following section of the Data Protection Notice.

INTERNATIONAL TRANSFER OF PERSONAL INFORMATION OUTSIDE THE EUROPEAN ECONOMIC AREA

Due to the global nature of the Services you are entitled to and the need to provide the group with compliance solutions to meet its needs and ensure that you have access to the Services in the location of your assignment, your Personal Information can be shared with and/or accessed by parties located in other countries outside the European Economic Area that have a different data protection regime than the one found in the country where the group, signing the contract with us, is located. The countries to which we may transfer your Personal Information may not be regarded by the European Commission as ensuring an adequate level of protection for Personal Information (for instance, the United States).

In any case, where we transfer your Personal Information to any of these countries, we will conduct the transfer in accordance with applicable data protection law. This may include ensuring that appropriate safeguards, such as contractual obligations, are put in place with respect to the protection of your Personal Information and your fundamental rights and freedoms, and your rights in relation to your Personal Information. If you would like further information regarding the steps we take to safeguard your Personal Information, or to obtain a copy of the safeguards we put in place to protect it when it is transferred, please contact us using the details in the "Contact Us" section below.

Depending on the country of your assignment or location and the compliance requirements that may apply there you may receive additional privacy notices from us or from our partners.

RETAINING YOUR PERSONAL INFORMATION

We ensure that proper procedures are in place to manage your Personal Information and to remove and/or archive it when necessary.

In general terms, we only retain your Personal Information for as long as is necessary to:

> Provide you with the Services;

> Fulfil the purposes outlined in this Data Protection Notice; and

> Comply with our legal obligations and/or protect our rights.

When your group instructs us to terminate your access to the Services, we will protect your Personal information and will delete it once our retention period to comply with our legal or regulatory obligations and/or protects our rights has lapsed. Our default retention period is 10 years. However, depending on the jurisdiction that governs our contract and the type of information involved, our general retention period may vary between 7 to 10 years.

If you would like further information regarding the periods for which your Personal Information will be stored, please contact us using the details in the “Contact Us” section below.

MARKETING

We may use your Personal Information to provide you with information about our products and services where you have provided your consent for us to do so. In certain circumstances, we may also use your Personal Information to contact you for marketing purposes where we have a legitimate interest to do so, in order to provide you with information about our other products or services which we consider may be of interest to you. If you wish to unsubscribe from emails sent by us, you may do so at any time by clicking on the "unsubscribe" link that appears in all emails. Otherwise you can always contact us using the details set out in the “CONTACT US” section below to update your contact preferences. Please note, however, that we will continue to send you service related (non-marketing) communications.

YOUR RIGHTS

Under data protection law you have certain rights in relation to the Personal Information that we hold about you. You may exercise, as may be applicable, these rights at any time by contacting us using the details set out in the “Contact Us” section below.

Your rights include:

The right to access your Personal Information

You are entitled to a copy of the Personal Information we hold about you and certain details about how we use it. There will not usually be a charge for dealing with these requests.

Your information will usually be provided to you in writing, unless otherwise requested, or where you have made the request by electronic means, in which case the information will be provided to you by electronic means where possible.

The right to rectification

We take reasonable steps to ensure that the Personal Information we hold about you is accurate and complete. However, if you do not believe this is the case, you can ask us to update or amend it.

The right to erasure

In certain circumstances, you have the right to ask us to erase your Personal Information. Please note that in some circumstances exercise of this right will mean we are unable to continue providing you with the Services as outlined above.

The right to object to, and/or to request restriction of processing

In certain circumstances, you are entitled to object to our processing of your Personal Information, or ask us to stop using your Personal Information. Please note that in some circumstances exercise of these rights will mean we are unable to continue providing you with the Services.

The right to data portability

In certain circumstances, you have the right to ask that we provide your Personal Information to you in a commonly used electronic format, and to transfer any Personal Information

that you have provided to us to another third party of your choice.

The right to object to marketing

You can request that we stop sending you marketing messages at any time by clicking on the "unsubscribe" button in any emails that we send to you or by contacting us using the details set out in the “CONTACT US” section of this Data Protection Notice. Please note that even if you exercise this right because you do not want to receive marketing messages, we may still send you service related communications where necessary.

The right not to be subject to automated decision-making (including profiling)

You have a right in some circumstances to not be subject to a decision based solely on automated means, but we do not base our decisions only on automated means.

The right to withdraw consent

As explained previously, we collect and process your Personal Information (including sensitive data) to provide the Services under different grounds, so that is why we do not ask for your consent.

The right to lodge a complaint with a data protection authority

You have a right to complain to your local data protection authority if you believe that any use of your Personal Information by us is in breach of applicable data protection laws and regulations.

Making a complaint will not affect any other legal rights or remedies that you have.

SECURITY

We will take appropriate technical, physical, legal and organizational measures, which are consistent with applicable data protection laws to protect your Personal Information.

CHANGES TO THIS DATA PROTECTION NOTICE

We may update this Data Protection Notice from time to time to ensure that it remains accurate. Please check back each time that you provide additional Personal Information to us. Where changes to the Notice will have a fundamental impact on the nature of our processing of your Personal Information, or otherwise have a substantial impact on you, we will give you sufficient advance notice so that you have the opportunity to exercise your rights in relation to your Personal Information.

This Data Protection Notice was last updated August 2022.

CONTACT US

Data Protection Officer
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Antwerp, Belgium
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