Mohawk ESV, Inc. Health and Welfare Benefit Plan

OPEN ACCESS PLUS MEDICAL BENEFITS

Health Savings Account

EFFECTIVE DATE: January 1, 2020

ASO13

2500322, 2500325

This document printed in March, 2020 takes the place of any documents previously issued to you which described your benefits.

Printed in U.S.A.

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Important Information

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

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CIGNA. BECAUSE THE PLAN IS NOT INSURED BY CIGNA, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CIGNA," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN YOUR "EMPLOYER" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."

Effective Date: January 1, 2020

Important Notices

Completing Your Health Assessment

Mohawk encourages employees and their spouses to make healthy lifestyle choices. As part of our wellness initiative, we encourage you and your spouse, if you are going to enroll in the Mohawk medical benefit program, to complete your **biometric screening**. This allows you to focus on your health and save money while doing so!

It is your choice whether you participate in the biometric screening or not. However, if you and your covered spouse complete the biometric screening and meet the recommended biometric standards (as outlined in your benefits enrollment materials), you will avoid having to pay the wellness surcharge. The wellness surcharge is an additional $28.85 per week (or $125 per month) for both you and your spouse on top of your regular contributions for medical coverage (for a maximum surcharge of $57.70 per week, or $250 per month).

If you and your covered spouse complete the biometric screening but do not meet the recommended biometric standards, you can still avoid the wellness surcharge by engaging in healthy lifestyle support via face-to-face, telephonic, or online learning. Alternatively, you can work with your personal physician on a wellness plan.

You will have a total of 60 days to complete your biometric screening after your benefit effective date. If you miss the deadline or choose not to complete this, your medical coverage contribution amount for both you and your covered spouse will increase by $125 per month ($28.85 per week).

You may complete a biometric screening at NO COST to you at ONE of the following:

- at a **Healthy Life Center** in your area. Before calling, visit **WWW.MYMOHAWKBENEFITS.COM** to see if a Healthy Life Center is located near you, and to locate the number for your Healthy Life Center.
- at a **Quest Diagnostics** facility in your area. To locate a Quest Diagnostics facility near you, visit **www.my.blueprintforwellness.com**. To schedule an appointment at a Quest facility, call **1-866-908-9440**.
- For participants asked to do a re-test, visit the www.mymohawkbenefits.com website for the current keycode.

Mohawk is committed to helping you achieve your best health. All employees can avoid the wellness surcharge by participating in the wellness program described above. If you think you might be unable to meet a standard for avoiding the wellness surcharge under this wellness program, you might qualify for an opportunity to avoid the wellness surcharge by different means. Contact the Benefits Service Center at 1-866-481-4922 and we will work with you (and, if you wish, with your physician) to find a wellness program with the same reward that is right for you in light of your health status.

2020 Medical Plan Spousal Surcharge

If your spouse is eligible for medical benefits through another employer and chooses to remain on the Mohawk medical benefit program, your spouse will be subject to a $125 surcharge each month ($28.85 per week).

You will receive a communication in the mail from Hodges and Mace approximately 6 weeks after your benefits effective date. Hodges and Mace will be conducting an audit of dependent enrollments, and you will be asked to provide documentation (birth certificate, marriage certificate, etc.). If you enroll a spouse in the Mohawk medical benefit program, then he or she will be included in a spousal audit for other medical coverage. If your spouse's company offers insurance and you elect to cover him or her on Mohawk's medical benefit program, you will pay an additional $125 per month ($28.85 per week) in medical contributions. Hodges and Mace can be contacted at 1-877-308-9157. Failure to provide the proper documentation in a timely manner will result in benefit termination for your dependent. Furthermore, submission of fraudulent documentation could result in disciplinary action up to and including termination.

A Mohawk employee currently married to another Mohawk employee can stay on their current plan with no surcharge.

Effective Date: January 1, 2020

MOHAWK ESV, INC. HEALTH AND WELFARE BENEFIT PLAN
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact Mohawk's privacy official, the Privacy Officer, who can be contacted at Mohawk Industries, 160 South Industrial Boulevard, Calhoun, GA 30701, or by phone at (866) 481-4922.

Who Will Follow This Notice

This Notice describes the medical privacy practices of the self-funded group health benefit programs offered under the Mohawk ESV, Inc. Health and Welfare Benefit Plan (the "Plan"). We are giving you this Notice to inform you of these rights and to comply with a federal law called the Health Insurance Portability and Accountability Act of 1996. This law is also known as "HIPAA."

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal, and we are committed to protecting that information. As part of that protection, we have created a record of your health care claims under the Plan. This Notice applies to all of the medical records the Plan maintains about you. Your personal doctor or personal health care provider may have different policies or notices regarding the uses and disclosures of your medical information which may have been created by that doctor or health care provider. In addition, some health benefits are provided through insurance where Mohawk does not have access to protected health information. If you are enrolled in any insured group health benefit program sponsored by Mohawk, you will receive a separate privacy notice from the insurer. Please note that the group health benefit programs offered under the Mohawk ESV, Inc. Health and Welfare Benefit Plan are part of an organized health care arrangement because they are all sponsored by Mohawk. This means that the benefit programs may share your protected health information with each other, as needed, for the purposes of payment and health care operations.

This Notice tells you about the ways in which the Plan may use or disclose medical information about you. It also describes the Plan's privacy obligations to you and your rights regarding the use and disclosure of your medical information.

The Plan is required by HIPAA to:

- make sure that medical information that identifies you is kept private;
- give you this Notice of its legal duties and privacy practices with respect to medical information about you; and
- follow the terms of this Notice until it is changed. If it is changed, you will receive a copy of the new Notice as long as the Plan keeps personalized health information about you.

In addition to HIPAA, special protections under state or other federal laws may apply to the use and disclosure of your protected health information. The Plan will comply with these state or federal laws where they are more protective of your privacy, but only to the extent these laws are not superseded by federal preemption.

How the Plan May Use and Disclose Medical Information About You

The following categories describe different ways that the Plan uses and discloses medical information about you. For each category of uses or disclosures, we will explain what we mean and present some examples. Obviously, we cannot list every possible use or disclosure which exists, but we will try to list the important ones. All of the ways the Plan is permitted to use and disclose information will fall within one of the categories.

Your Treatment. The first way the Plan may use or disclose medical information about you is to help you with medical treatment or services. The Plan may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, the Plan might disclose information about your prior prescriptions to a pharmacist to determine if a new prescription could cause health problems because it conflicts with prior prescriptions.

Payment of Your Claims. The Plan may use or disclose medical information about you to determine if you are eligible for Plan benefits, to pay for treatment or services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage with other plans. For example, the Plan may tell your health care providers about your medical history to determine if a particular treatment is experimental, investigational, or medically necessary, or to determine if the Plan will cover the treatment. The Plan may also share medical information with a utilization review or precertification service provider. In addition, the Plan may share medical information with another organization to help determine if a claim should be paid or if another person or Plan should be responsible for the claim.

Health Care Operations. The Plan may use or disclose medical information about you for other Plan health care operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use medical information to conduct quality assessment or improvement activities; to determine the cost of premiums or conduct activities relating to Plan coverage; to submit claims for stop-loss coverage; to conduct or arrange for medical review, legal services, audit services, or fraud and abuse detection programs; and to predict the cost of future claims or manage costs. The Plan's health care operations also include case management and coordination of care, for example, in connection with the Plan's wellness or disease management programs. However, federal law prohibits the Plan from using or disclosing protected health information that is genetic information (e.g., family medical history) for underwriting purposes, which include eligibility determinations, calculating premiums, and any other activities related to the creation, renewal, or replacement of a health insurance contract or health benefits.

Business Associates. The Plan may hire third parties that may need your medical information to perform certain services on behalf of the Plan. These third parties are "Business Associates" of the Plan. Business Associates must protect any protected health information they receive from, or create and maintain on behalf of, the Plan. For example, the Plan may hire a third-party administrator to process claims, an auditor to review how an insurer or third-party administrator is processing claims, or an insurance agent to assess coverages and help with claim problems. In addition to performing services for the Plan, Business Associates may use protected health information for their own management and legal responsibilities and for purposes of aggregating data for Plan health care operations.

Health Information Exchange. As permitted by law, the Plan may participate in Health Information Exchanges ("HIEs") to provide or receive medical information for activities described in this Notice (i.e., treatment, payment, and health care operations purposes). HIEs are organizations where participating health care providers or other health care entities can provide or receive information from each other related to your care.

As Required By Law. The Plan will disclose medical information about you when required to do so by federal, state or local law. For example, the Plan may disclose medical information when required by a court order in a lawsuit such as a malpractice action.

To Avert a Serious Threat to Health or Safety. The Plan may use or disclose medical information about you when necessary to prevent a serious threat to your health or safety, or to the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, the Plan may disclose medical information about you in a proceeding concerning the license of a doctor or nurse.

Special Situations

Disclosure to Mohawk or other Mohawk Plans. Your health information may be disclosed to another health Plan maintained by Mohawk for purposes of paying claims under that Plan. In addition, medical information may be disclosed to Mohawk to help you with a claim or to administer benefits under the Plan, such as to determine a claims appeal.

Disclosures to Provide You With Information. The Plan or its agents may contact you to remind you about appointments or provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Organ and Tissue Donation. If you are an organ donor, the Plan may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplants, or to an organ donation bank to help with organ or tissue donation.

Military and Veterans. If you are a member of the armed forces, the Plan may release medical information about you as required by the military. The Plan may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. The Plan may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. The Plan may disclose medical information about you for public health purposes. This includes disclosures:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if the Plan believes a patient has been the victim of abuse, neglect or domestic violence. The Plan will only make this disclosure if you agree or if required or authorized by law.

Health Oversight Activities. The Plan may disclose medical information to a government health agency for activities authorized by law. These activities include, for example, audits, investigations, inspections, and licensing. These activities are necessary for the government to monitor the health care system, government programs, and to comply with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, the Plan may disclose medical information about you in response to a court or administrative order. The Plan may also disclose medical information about you in response to a subpoena, discovery request, or other lawful demand by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. The Plan may release medical information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar court papers;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime even if, under certain limited circumstances, the Plan is unable to obtain your agreement;
- about a death the Plan believes may be the result of criminal conduct;
- about criminal conduct at a hospital; or
- in emergency circumstances to report a crime or the location of a crime or crime victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. The Plan may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify someone who has died or to determine the cause of death. The Plan may also release medical information about individuals to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. The Plan may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release medical information about you to the correctional institution or law enforcement official. This release may be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Your Rights Regarding Medical Information About You

You have the following rights regarding medical information the Plan maintains about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To do so, you must submit your request in writing to Mohawk Industries, 160 South Industrial Boulevard, Calhoun, GA 30701.

The Plan may deny your request to inspect and copy your information in certain circumstances. In most cases, if you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend. If you feel that medical information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment of your information as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to Mohawk Industries, 160 South Industrial Boulevard, Calhoun, GA 30701. In addition, you must provide a reason that supports your request.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an accounting of the prior disclosures of your health information if the disclosure was made for any purpose other than treatment, payment, or health care operations.

To request this list or accounting of disclosures, you must submit your request in writing to Mohawk Industries, 160 South Industrial Boulevard, Calhoun, GA 30701. Your request must state a time period which may not be longer than six years. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, the Plan may charge you for the costs of providing the list. The Plan will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on medical information the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information the Plan discloses about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery you had. Effective February 18, 2010, provided you paid out-of-pocket in full for the services received, we will honor any request you make to restrict information about those services from the Plan provided that such release is not necessary for your treatment. In all other circumstances, the Plan is not required to agree to your request.

To request restrictions, you must make your request in writing to Mohawk Industries, 160 South Industrial Boulevard, Calhoun, GA 30701. In your request, you must tell the Plan (1) what information you want to limit; (2) whether you want to limit the Plan's use or disclosure of this information, or both; and (3) to whom you want the restriction to apply, for example, you don't want information disclosed to your spouse.

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the Plan only contact you at work or by mail.

To request confidential communications, you must make your request in writing to Mohawk Industries, 160 South Industrial Boulevard, Calhoun, GA 30701. The Plan will not ask you the reason for your request, and will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask the Plan to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. To obtain a paper copy of this Notice, contact the Privacy Officer, Mohawk Industries, 160 South Industrial Boulevard, Calhoun, GA 30701.

Right to Receive Notification. You have a right to receive notification of a breach of your unsecured protected health information.

Medical Information Not Covered by This Notice

This Notice does not cover (1) health information that does not identify you and with respect to which there is no reasonable basis to believe that the information could be used to identify you; or (2) health information that Mohawk can have under applicable law (*e.g.*, the Family and Medical Leave Act, the Americans with Disabilities Act, workers' compensation laws, federal and state occupational health and safety laws, and other state and federal laws), or that Mohawk properly can get for employment-related purposes through sources other than the Plan and that is kept as part of your employment records (*e.g.*, pre-employment physicals, drug testing, fitness for duty examinations, *etc.*).

Changes to This Notice

The Plan reserves the right to change this Notice in the future, and to make the revised or changed Notice effective for medical information the Plan already has about you as well as any information it receives in the future. You will receive a copy of the changed Notice in the same manner that you received this Notice. The Notice will contain the effective date on the first page in the top right-hand corner.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the Privacy Officer, Mohawk Industries, 160 South Industrial Boulevard, Calhoun, GA 30701. All complaints must be submitted in writing. You will not be retaliated against for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to the Plan will be made only with your written permission. This written permission is called an "Authorization." For example, in general and subject to specific conditions, the Plan will not use or disclose psychiatric notes about you; will not use or disclose your protected health information for marketing; and will not sell your protected health information. If you provide the Plan with an Authorization to use or disclose medical information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, the Plan will no longer use or disclose medical information about you for the reasons covered by your written Authorization. You understand that the Plan is unable to take back any disclosures it has already made with your Authorization, and that the Plan is required by law to retain records of the care that it has provided to you.

Introduction

Mohawk ESV, Inc. and its participating affiliates (together, the "Employer") maintain the Mohawk ESV, Inc. Health and Welfare Benefit Plan for the benefit of eligible employees and their family members. This document is intended to serve as the booklet for the Open Access Plus Health Savings Account medical and prescription drug benefit program offered under the Mohawk ESV, Inc. Health and Welfare Benefit Plan (referred to in this booklet as the "Plan").

This booklet describes the Plan as in effect on January 1, 2020. Please read this booklet carefully and keep it for future reference. If you have any questions about the Plan, please contact Cigna, the claims administrator for the medical benefits provided under the Plan, or Express Scripts, the claims administrator for the prescription drug benefits provided under the Plan, using the toll-free number shown on the back of your ID card. You may also log onto mymohawkbenefits.com or contact the Benefits Service Center at 1-866-481-4922.

Explanation of Terms

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

The Schedule

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

Special Plan Provisions

When you select a Participating Provider, this Plan pays a greater share of the costs than if you select a non-Participating Provider. Participating Providers include Physicians, Hospitals and Other Health Care Professionals and Other Health Care Facilities. Consult your Physician Guide for a list of Participating Providers in your area. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

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.

HC-SPP44 04-17

Case Management

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

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

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

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

HC-SPP2 04-10
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Additional Programs

Cigna may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to Plan participants for the purpose of promoting the general health and well being of our participants. Cigna may also arrange for the reimbursement of all or a portion of the cost of

services provided by other parties to the Employer. Contact us for details regarding any such arrangements.

HC-SPP3 04-10
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Care Management and Care Coordination Services

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

HC-SPP27 06-15
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Important Notices

Direct Access to Obstetricians and Gynecologists

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in Cigna's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

Selection of a Primary Care Provider

This Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.mycigna.com or contact customer service at the phone number listed on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

HC-NOT5 M 01-11

Important Information

Rebates and Other Payments

Cigna or its affiliates may receive rebates or other remuneration from pharmaceutical manufacturers in connection with certain Medical Pharmaceuticals covered under the Plan. These rebates or remuneration are not obtained on you or your Employer's or plan's behalf or for your benefit. Cigna, its affiliates and the plan are not obligated to pass these rebates on to you, or apply them to your plan's Deductible if any or take them into account in determining your Copayments and/or Coinsurance. Cigna and its affiliates or designees, conduct business with various pharmaceutical manufacturers separate and apart from this plan's Medical Pharmaceutical benefits. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Plan. Cigna and its affiliates are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, Cigna or its designee may send mailings to you or your Dependents or to your Physician that communicate a variety of messages, including information about Medical Pharmaceuticals. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you or your Dependents, at your discretion, to purchase the described Medical Pharmaceutical at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Cigna, its affiliates and the Plan are not responsible in any way for any decision you make in connection with any coupon, incentive, or other offer you may receive from a pharmaceutical manufacturer or Physician.

HC-IMP258 M 01-19

Discrimination is Against the Law

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

Cigna:

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

- Provides free language services to people whose primary language is not English, such as
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free phone number shown on your ID card, and ask a Customer Service Associate for assistance.

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

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

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

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

HC-NOT96 07-17

Proficiency of Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

Japanese –
注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaの
お客様は、IDカード裏面の電話番号まで、お電話にてご

連絡ください。その他の方は、1.800.244.6224（TTY: 711）まで、お電話にてご連絡ください。

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

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

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

HC-NOT97 07-17

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

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

Non-Quantitative Treatment Limitations (NQTLs) include:

- Medical management standards limiting or excluding benefits based on Medical Necessity or whether the treatment is experimental or investigative;
- Prescription drug formulary design;
- Network admission standards;
- Methods for determining in-network and out-of-network provider reimbursement rates;
- Step therapy a/k/a fail-first requirements; and
- Exclusions and/or restrictions based on geographic location, facility type or provider specialty.

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

Employers (Plan Administrators): https://cignaaccess.cigna.com/secure/app/ca/centralRepo - Log in, select Resources and Training, then select the NQTL document.

Covered Persons: www.cigna.com\sp

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

HC-NOT113 01-20

How To File Your Claim

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

You may get the required claim forms from the website listed on your identification card or by using the toll-free number on your identification card.

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE CIGNA'S CLAIM FORMS, OR WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.

  YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

  YOUR ACCOUNT/GROUP NUMBER IS SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- BE SURE TO FOLLOW THE INSTRUCTIONS LISTED ON THE BACK OF THE CLAIM FORM CAREFULLY WHEN SUBMITTING A CLAIM TO CIGNA.

Timely Filing of Out-of-Network Claims

The Plan will consider claims for coverage under the Plans when proof of loss (a claim) is submitted within 180 days for Out-of-Network benefits after services are rendered. If services are rendered on consecutive days, such as for a Hospital Confinement, the limit will be counted from the last

date of service. If claims are not submitted within 180 days for Out-of-Network benefits, the claim will not be considered valid and will be denied.

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.

HC-CLM25 01-11
V11M

Eligibility - Effective Date

Employee Coverage

This Plan is offered to you as an Employee.

Eligibility for Employee Coverage

You are eligible to participate in the Plan if you are classified by the Employer as a full-time employee that is regularly scheduled to work at least 30 hours of service per week (an "Employee") and you complete the Plan's waiting period (as described below).

You are not an Employee that is eligible to participate in the Plan if:

- you are a leased employee;
- you are an individual classified by the Employer as an independent contractor, a leased employee, or an employee of a non-participating affiliate, whether or not you are an actual employee of the Employer
- you are a union employee, unless otherwise required by a collective bargaining agreement;
- you are a nonresident alien that does not receive U.S. source income; or
- you are covered by a welfare plan maintained by a foreign affiliate.

Waiting Period

As an eligible Employee, you may begin participating in the Plan on the first of the month following 60 days of employment as an eligible Employee as defined above.

If you are laid off and are called back within six months of your layoff date, your benefits are reinstated as they were prior to your layoff. The waiting period is waived. If you are laid off and then called back more than six months after your layoff date, you will be need to complete the Plan's waiting period again before you are eligible for Plan benefits.

If you leave voluntarily and have a break in service that is 13 weeks or longer, you are considered "rehired" and your benefits are applied as any other new hire (i.e. the waiting period applies). If you leave voluntarily and have a break in service that is less than 13 weeks, you will be immediately eligible for the Plan without being subject to the Plan's waiting period.

If you cease to be an eligible Employee for reasons other than termination of employment and then return to eligible Employee status, your prior service as an Employee will count toward the Plan's waiting period, regardless of whether you return to eligible Employee status within 13 weeks.

Effective Date of Employee Coverage

You will become covered by the Plan on the date you satisfy the Plan's waiting period if you elect coverage under the Plan through Mohawk's online enrollment system or by calling Mohawk's Benefit Service Center at 1-866-481-4922 within 30 days of becoming eligible to participate in the Plan. You will not be denied enrollment due to your health status.

You will become covered by the Plan 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.

To begin participating in the Plan, you must enroll in the Plan by following the instructions in your enrollment materials within 30 days of the date you complete the Plan's waiting period (this 30-day period is referred to as your "initial enrollment period"). You will not be enrolled in the Plan if you do not enroll within 30 days of the date you become eligible, unless you qualify under the section of this booklet entitled "Special Enrollment Rights Under the Health Insurance Portability & Accountability Act (HIPAA)" or experience another qualified change event (as described in the section of this booklet entitled "Effect of Section 125 Tax Regulations on This Plan") and timely enroll in the Plan, or unless you enroll during the Plan's next open enrollment period.

The benefit choices you make during your initial enrollment period will remain in effect for the remainder of the plan year, unless you qualify for a special enrollment period or you experience a qualified change event (as described later in this booklet) and you make new benefit elections.

Special Eligibility Rules

The Plan Administrator may establish different eligibility requirements (for example, waiving the Waiting Period or recognizing prior service) with respect to Employees who become employed by the Employer as a result of a corporate transaction.

Dependent Coverage

For your Dependents to be covered by the Plan, you will have to timely enroll your Dependents, provide proof of Dependent status to the Plan, and pay the required contribution toward the cost of Dependent coverage.

Eligible Dependents

Dependent for purposes of the Plan means:

- An Employee's spouse, meaning the one individual with whom the Employee has established a valid marriage according to state law, including a common law marriage. A divorced former spouse of an Employee is not an eligible Dependent.

  Please Note: If your spouse is eligible for benefits through another employer and you elect coverage for him or her under the Plan, you will pay an additional amount (as outlined in the Plan's enrollment materials) for the spouse's coverage. An eligible Employee currently married to another eligible Employee can remain on the Plan without the spousal surcharge.
- An Employee's child who is less than 26 years of age. Coverage of a Dependent child will continue until the end of the calendar month in which the child turns age 26.
- An Employee's child, regardless of age, who (i) is unmarried and primarily supported by the Employee; (ii) was continuously covered under the Plan as a Dependent prior to attaining age 26; and (iii) is incapable of sustaining his or her own living by reason of a mental or physical disability. The child must have been mentally or physically incapable of earning his or her own living due to the disabling condition prior to attaining age 26. Written proof of incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the child reaches age 26. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan of the child's continuing disability.

"Child" for purposes of the Plan means an Employee's natural child, stepchild, legally adopted child, foster child, or any other child for whom the Employee has been named legal guardian. The term "child" will also include an Employee's grandchild who is considered the Employee's dependent for federal income tax purposes. For purposes of this definition, a legally adopted child shall include a child placed in an Employee's physical custody in anticipation of adoption.

"Child" shall also mean a covered Employee's child who is an Alternate Recipient under a Qualified Medical Child Support Order, as required by the Federal Omnibus Budget Reconciliation Act of 1993.

Residents of a country other than the United States are not eligible for Dependent coverage under the Plan.

To establish a Dependent relationship, the Plan reserves the right to require documentation satisfactory to the Plan Administrator.

An individual may be enrolled in the Plan as an Employee or a Dependent, but not both. No one may be considered as a Dependent of more than one Employee.

Effective Date of Dependent Coverage

Insurance for your Dependents will become effective on the date you complete the Plan's waiting period, if you timely elect Dependent coverage during your initial enrollment period in the manner outlined in the Plan's enrollment materials..

Your Dependents will be covered only if you are enrolled in the Plan.

If you do not enroll your eligible Dependents during your initial enrollment period, you will not be able to enroll them in the Plan until the next open enrollment period, unless you qualify for a special enrollment period or you experience another qualified change event (as described later in this booklet) and you make new benefit elections.

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, no benefits for expenses incurred will be payable for that child.

HC-ELG274M 01-19

Important Information About Your Medical Plan

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

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician:

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

different from the Primary Care Physician you select for each of your Dependents.

Changing Primary Care Physicians:

You may request a transfer from one Primary Care Physician to another by contacting us at the member services number on your ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

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

HC-IMP212 01-18

Open Access Plus Medical Benefits

The Schedule

For You and Your Dependents

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

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

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

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

Copayments/Deductibles

Copayments are expenses to be paid by you or your Dependent for covered services. Deductibles are also expenses to be paid by you or your Dependent. 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 year.

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

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

Accumulation of Plan Deductibles and Out-of-Pocket Maximums

Deductibles and Out-of-Pocket Maximums do not cross-accumulate (that is, In-Network will accumulate only to In-Network and Out-of-Network will accumulate only to Out-of-Network). All other Plan maximums and service-specific maximums (dollar and occurrence) cross-accumulate between In- and Out-of-Network unless otherwise noted.

Accumulation of Pharmacy Benefits

If your Plan provides Pharmacy benefits separately, any In-Network medical Out-of-Pocket Maximums will cross accumulate with any In-Network Pharmacy Out-of-Pocket Maximums.

Note:
For information about your health savings account and how it can help you pay for expenses that may not be covered under this Plan, refer to "What You Should Know about Cigna Choice Fund" at the end of this booklet.

Multiple Surgical Reduction

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

Open Access Plus Medical Benefits

The Schedule

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

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

Co-Surgeon

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

Out-of-Network Emergency Services Charges

1. Emergency Services are covered at the In-Network cost-sharing level if services are received from a non-participating (Out-of-Network) provider.
2. The allowable amount used to determine the Plan's benefit payment for covered Emergency Services rendered in an Out-of-Network Hospital, or by an Out-of-Network provider in an In-Network Hospital, is the amount agreed to by the Out-of-Network provider and Cigna, or if no amount is agreed to, the greatest of the following, not to exceed the provider's billed charges: (i) the median amount negotiated with In-Network providers for the Emergency Service, excluding any In-Network copay or coinsurance; (ii) the Maximum Reimbursable Charge; or (iii) the amount payable under the Medicare program.

The member is responsible for applicable In-Network cost-sharing amounts (any deductible, copay or coinsurance). The member is also responsible for all charges that may be made in excess of the allowable amount. If the Out-of-Network provider bills you for an amount higher than the amount you owe as indicated on the Explanation of Benefits (EOB), contact Cigna Customer Service at the phone number on your ID card.

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	Unlimited	
The Percentage of Covered Expenses the Plan Pays	80%	50% of the Maximum Reimbursable Charge

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Maximum Reimbursable Charge Maximum Reimbursable Charge is determined based on the lesser of the provider's normal charge for a similar service or supply; or A policyholder-selected 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 fee for the same or similar services within the geographic market. In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of: • the provider's normal charge for a similar service or supply; or • the 80th percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by Cigna. If sufficient charge data is unavailable in the database for that geographic area to determine the Maximum Reimbursable Charge, then data in the database for similar services may be used. **Note:** The provider may bill you for the difference between the provider's normal charge and the Maximum Reimbursable Charge, in addition to applicable deductibles, copayments and coinsurance. **Note:** Some providers forgive or waive the cost share obligation (e.g. your copayment, deductible and/or coinsurance) that this Plan requires you to pay. Waiver of your required cost share obligation can jeopardize your coverage under this Plan. For more details, see the Exclusions Section.	Not Applicable	110%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
How the Employer Funding of Your Health Savings Account Works: You will receive 50% of your Employer Contribution (as shown in the schedule below) as a seed contribution in January. If you contribute to your HSA in an amount equal to or greater than the 50% Employer seed contribution, the Employer will match the additional 50% to your account up to the total Annual Employer Contribution. **New Hires and New Participants.** All employees hired on or after Jan. 1, 2020, and new participants to the Plan in 2020 may contribute to their HSA once they become benefit eligible. However, the employee will not receive any Employer money during the first calendar year of employment or participation in the Plan, as applicable. In 2021, the employee will be eligible to receive the initial 2021 Employer seed contribution and the 2021 Employer match (as long as the employee is contributing at the appropriate level to their HSA Plan in 2021). **Qualifying Life Event.** If an HSA participant has a qualifying life event during the year and changes his or her Plan coverage (for example changes their Plan coverage tier from Employee Only to Employee + Spouse), the employee may continue to contribute and receive appropriate Employer match, however their initial Employer seed money provided in January 2020 will not be modified.		
Employee	$500 (if you contribute $250 or more)	
Employee & Spouse	$800 (if you contribute $400 or more)	
Employee & Child	$800 (if you contribute $400 or more)	
Family	$1,100 (if you contribute $550 or more)	

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
How the Employee Funding of a Health Savings Account Works: An Employee may contribute up to the maximum contribution amount shown below, combined with any contributions provided by the Employer.		
Employee	up to $3,550	
Employee & Spouse	up to $7,100	
Employee & Child	up to $7,100	
Family	up to $7,100	
Employees age 55+	up to an additional $1,000	
Calendar Year Deductible		
Employee	$1,700	$3,300
Employee Plus Spouse	$3,400	$6,600
Employee Plus Child(ren)	$3,400	$6,600
Family	$3,300	$6,600
Plan deductibles do not cross-accumulate and must be satisfied separately (e.g. out-of-network services will only accumulate to out-of-network Plan deductible and in-network services will only apply to in-network Plan deductible).		
Collective Deductible: All family members contribute towards the family deductible. An individual cannot have claims covered under the Plan coinsurance until the total family deductible has been satisfied.		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Out-of-Pocket Maximum		
Employee	$5,000	Unlimited
Employee Plus Spouse	$13,000	Unlimited
Employee Plus Child(ren)	$13,000	Unlimited
Individual limit under Employee Plus Spouse, Employee Plus Child(ren), or Family coverage	$6,500	Unlimited
Family	$13,000	Unlimited
Out-of-Pocket Maximums do not cross-accumulate between in and out-of-network services.		
Individual Calculation: For the In-Network Out-of-Pocket Maximum, family members must meet only their individual Out-of-Pocket Maximum ($6,500) and then their In-Network claims will be covered at 100%; if the family In-Network Out-of-Pocket Maximum has been met prior to their individual In-Network Out-of-Pocket Maximum being met, their In-Network claims will be paid at 100%.		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Physician's Services		
Primary Care Physician's Office Visit	Plan deductible, then $35 per visit copay, then 100%	Plan deductible, then 50%
Specialty Care Physician's Office Visit	Plan deductible, then $35 per visit copay, then 100%	Plan deductible, then 50%
Consultant and Referral Physician's Services		
Note: OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with Cigna on an In-Network basis. Out-of-Network OB/GYN providers will be considered a Specialist.		
Surgery Performed in the Physician's Office		
Primary Care Physician	Plan deductible, then 80%	Plan deductible, then 50%
Specialty Care Physician	Plan deductible, then 80%	Plan deductible, then 50%
Second Opinion Consultations (provided on a voluntary basis)		
Primary Care Physician's Office Visit	Plan deductible, then $35 per visit copay, then 100%	Plan deductible, then 50%
Specialty Care Physician's Office Visit	Plan deductible, then $35 per visit copay, then 100%	Plan deductible, then 50%
Allergy Treatment/Injections		
Primary Care Physician's Office Visit	Plan deductible, then 80%	Plan deductible, then 50%
Specialty Care Physician's Office Visit	Plan deductible, then 80%	Plan deductible, then 50%
Allergy Serum (dispensed by the `Physician in the office)		
Primary Care Physician	Plan deductible, then 80%	Plan deductible, then 50%
Specialty Care Physician	Plan deductible, then 80%	Plan deductible, then 50%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Preventive Care **Note:** Includes coverage of additional services, such as urinalysis, EKG, and other laboratory tests, supplementing the standard Preventive Care benefit.		
Routine Preventive Care - all ages		
Primary Care Physician's Office Visit	100%	Plan deductible, then 50%
Specialty Care Physician's Office Visit	100%	Plan deductible, then 50%
Immunizations - all ages		
Primary Care Physician's Office Visit	100%	Plan deductible, then 50%
Specialty Care Physician's Office Visit	100%	Plan deductible, then 50%
Mammograms		
Preventive Care Related Services (i.e. "routine" services) **Note:** Preventive 3D mammograms are limited to $285 payment maximum per occurrence and all other preventive mammograms are limited to $225 payment maximum per occurence. Maximum applies to technical component only.	100%	100%
Diagnostic Related Services (i.e. "non-routine" services) **Note:** Includes all related charges including professional services.	100%	100%
PSA, PAP Smear		
Preventive Care Related Services (i.e. "routine" services)	100%	Plan deductible, then 50%
Diagnostic Related Services (i.e. "non-routine" services)	Subject to the plan's x-ray benefit & lab benefit; based on place of service	Subject to the plan's x-ray benefit & lab benefit; based on place of service

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Early Cancer Detection Colon/Rectal **Note:** Preventive colonoscopies are limited to $2,250 payment maximum per occurrence. Includes all related charges including professional services. Maximum applies to technical component only.		
Preventive Care Related Services (i.e. "routine" services)	100%	Plan deductible, then 50%
Diagnostic Related Services (i.e. "non-routine" services)	100%	Plan deductible, then 50%
Inpatient Hospital - Facility Services	Plan deductible, then 80%	Plan deductible, then 50%
Semi-Private Room and Board	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Private Room	Limited to the semi-private room negotiated rate	Limited to the semi-private room rate
Special Care Units (ICU/CCU)	Limited to the negotiated rate	Limited to the ICU/CCU daily room rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room	Plan deductible, then 80%	Plan deductible, then 50%
Inpatient Hospital Physician's Visits/Consultations	Plan deductible, then 80%	Plan deductible, then 50%
Inpatient Professional Services Surgeon Radiologist, Pathologist, Anesthesiologist	Plan deductible, then 80%	Plan deductible, then 50%
Outpatient Professional Services Surgeon Radiologist, Pathologist, Anesthesiologist	Plan deductible, then 80%	Plan deductible, then 50%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Urgent Care Services		
Urgent Care Facility or Outpatient Facility Includes Outpatient Professional Services, X-ray and/or Lab services performed at the Urgent Care Facility and billed by the facility as part of the UC visit.	Plan deductible, then $25 per visit copay, then 100%	Plan deductible, then $25 per visit copay, 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 100%
Emergency Services		
Hospital Emergency Room Includes Outpatient Professional Services, X-ray and/or Lab services performed at the Emergency Room and billed by the facility as part of the ER visit.	Plan deductible, then 80%	Plan deductible, then 80%
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.) billed by the facility as part of the ER visit	Plan deductible, then 80%	Plan deductible, then 80%
Ambulance	Plan deductible, then 80%	Plan deductible, then 80%
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: Unlimited	Plan deductible, then 80%	Plan deductible, then 50%
Laboratory Services		
Primary Care Physician's Office Visit	Plan deductible, then 80%	Plan deductible, then 50%
Specialty Care Physician's Office Visit	Plan deductible, then 80%	Plan deductible, then 50%
Outpatient Hospital Facility	Plan deductible, then 80%	Plan deductible, then 50%
Independent Lab Facility	Plan deductible, then 80%	Plan deductible, then 50%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Radiology Services		
Primary Care Physician's Office Visit	Plan deductible, then 80%	Plan deductible, then 50%
Specialty Care Physician's Office Visit	Plan deductible, then 80%	Plan deductible, then 50%
Outpatient Hospital Facility	Plan deductible, then 80%	Plan deductible, then 50%
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans) **Note:** MRIs are limited to $2,300 payment maximum per scan. CAT Scans are limited to $2,000 payment maximum per scan. Maximum applies to physician's office, outpatient free standing imaging center and Outpatient Imaging Department at a Hospital (non-ER location/non-urgent care).		
Primary Care Physician's Office Visit	Plan deductible, then 80%	Plan deductible, then 50%
Specialty Care Physician's Office Visit	Plan deductible, then 80%	Plan deductible, then 50%
Inpatient Facility	Plan deductible, then 80%	Plan deductible, then 50%
Outpatient Facility	Plan deductible, then 80%	Plan deductible, then 50%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Outpatient Therapy Services (The limit is not applicable to mental health conditions.) Calendar Year Maximum: 60 days Includes: Physical Therapy Calendar Year Maximum: 30 days per therapy for each additional therapy Includes: Cardiac Rehab Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy		
Primary Care Physician's Office Visit	Plan deductible, then $35 per visit copay*, then 100%	Plan deductible, then 50%
Specialty Care Physician's Office Visit	Plan deductible, then $35 per visit copay*, then 100% ***Note:** Outpatient Therapy Services copay applies, regardless of place of service, including the home.	Plan deductible, then 50%
Chiropractic Care Calendar Year Maximum: 12 days		
Primary Care Physician's Office Visit	Plan deductible, then 80%	Plan deductible, then 50%
Specialty Care Physician's Office Visit	Plan deductible, then 80%	Plan deductible, then 50%
Home Health Care Calendar Year Maximum: 120 days (includes outpatient private nursing when approved as Medically Necessary) (The limit is not applicable to Mental Health and Substance Use Disorder conditions.)	Plan deductible, then 80%	Plan deductible, then 50%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Hospice		
Inpatient Services	Plan deductible, then 80%	Plan deductible, then 50%
Outpatient Services (same coinsurance level as Home Health Care)	Plan deductible, then 80%	Plan deductible, then 50%
Bereavement Counseling Services provided as part of Hospice Care		
Inpatient	Plan deductible, then 80%	Plan deductible, then 50%
Outpatient	Plan deductible, then 80%	Plan deductible, then 50%
Services provided by Mental Health Professional	Covered under Mental Health benefit	Covered under Mental Health benefit
Medical Pharmaceuticals		
Physician's Office	Plan deductible, then 100%	Plan deductible, then 50%
Home Care	Plan deductible, then 80%	Plan deductible, then 50%
Inpatient Facility	Plan deductible, then 80%	Plan deductible, then 50%
Outpatient Facility	Plan deductible, then 80%	Plan deductible, then 50%
Gene Therapy Includes prior authorized gene therapy products and services directly related to their administration, when Medically Necessary. Gene therapy must be received at an In-Network facility specifically contracted with Cigna to provide the specific gene therapy. Gene therapy at other In-Network facilities is not covered.		
Gene Therapy Product	Covered same as Medical Pharmaceuticals	In-Network coverage only
Inpatient Facility	Plan deductible, then 80%	In-Network coverage only
Outpatient Facility	Plan deductible, then 80%	In-Network coverage only
Inpatient Professional Services	Plan deductible, then 80%	In-Network coverage only
Outpatient Professional Services	Plan deductible, then 80%	In-Network coverage only
Travel Maximum: $10,000 per episode of gene therapy	Plan deductible, then 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

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Maternity Care Services		
Initial Visit to Confirm Pregnancy		
Note: OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with Cigna on an In-Network basis. Out-of-Network OB/GYN providers will be considered a Specialist.		
Primary Care Physician's Office Visit	Plan deductible, then $35 per visit copay, then 100%	Plan deductible, then 50%
Specialty Care Physician's Office Visit	Plan deductible, then $35 per visit copay, then 100%	Plan deductible, then 50%
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	Plan deductible, then 100%	Plan deductible, then 50%
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist		
Primary Care Physician's Office Visit	Plan deductible, then $35 per visit copay, then 100%	Plan deductible, then 50%
Specialty Care Physician's Office Visit	Plan deductible, then $35 per visit copay, then 100%	Plan deductible, then 50%
Delivery - Facility (Inpatient Hospital)	Plan deductible, then 80%	Plan deductible, then 50%
Delivery - Facility (Birthing Center)	Plan deductible, then 100%	Plan deductible, then 50%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Abortion		
Includes only non-elective procedures		
Primary Care Physician's Office Visit	Plan deductible, then $35 per visit copay, then 100%	Plan deductible, then 50%
Specialty Care Physician's Office Visit	Plan deductible, then $35 per visit copay, then 100%	Plan deductible, then 50%
Surgery Performed in the Physician's Office		
Primary Care Physician	Plan deductible, then 80%	Plan deductible, then 50%
Specialty Care Physician	Plan deductible, then 80%	Plan deductible, then 50%
Inpatient Facility	Plan deductible, then 80%	Plan deductible, then 50%
Outpatient Facility	Plan deductible, then 80%	Plan deductible, then 50%
Inpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 50%
Outpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 50%
Women's Family Planning Services		
Office Visits, Lab and Radiology Tests and Counseling		
Note: Includes coverage for contraceptive devices (e.g., Depo-Provera and Intrauterine Devices (IUDs)) as ordered or prescribed by a physician. Diaphragms also are covered when services are provided in the physician's office.		
Primary Care Physician	100%	Plan deductible, then 50%
Specialty Care Physician	100%	Plan deductible, then 50%
Surgical Sterilization Procedures for Tubal Ligation (excludes reversals)		
Primary Care Physician's Office Visit	100%	Plan deductible, then 50%
Specialty Care Physician's Office Visit	100%	Plan deductible, then 50%
Inpatient Facility	100%	Plan deductible, then 50%
Outpatient Facility	100%	Plan deductible, then 50%
Inpatient Professional Services	100%	Plan deductible, then 50%
Outpatient Professional Services	100%	Plan deductible, then 50%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Men's Family Planning Services		
Note: Applies to employees and spouses only.		
Office Visits, Lab and Radiology Tests and Counseling		
Primary Care Physician	Plan deductible, then $35 per visit copay, then 100%	Plan deductible, then 50%
Specialty Care Physician	Plan deductible, then $35 per visit copay, then 100%	Plan deductible, then 50%
Surgical Sterilization Procedures for Vasectomy (excludes reversals)		
Primary Care Physician's Office Visit	Plan deductible, then 80%	Plan deductible, then 50%
Specialty Care Physician's Office Visit	Plan deductible, then 80%	Plan deductible, then 50%
Inpatient Facility	Plan deductible, then 80%	Plan deductible, then 50%
Outpatient Facility	Plan deductible, then 80%	Plan deductible, then 50%
Inpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 50%
Outpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 50%
Infertility Services Coverage will be provided for the following services: • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). Surgical Treatment: Limited to procedures for the correction of infertility (excludes Artificial Insemination, In-vitro, GIFT, ZIFT, etc.)		
Physician's Office Visit (Lab and Radiology Tests, Counseling)		
Primary Care Physician	Plan deductible, then $35 per visit copay, then 100%	Plan deductible, then 50%
Specialty Care Physician	Plan deductible, then $35 per visit copay, then 100%	Plan deductible, then 50%
Inpatient Facility	Plan deductible, then 80%	Plan deductible, then 50%
Outpatient Facility	Plan deductible, then 80%	Plan deductible, then 50%
Inpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 50%
Outpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 50%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Organ Transplants Includes all medically appropriate, non-experimental transplants		
Primary Care Physician's Office Visit	Plan deductible, then $35 per visit copay, then 100%	In-Network coverage only
Specialty Care Physician's Office Visit	Plan deductible, then $35 per visit copay, then 100%	In-Network coverage only
Inpatient Facility	Plan deductible, then 100% at LifeSOURCE center, otherwise not covered	In-Network coverage only
Inpatient Professional Services	Plan deductible, then 100% at LifeSOURCE center, otherwise not covered	In-Network coverage only
Travel Maximum: $10,000 per transplant	100% (only available when using LifeSOURCE facility)	In-Network coverage only
Durable Medical Equipment Calendar Year Maximum: Unlimited	Plan deductible, then 80%	Plan deductible, then 50%
Breast Feeding Equipment and Supplies **Note:** Includes the rental of one breast pump per birth as ordered or prescribed by a physician. Includes related supplies.	100%	Plan deductible, then 50%
External Prosthetic Appliances Calendar Year Maximum: Unlimited	Plan deductible, then 80%	Plan deductible, then 50%
Nutritional Evaluation Calendar Year Maximum: 3 visits per person however, the 3 visit limit will not apply to treatment of mental health and substance use disorder conditions.		
Primary Care Physician's Office Visit	Plan deductible, then $35 per visit copay, then 100%	Plan deductible, then 50%
Specialty Care Physician's Office Visit	Plan deductible, then $35 per visit copay, then 100%	Plan deductible, then 50%
Inpatient Facility	Plan deductible, then 80%	Plan deductible, then 50%
Outpatient Facility	Plan deductible, then 80%	Plan deductible, then 50%
Inpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 50%
Outpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 50%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Genetic Counseling Calendar Year Maximum: 3 visits per person for Genetic Counseling for both pre- and post-genetic testing; however, the 3 visit limit will not apply to Mental Health and Substance Use Disorder conditions.		
Primary Care Physician's Office Visit	Plan deductible, then $35 per visit copay, then 100%	Plan deductible, then 50%
Specialty Care Physician's Office Visit	Plan deductible, then $35 per visit copay, then 100%	Plan deductible, then 50%
Inpatient Facility	Plan deductible, then 80%	Plan deductible, then 50%
Outpatient Facility	Plan deductible, then 80%	Plan deductible, then 50%
Inpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 50%
Outpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 50%
External Breast Prosthesis Calendar Year Maximum: Two mastectomy bras	Plan deductible, then 80%	Plan deductible, then 50%
Wigs Calendar Year Maximum: One wig	Plan deductible, then 80%	Plan deductible, then 50%
Inpatient Hospital Facility Services/Dialysis Note: Out-of-network dialysis paid at 50% after deductible with no enhancement to in-network benefit level based on network adequacy.	Plan deductible, then 80%	Plan deductible, then 50%
Dental Care Limited to charges made for a continuous course of dental treatment started within twelve months of an injury to teeth.		
Primary Care Physician's Office Visit	Plan deductible, then $35 per visit copay, then 100%	Plan deductible, then 50%
Specialty Care Physician's Office Visit	Plan deductible, then $35 per visit copay, then 100%	Plan deductible, then 50%
Inpatient Facility	Plan deductible, then 80%	Plan deductible, then 50%
Outpatient Facility	Plan deductible, then 80%	Plan deductible, then 50%
Inpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 50%
Outpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 50%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
TMJ Surgical and Non-Surgical Includes appliances and orthodontia specifically for the treatment of TMJ.		
Primary Care Physician's Office Visit	Plan deductible, then $35 per visit copay, then 100%	Plan deductible, then 50%
Specialty Care Physician's Office Visit	Plan deductible, then $35 per visit copay, then 100%	Plan deductible, then 50%
Inpatient Facility	Plan deductible, then 80%	Plan deductible, then 50%
Outpatient Facility	Plan deductible, then 80%	Plan deductible, then 50%
Inpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 50%
Outpatient Professional Services	Plan deductible, then 80%	Plan deductible, then 50%
Obesity/Bariatric Surgery **Note:** Coverage is provided subject to medical necessity and clinical guidelines subject to any limitations shown in the "Exclusions, Expenses Not Covered and General Limitations" section of this certificate.		
Primary Care Physician's Office Visit	Plan deductible, then $35 per visit copay, then 100%	In-Network coverage only
Specialty Care Physician's Office Visit	Plan deductible, then $35 per visit copay, then 100%	In-Network coverage only
Inpatient Facility	Plan deductible, then 80%	In-Network coverage only
Outpatient Facility	Plan deductible, then 80%	In-Network coverage only
Inpatient Professional Services	Plan deductible, then 80%	In-Network coverage only
Outpatient Professional Services	Plan deductible, then 80%	In-Network coverage only
Surgical Professional Services Lifetime Maximum: $10,000 **Notes:** • Includes charges for surgeon only; does not include radiologist, anesthesiologist, etc.		

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Routine Foot Disorders Calendar Year Maximum: $1,000		
Primary Care Physician's Office Visit	Plan deductible, then $35 per visit copay, then 100%	Plan deductible, then 50%
Specialty Care Physician's Office Visit	Plan deductible, then $35 per visit copay, then 100%	Plan deductible, then 50%
Treatment Resulting From Life Threatening Emergencies Medical treatment required as a result of an emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized. Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance use disorder expense will be determined by the utilization review Physician in accordance with the applicable mixed services claim guidelines.		
Mental Health		
Inpatient Includes Acute Inpatient and Residential Treatment Calendar Year Maximum: Unlimited	Plan deductible, then 80%	Plan deductible, then 50%
Outpatient		
Outpatient - Office Visits Includes individual, family and group psychotherapy; medication management, etc. Calendar Year Maximum: Unlimited	Plan deductible, then $35 per visit copay, then 100%	Plan deductible, then 50%
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, etc. Calendar Year Maximum: Unlimited	Plan deductible, then 80%	Plan deductible, then 50%

BENEFIT HIGHLIGHTS	IN-NETWORK	OUT-OF-NETWORK
Substance Use Disorder		
Inpatient Includes Acute Inpatient Detoxification, Acute Inpatient Rehabilitation and Residential Treatment Calendar Year Maximum: Unlimited	Plan deductible, then 80%	Plan deductible, then 50%
Outpatient		
Outpatient - Office Visits Includes individual, family and group psychotherapy; medication management, etc. Calendar Year Maximum: Unlimited	Plan deductible, then $35 per visit copay, then 100%	Plan deductible, then 50%
Outpatient - All Other Services Includes Partial Hospitalization, Intensive Outpatient Services, etc. Calendar Year Maximum: Unlimited	Plan deductible, then 80%	Plan deductible, then 50%

Open Access Plus Medical Benefits

Certification Requirements - Out-of-Network

For You and Your Dependents

Pre-Admission Certification/Continued Stay Review for Hospital Confinement

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

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

You or your Dependent should request PAC prior to any non-emergency treatment in a Hospital described above. In the case of an emergency admission, you should contact the Review Organization within 48 hours after the admission. For an admission due to pregnancy except for 48/96 hour maternity stays, 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.

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

Outpatient Certification Requirements – Out-of-Network

Outpatient Certification refers to the process used to certify the Medical Necessity of outpatient diagnostic testing and outpatient procedures, including, but not limited to, those listed in this section when performed as an outpatient in a Free-Standing Surgical Facility, Other Health Care Facility or a Physician's office. You or your Dependent should call the toll-free number on the back of your I.D. card to determine if Outpatient Certification is required prior to any outpatient diagnostic testing or outpatient procedures. Outpatient Certification is performed through a utilization review program by a Review Organization with which Cigna has contracted. Outpatient Certification should only be requested for non-emergency procedures or services, and 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 the first $500 for charges made for any outpatient diagnostic testing or outpatient procedure performed unless Outpatient Certification is received prior to the date the testing or procedure is performed.

Covered Expenses incurred will not include the first $500 for charges made for outpatient diagnostic testing or 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.

Diagnostic Testing and Outpatient Procedures

Including, but not limited to:

- Advanced radiological imaging – CT Scans, MRI, MRA or PET scans.
- Home Health Care Services.
- Medical Pharmaceuticals.
- Radiation Therapy.

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Prior Authorization/Pre-Authorized

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

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

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

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Covered Expenses

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

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

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

Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.
- charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.
- charges made for diagnosis and treatment of: corns, calluses, weak or flat feet; any fallen arches, chronic foot strain or instability or imbalance of the feet; toenails (other than removal of nail matrix or root, or services furnished in connection with treatment of metabolic or peripheral vascular disease or of a neurological condition).
- charges made for an annual prostate-specific antigen test (PSA).
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives, after appropriate counseling, medical services connected with surgical therapies (tubal ligations, vasectomies).
- abortion when a Physician certifies in writing that the pregnancy would endanger the life of the mother, or when the expenses are incurred to treat medical complications due to abortion.
- charges made for the following preventive care services (detailed information is available at www.healthcare.gov.):
  (1) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
  (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the covered person involved;
  (3) for infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
  (4) for women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- charges made for surgical or non-surgical treatment of Temporomandibular Joint Dysfunction.

Clinical Trials

This Plan covers routine patient care costs related to a qualified clinical trial for an individual who meets the following requirements:

(a) is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition; and

(b) either

- 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 based upon the individual meeting the conditions described in paragraph (a); or
- the individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (a).

For purposes of clinical trials, the term "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

The clinical trial must meet the following requirements:

The study or investigation must:

- be approved or funded by any of the agencies or entities authorized by federal law to conduct clinical trials;
- be conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
- involve a drug trial that is exempt from having such an investigational new drug application.

Routine patient care costs are costs associated with the provision of health care items and services including drugs, items, devices and services otherwise covered by this Plan for an individual who is not enrolled in a clinical trial and, in addition:

- services required solely for the provision of the investigational drug, item, device or service;
- services required for the clinically appropriate monitoring of the investigational drug, device, item or service;
- services provided for the prevention of complications arising from the provision of the investigational drug, device, item or service; and
- reasonable and necessary care arising from the provision of the investigational drug, device, item or service, including the diagnosis or treatment of complications.

Routine patient care costs do not include:

- the investigational drug, item, device, or service, itself; or
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

If your Plan includes In-Network providers, clinical trials conducted by non-Participating Providers will be covered at the In-Network benefit level if:

- there are not In-Network providers participating in the clinical trial that are willing to accept the individual as a patient, or
- the clinical trial is conducted outside the individual's state of residence.

Genetic Testing

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

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

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

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing.

Nutritional Evaluation and Counseling

Charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

Internal Prosthetic/Medical Appliances

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

Obesity Treatment

- charges made for medical and surgical services only at approved centers for the treatment or control of clinically severe (morbid) obesity as defined below and if the services are demonstrated, through existing peer reviewed, evidence

based, scientific literature and scientifically based guidelines, to be safe and effective for the treatment or control of the condition. Clinically severe (morbid) obesity is defined by the National Heart, Lung and Blood Institute (NHLBI) as a Body Mass Index (BMI) of 40 or greater without comorbidities, or a BMI of 35-39 with comorbidities. The following items are specifically excluded:

- medical and surgical services to alter appearances or physical changes that are the result of any medical or surgical services performed for the treatment or control of obesity or clinically severe (morbid) obesity; and
- weight loss programs or treatments, whether or not they are prescribed or recommended by a Physician or under medical supervision.

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Orthognathic Surgery

- orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone can not correct, provided:
  - the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
  - the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease; or
  - the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

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

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Home Health Services

- charges made for Home Health Services when you: require skilled care; are unable to obtain the required care as an ambulatory outpatient; and do not require confinement in a Hospital or Other Health Care Facility.

  Home Health Services are provided only if Cigna has determined that the home is a medically appropriate setting.

  If you are a minor or an adult who is dependent upon others for nonskilled care and/or custodial services (e.g., bathing, eating, toileting), Home Health Services will be provided for you only during times when there is a family member or care giver present in the home to meet your nonskilled care and/or custodial services needs.

  Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals. A visit is defined as a period of 2 hours or less. Home Health Services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health Services are covered. Home Health Services do not include services by 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 even if that person is an Other Health Care Professional. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations. Physical, occupational, and other Outpatient Therapy Services provided in the home are not subject to the Home Health Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Outpatient Therapy Services Maximum shown in The Schedule.

HC-COV863 01-20

Hospice Care Services

- charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
  - by a Hospice Facility for Bed and Board and Services and Supplies;
  - by a Hospice Facility for services provided on an outpatient basis;
  - by a Physician for professional services;
  - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
  - for pain relief treatment, including drugs, medicines and medical supplies;
  - by an Other Health Care Facility for:
    - part-time or intermittent nursing care by or under the supervision of a Nurse;

- part-time or intermittent services of an Other Health Care Professional;
- physical, occupational and speech therapy;
- medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

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

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

Mental Health and Substance Use Disorder Services

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

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

Inpatient Mental Health Services

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

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

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

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

Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group or Mental Health Partial Hospitalization or Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

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

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

Inpatient Substance Use Disorder Rehabilitation Services

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

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

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

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

Outpatient Substance Use Disorder Rehabilitation Services

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

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

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

Substance Use Disorder Detoxification Services

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

Exclusions

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

- treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- counseling for activities of an educational nature.
- counseling for borderline intellectual functioning.
- counseling for occupational problems.
- counseling related to consciousness raising.
- vocational or religious counseling.
- I.Q. testing.
- custodial care, including but not limited to geriatric day care.
- psychological testing on children requested by or for a school system.
- occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

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 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. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

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, respirators, wheel chairs, and dialysis machines.

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.

- **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs.
- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps.
- **Car/Van Modifications.**
- **Air Quality Items:** room humidifiers, vaporizers, air purifiers and electrostatic machines.
- **Blood/Injection Related Items:** blood pressure cuffs, centrifuges, nova pens and needleless injectors.
- **Other Equipment:** heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines.

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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:

- Non-foot orthoses – only the following non-foot orthoses are covered:
  - rigid and semi-rigid custom fabricated orthoses;
  - semi-rigid prefabricated and flexible orthoses; and
  - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
  - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
  - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
  - for persons with neurologic or neuromuscular 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;
- 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 or power controls for prosthetic limbs and terminal devices; and
- myoelectric prostheses peripheral nerve stimulators.

HC-COV732 M 01-19

Infertility Services

- charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; and diagnostic evaluations.

  Infertility is defined as:

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

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

However, the following are specifically excluded infertility services:

- Infertility drugs;
- Artificial Insemination;
- In vitro fertilization (IVF); gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT) and variations of these procedures;
- Reversal of male and female voluntary sterilization;
- Infertility services when the infertility is caused by or related to voluntary sterilization;
- Donor charges and services;
- Cryopreservation of donor sperm and eggs; and
- Any experimental, investigational or unproven infertility procedures or therapies.

HC-COV733M 01-19

Outpatient Therapy Services

Charges for the following therapy services:

Cognitive Therapy, Occupational Therapy, Osteopathic Manipulation, Physical Therapy, Pulmonary Rehabilitation, Speech Therapy

- Charges for therapy services are covered when provided as part of a program of treatment.

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

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 Illness, 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 Illness or Injury or Sickness.

Therapy services that are not covered include:

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

A separate Copayment applies to the services provided by each provider for each therapy type per day.

HC-COV864 01-20

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.

HC-COV631 12-17

Transplant Services

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

Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell,

autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral.

All Transplant services, other than cornea, are covered at 100% after deductible when received at Cigna LIFESOURCE Transplant Network® facilities. Cornea transplants are not covered at Cigna LIFESOURCE Transplant Network® facilities. Transplant services received at facilities other than Cigna LIFESOURCE Transplant Network® facilities are not covered.

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

Transplant Travel Services

Charges made for non-taxable travel expenses incurred by you in connection with a pre-approved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for transportation and lodging are available to you only if you are the recipient of a preapproved organ/tissue transplant from a designated Cigna LIFESOURCE Transplant Network® facility. The term recipient is defined to include a person receiving authorized transplant related services during any of the following: evaluation, candidacy, transplant event, or post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); and lodging while at, or traveling to and from the transplant site.

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

These benefits are only available when the covered person is the recipient of an organ/tissue transplant. Travel expenses for the designated live donor for a covered recipient are covered subject to the same conditions and limitations noted above. Charges for the expenses of a donor companion are not covered. No benefits are available when the covered person is a donor.

HC-COV482M 12-15

Medical Pharmaceuticals

The Plan's medical benefit program 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 provided under the Plan's prescription drug benefit program are described in the section of this booklet entitled "Prescription Drug Benefits."

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. Benefits payable under this section include Medical Pharmaceuticals whose administration may initially, or typically, require Physician oversight but may be self-administered under certain conditions specified in the product's FDA labeling.

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

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

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

HC-COV526M 10-16

Gene Therapy

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

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

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

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

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

Gene Therapy Travel Services

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

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

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

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, 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.

HC-COV873 01-20

Exclusions, Expenses Not Covered and General Limitations

Exclusions and Expenses Not Covered

Additional coverage limitations 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.
- treatment of an Injury or Sickness which is due to war, declared, or undeclared.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this Plan. For example, if Cigna determines that a provider or Pharmacy is or has waived, reduced, or forgiven any portion of its charges and/or any portion of Copayment, Deductible, and/or Coinsurance amount(s) you are required to pay for a Covered Expense (as shown on The Schedule) without

Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Expense, 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 the Plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by the Plan. This exclusion includes, but is not limited to, charges of a non-Participating Provider who has agreed to charge you or charged you at an In-Network benefits level or some other benefits level not otherwise applicable to the services received.

- charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- for or in connection with experimental, investigational or unproven services.

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

  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed;
  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the "Clinical Trials" sections of this booklet; or
  - the subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials as provided in the "Clinical Trials" sections of this booklet.

  In determining whether any such technologies, supplies, treatments, drug or Biologic therapies, or devices are experimental, investigational, and/or unproven, the utilization review Physician may rely on the clinical coverage policies maintained by Cigna or the Review Organization. Clinical coverage policies may incorporate, without limitation and as applicable, criteria relating to U.S. Food and Drug Administration-approved labeling, the standard medical reference compendia and peer-reviewed, evidence-based scientific literature or guidelines.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem.
- the following services are excluded from coverage regardless of clinical indications: acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. Charges made for services or supplies provided for or in connection with an accidental Injury to teeth are covered provided a continuous course of dental treatment is started within twelve months of an accident. Additionally, charges made by a Physician for any of the following Surgical Procedures are covered: excision of unerupted impacted tooth, including removal of alveolar bone and sectioning of tooth; removal of residual root (when performed by a Dentist other than the one who extracted the tooth).
- medical and surgical services, initial and repeat, intended for the treatment or control of obesity, except for treatment of clinically severe (morbid) obesity as shown in Covered Expenses, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.
- unless otherwise covered in this booklet, for reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this booklet.
- any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible for coverage as an eligible Dependent and is timely enrolled in the Plan.

- non-medical counseling and/or ancillary services, including but not limited to Custodial Services, educational services, vocational counseling, training and, rehabilitation services, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, return to work services, work hardening programs and driver safety courses.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care 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 Services" or "Breast Reconstruction and Breast Prostheses" sections of this booklet.
- private Hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets and dentures.
- 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.
- aids or devices that assist with non-verbal communications, including but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery).
- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- treatment by acupuncture.
- 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 booklet.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.
- all nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- telephone, email, internet consultations and telemedicine, except for telemedicine access with Amwell or the Employer's virtual Healthy Life Centers.
- massage therapy.
- abortions, unless a Physician certifies in writing that the pregnancy would endanger the life of the mother, or the expenses are incurred to treat medical complications due to abortion.
- for or in connection with the pregnancy of a Dependent child, other than Complications of Pregnancy.

General Limitations

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

- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.

- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- for charges which would not have been made if the person had no insurance.
- to the extent that they are more than Maximum Reimbursable Charges.
- to the extent of the exclusions imposed by any certification requirement shown in this booklet.
- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- charges made by any covered provider who is a member of your family or your Dependent's family.
- expenses incurred outside the United States other than expenses for Medically Necessary urgent or emergent care while temporarily traveling abroad.

Coordination of Benefits

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

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

Definitions

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

Plan

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

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

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

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 which limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

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

Secondary Plan

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

Reasonable Cash Value

An amount 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 if rendered under similar or comparable circumstances by other health care providers located within the immediate geographic area where the health care service was delivered.

Order of Benefit Determination Rules

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

- The Plan that covers a person as an enrollee or an employee shall be the Primary Plan and the Plan that covers that person as a Dependent shall be the Secondary Plan;
- For a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year;
- For the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - first, if a court decree states 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 noncustodial parent of the child, and
  - finally, the Plan of the spouse of the parent not having custody of the child.
- The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the

Plan that covers you as laid-off or retired employee (or as that employee's Dependent) shall be the secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

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

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

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

Effect on the Benefits of This Plan

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

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

Recovery of Excess Benefits

If the Plan pays charges for services and supplies that should have been paid by the Primary Plan, the Plan will have the right to recover such payments.
The Plan will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments were made by any insurance company, healthcare plan or other organization. If requested by the Plan, you shall execute and deliver to the Plan such instruments and documents as the Plan determines are necessary to secure the right of recovery.

Right to Receive and Release Information

The Plan, 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 the Plan 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.

Medicare Eligibles

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

(a) a former Employee who is eligible for Medicare due to age or disability and whose Plan coverage is continued for any reason as provided in this booklet (for example, due to electing COBRA continuation coverage);

(b) a former Employee's Dependent, or a former Dependent spouse or child, who is eligible for Medicare due to age or disability and whose Plan coverage is continued for any reason as provided in this booklet (for example, due to electing COBRA continuation coverage);

(c) any enrolled individual who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

Cigna will assume the amount payable under:

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

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

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

Expenses For Which A Third Party May Be Responsible

This Plan does not cover:

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

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 the paragraph immediately above, but only to the extent of the benefits provided by the Plan.

Lien of the Plan

By accepting benefits under this Plan, a Participant:

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

Additional Terms

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

- Any reference to state law in any other provision of this Plan shall not be applicable to this provision, if the Plan is governed by ERISA. By acceptance of benefits under the Plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.
- Participants must assist the Plan in pursuing any subrogation or recovery rights by providing requested information.

HC-SUB77M 01-17

Payment of Benefits

Prohibition on Assignment and Payment of Benefits

You may not assign to any party, including, but not limited to, a provider of healthcare services/items, your right to benefits under this Plan, nor may you assign any administrative, statutory, or legal rights or causes of action you may have under ERISA, including, but not limited to, any right to make a claim for Plan benefits, to request Plan or other documents, to file appeals of denied claims or grievances, to file lawsuits or assert any causes of action under ERISA, or to assert any other rights or remedies under this Plan. Any attempt to assign such rights and/or benefits shall be void and unenforceable under all circumstances. The foregoing prohibition on assignments applies to both Plan participants and their Dependents.

You may, however, authorize Cigna to pay any healthcare benefits under this Plan 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 the Plan, it is the provider's responsibility to reimburse the overpayment to you. The Plan may pay all healthcare benefits for Covered Services 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 directly to a Participating or Non-Participating Provider as the authority to assign any rights or benefits under this Plan to any party, including, but not limited to, a provider of healthcare services/items, or as a waiver of the Plan's prohibition against assignments.

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

If any person to whom benefits are payable is a minor or, in the opinion of Cigna is not able to give a valid receipt for any payment due 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 a Plan participant passes away, Cigna may receive notice that an executor of the estate has been established. Benefit payments for claims properly filed and payable under the terms of the Plan should be made payable to the executor.

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

Recovery of Overpayment

When an overpayment has been made by the Plan, the Plan will have the right at any time to: recover that overpayment from the person to whom or on whose behalf it was made; or offset the amount of that overpayment from a future claim payment from the Plan. In addition, your acceptance of benefits under this Plan separately creates an equitable lien by agreement pursuant to which the Plan may seek recovery of any overpayment. You agree that the Plan, in seeking recovery of any overpayment as a contractual right or as an equitable lien by agreement, may pursue the general assets of the person or entity to whom or on whose behalf the overpayment was made.

Calculation of Covered Expenses

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

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

HC-POB132M 01-19

Termination of Plan Coverage

Employees

Your coverage under the Plan will cease on the earliest date below:

- the date you cease to be an eligible Employee under the Plan for any reason.
- the last day for which you have made any required contribution for the Plan.
- the date the Plan is terminated.
- as soon as administratively practicable following the date you request that such coverage be terminated due to a qualified change event.
- the last day of the current plan year, if you voluntarily cancel your participation in the Plan during an open enrollment period.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your coverage under the Plan will be continued for a period of up to 90 days (with the exception of FMLA leave, in which case your insurance will terminate on the last day of your approved FMLA leave).

Dependents

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

- the date your coverage ceases.
- the date the individual is no longer an eligible Dependent, even if the Plan learns of the ineligibility at a later date (your child will continue to be an eligible Dependent, if all other criteria are met, until the end of the month in which your child turns age 26).
- the last day of the current plan year, if you voluntarily cancel your eligible Dependent's participation in the Plan during an open enrollment period.
- as soon as administratively practicable after you voluntarily cancel your Dependent's participation in the Plan due to a qualifying change event.
- the last day for which you have made any required contribution for the coverage.
- the date the Plan or Dependent coverage under the Plan is terminated.

HC-TRM128 M 12-17

Please Note: If you commit fraud or make a material misrepresentation in applying for or obtaining coverage under the Plan, or in obtaining benefits under the Plan, then the Plan may terminate coverage for you and/or any other individual you have enrolled in the Plan as of a date to be determined at the Plan Administrator's discretion, consistent with applicable law including the rules regarding rescission.

Rescissions

Your coverage may not be rescinded (retroactively terminated) by Cigna or the plan sponsor unless the plan sponsor or an individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud; or the plan sponsor or individual (or a person seeking coverage on behalf of the individual) makes an intentional misrepresentation of material fact.

HC-TRM80 M 01-11

Medical Benefits Extension During Hospital Confinement

If the Medical Benefits under this plan cease for you or your Dependent, 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 you are covered for medical benefits under another group plan;
- the date you or your Dependent is no longer Hospital Confined; or
- 3 months from the date your Medical Benefits cease.

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.

Note: Limited Extension of Benefits applies to Inpatient Hospital Facility Claims Only, No Professional Charges.

HC-BEX44 01-13

Federal Requirements

The following pages explain your rights and responsibilities under federal laws and regulations.

HC-FED1 M 10-10

Notice of Provider Directory/Networks

Notice Regarding Provider Directories and Provider Networks

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

HC-FED78 10-10

Qualified Medical Child Support Order (QMCSO)

Eligibility for Coverage Under a QMCSO

If a Qualified Medical Child Support Order (QMCSO) is issued for your child, that child will be eligible for coverage as required by the order and you will be entitled to enroll yourself and your child as required by the order outside of the Plan's open enrollment period.

Qualified Medical Child Support Order Defined

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

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

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

Participants and beneficiaries can obtain, without charge, a copy of the Plan's procedures governing QMCSO determinations from the Plan Administrator.

Payment of Benefits

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

HC-FED4 M 10-10

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

If you or your eligible Dependent(s) experience a special enrollment event as described below, you or your eligible Dependent(s) may be entitled to enroll in the Plan outside of a designated enrollment period upon the occurrence of one of the special enrollment events listed below. If you are already enrolled in the Plan, you may request enrollment for you and your eligible Dependent(s) under a different option offered by the Employer for which you are currently eligible. If you are not already enrolled in the Plan, you must request special enrollment for yourself in addition to your eligible Dependent(s) by calling the Benefits Service Center at 1-866-481-4922. You and all of your eligible Dependent(s) must be covered under the same option. The special enrollment events include:

- **Acquiring a new Dependent.** If you acquire a new Dependent(s) through marriage, birth, adoption or placement for adoption, you may request special enrollment for any of the following combinations of individuals if not already enrolled in the Plan: Employee only; spouse only;

Employee and spouse; Dependent child(ren) only; Employee and Dependent child(ren); Employee, spouse and Dependent child(ren). Enrollment of Dependent children is limited to the newborn or adopted children or children who became Dependent children of the Employee due to marriage. **You must request enrollment within 31 days of the marriage, birth, adoption, or placement for adoption, regardless of whether the enrollment will result in an increase in your benefit contributions (*i.e.*, you are already enrolled in Employee + Children or Family coverage).**

- **Loss of eligibility for State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) were covered under a state Medicaid or CHIP plan and the coverage is terminated due to a loss of eligibility, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after termination of Medicaid or CHIP coverage.
- **Loss of eligibility for other coverage (excluding continuation coverage).** If coverage was declined under this Plan for yourself and your Dependents due to coverage under another plan, and eligibility for the other coverage is lost, you and all of your eligible Dependent(s) may request special enrollment in this Plan.This provision applies to loss of eligibility as a result of any of the following:
  - divorce or legal separation;
  - cessation of Dependent status (such as reaching the limiting age);
  - death of the Employee;
  - termination of employment;
  - reduction in work hours to below the minimum required for eligibility;
  - you or your Dependent(s) no longer reside, live or work in the other plan's network service area and no other coverage is available under the other plan;
  - you or your Dependent(s) incur a claim which meets or exceeds the lifetime maximum limit that is applicable to all benefits offered under the other plan; or
  - the other plan no longer offers any benefits to a class of similarly situated individuals.
- **Termination of Employer contributions (excluding continuation coverage).** If another employer ceases all contributions toward the Employee's or Dependent's other coverage, special enrollment may be requested in this Plan for you and your eligible Dependent(s).
- **Exhaustion of COBRA or other continuation coverage.** Special enrollment may be requested in this Plan for you and all of your eligible Dependent(s) upon exhaustion of COBRA or other continuation coverage. If you or your Dependent(s) elect COBRA or other continuation coverage following loss of coverage under another plan, the COBRA or other continuation coverage must be exhausted before any special enrollment rights exist under this Plan. An individual is considered to have exhausted COBRA or other continuation coverage only if such coverage ceases: due to failure of the Employer or other responsible entity to remit premiums on a timely basis; when the person no longer resides or works in the other plan's service area and there is no other COBRA or continuation coverage available under the plan; or when the individual incurs a claim that would meet or exceed a lifetime maximum limit on all benefits and there is no other COBRA or other continuation coverage available to the individual. This does not include termination of an Employer's limited period of contributions toward COBRA or other continuation coverage as provided under any severance or other agreement.
- **Eligibility for employment assistance under State Medicaid or Children's Health Insurance Program (CHIP).** If you and/or your Dependent(s) become eligible for assistance with group health plan premium payments under a state Medicaid or CHIP plan, you may request special enrollment for yourself and any affected Dependent(s) who are not already enrolled in the Plan. You must request enrollment within 60 days after the date you are determined to be eligible for assistance.

Except as stated above, special enrollment must be requested within 31 days after the occurrence of the special enrollment event by calling the Benefits Service Center at 1-866-481-4922. If the special enrollment event is the birth or adoption of a Dependent child, coverage will be effective immediately on the date of birth, adoption or placement for adoption if enrollment is timely requested. Coverage with regard to any other special enrollment event will be effective no later than the first day of the first calendar month following receipt of the request for special enrollment.

If you have any questions about your special enrollment rights under the Plan, please contact the Benefits Service Center at 1-866-481-4922.

HC-FED96M 04-17

Effect of Section 125 Tax Regulations on This Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, you may agree to a pretax salary reduction put toward the cost of your benefits.

Otherwise, you will receive your taxable earnings as cash (salary).

A. Coverage elections

Per Section 125 regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed:

- if you meet Special Enrollment criteria and enroll as described in the Special Enrollment section; or
- if you meet the criteria shown in the following Sections B through G and enroll for or change coverage within 31 days of the qualifying change event.

To make an election change, you must call the Benefits Service Center at 1-866-481-4922 within 31 days of the qualifying change event.

B. Change of status

A change in status is defined as:

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

C. Court order

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

D. Medicare or Medicaid eligibility/entitlement

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

E. Change in cost of coverage

If the cost of benefits increases or decreases during a plan year by an insignificant amount (as determined by the Plan Administrator), your Employer may, in accordance with plan terms, automatically change your elective contribution.

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

F. Changes in coverage of spouse or Dependent under another employer's plan

You may make a coverage election change if the plan of your spouse or Dependent: incurs a change such as adding or deleting a benefit option; allows election changes due to Special Enrollment, Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or this Plan and the other plan have different periods of coverage or open enrollment periods.

G. Enrollment in a Qualified Health Plan (QHP)

The Employee must be eligible for a Special Enrollment Period to enroll in a QHP through a Marketplace or the Employee wants to enroll in a QHP through a Marketplace during the Marketplace's annual open enrollment period; and the disenrollment from the Plan corresponds to the intended enrollment of the Employee (and family) in a QHP through a Marketplace for new coverage effective beginning no later than the day immediately following the last day of the original coverage under the Plan.

HC-FED95 M 04-17

Eligibility for Coverage for Adopted Children

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

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

The provisions in this document that describe requirements for enrollment and effective date of coverage for a newborn child will also apply to an adopted child or a child placed with you for adoption.

HC-FED67 M 09-14

Coverage for Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under a federal law known as the "Newborns' and Mothers' Health Protection Act": restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section; or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

HC-FED11 10-10

Women's Health and Cancer Rights Act (WHCRA)

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

HC-FED12 10-10

Group Plan Coverage Instead of Medicaid

If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

HC-FED13 10-10

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

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

Continuation of Health Insurance During Leave

Your health coverage under the Plan will be continued during a leave of absence if:

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

Your Plan coverage will be continued on the same terms and conditions as if you were still active (that is, the Employer will continue to pay its share of the contributions). If you are on a paid FMLA leave of absence, your share of the benefit contributions will be paid by the method normally used during any paid leave (*i.e.*, on a pre-tax salary reduction basis). If you are on an unpaid FMLA leave of absence, then the Employer will fund coverage during the leave and withhold "catch-up" amounts from your pay when you return to work.

Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, as amended, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

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

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

HC-FED93 M 10-17

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

The Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical coverage under the Plan for you and your Dependents.

Continuation of Coverage

For leaves of less than 91 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 91 days or more, you may continue coverage for yourself and your Dependents as follows:

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

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

Your Employer may charge you and your Dependents up to 102% of the total premium for continuation coverage that extends beyond 90 days of qualified military leave.

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave of absence because you do not elect USERRA at the expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if you gave your Employer advance written or verbal notice of your military service leave, and the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

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

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

HC-FED18 M 10-10

Claim Determination Procedures under ERISA

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

Procedures Regarding Medical Necessity Determinations

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

Certain services require prior authorization in order to be covered. The booklet describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care professional) must request prior authorization according to the procedures described below, in the booklet, and in your provider's network participation documents as applicable.

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

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

Preservice Determinations

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

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

However, if necessary information is missing from the request, Cigna will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to Cigna within 48 hours after receiving the

notice. Cigna will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

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

Concurrent Determinations

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

Postservice Determinations

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

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

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: information sufficient to identify the claim including, if applicable, the date of service, provider and claim amount; diagnosis and treatment codes, and their meanings; the specific reason or reasons for the adverse determination including, if applicable, the denial code and its meaning and a description of any standard that was used in the denial; reference to the specific plan provisions on which the determination is based; a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal, (if applicable); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim; and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; a description of any available internal appeal and/or external review process(es); information about any office of health insurance consumer assistance or ombudsman available to assist you with the appeal process; and in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

Appointment of Authorized Representative

You may appoint an authorized representative to assist you in submitting a claim or appealing a claim denial. However, Cigna may require you to designate your authorized representative in writing using a form approved by Cigna. At all times, the appointment of an authorized representative is revocable by you. To ensure that a prior appointment remains valid, Cigna may require you to re-appoint your authorized representative, from time to time.

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

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

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

HC-FED88 01-17

Medical - When You Have a Complaint or an Appeal

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

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

Start With Customer Service

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, contractual benefits, or a rescission of coverage, you may call the toll-free number on your ID card, explanation of benefits, or claim form and explain your concern to one of our Customer Service representatives. You may also express that concern in writing.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

Internal Appeals Procedure

To initiate an appeal of an adverse benefit determination, you must submit a request for an appeal to Cigna within 180 days of receipt of a denial notice. However, if Cigna reduces or terminates coverage (except where the reduction or termination is due to a plan amendment or termination) for an ongoing course of treatment that Cigna previously approved, then to initiate an appeal you must submit a request for an appeal of that reduction or termination in coverage within 30 days of receipt of the denial notice. If you appeal timely a reduction or termination in coverage for an ongoing course of treatment that Cigna previously approved, you will receive, as required by applicable law, continued coverage pending the outcome of an appeal.

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

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

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

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

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your health care provider would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay.

If you request that your appeal be expedited based on (a) above, you may also ask for an expedited external review at the same time, if the time to complete an expedited review would be detrimental to your medical condition.

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

External Review Procedure

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

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

To request an external review, you must notify the Appeals Coordinator within 4 months of your receipt of Cigna's appeal review denial. Cigna will then forward the file to a

randomly selected IRO. The IRO will render an opinion within 45 days.

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

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: information sufficient to identify the claim including, if applicable, the date of service, provider and claim amount; diagnosis and treatment codes, and their meanings; the specific reason or reasons for the adverse determination including, if applicable, the denial code and its meaning and a description of any standard that was used in the denial; reference to the specific plan provisions on which the determination is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined below; a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a), upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; and information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process. A final notice of an adverse determination will include a discussion of the decision.

Relevant Information

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

Legal Action

After you have exhausted the Plan's internal appeal procedures, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the appeals procedure.

If you wish to file an action in court, you must do so within one year of completing the Plan's claim and appeal procedures (including, if applicable, external review).

Any action arising out of or in connection with the Plan may only be brought or filed in Federal District Court for the Northern District of Georgia, Atlanta Division.

HC-FED107 M 01-20

COBRA Continuation Rights Under Federal Law

For You and Your Dependents

What is COBRA Continuation Coverage?

Under federal law, you and/or your Dependents must be given the opportunity to continue health insurance when there is a "qualifying event" that would result in loss of coverage under the Plan. You and/or your Dependents will be permitted to continue the same coverage under which you or your Dependents were covered on the day before the qualifying event occurred. You and/or your Dependents cannot change coverage options until the next open enrollment period.

When is COBRA Continuation Available?

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

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

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

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

Who is Entitled to COBRA Continuation?

Only a "qualified beneficiary" (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were

covered by the Plan on the day the qualifying event occurred: you, your spouse, and your Dependent children. Each qualified beneficiary has their own right to elect or decline COBRA continuation coverage even if you decline or are not eligible for COBRA continuation.

Secondary Qualifying Events

If, as a result of your termination of employment or reduction in work hours, your Dependent(s) have elected COBRA continuation coverage and one or more Dependents experience another COBRA qualifying event, the affected Dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (7 months if the secondary event occurs within the disability extension period) for a maximum of 36 months from the initial qualifying event. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage or within the disability extension period discussed below. Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event. Secondary qualifying events are: your death; your divorce or legal separation; or, for a Dependent child, failure to continue to qualify as a Dependent under the Plan, to the extent that such an event would have caused your Dependent to lose coverage under the Plan had the first qualifying event not occurred.

This extension due to a second qualifying event is available only if you notify the COBRA Administrator in writing of the second qualifying event within 60 days after the date of the second qualifying event. If you fail to provide notice of a second qualifying event during this 60-day notice period, then there will be no extension of coverage due to a second qualifying event.

All causes for "Termination of COBRA Continuation" listed below will also apply to the period of extension due to a second qualifying event.

Disability Extension

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

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

- SSA must determine that the disability occurred prior to or within 60 days after the disabled individual elected COBRA continuation coverage; and
- A copy of the written SSA determination must be provided to the COBRA Administrator within 60 calendar days (1) after the latest of (i) the date the SSA determination is made; (ii) the date of the qualifying event (*i.e.*, the employee's termination of employment or reduction of hours); and (iii) the date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event AND (2) before the end of the initial 18-month continuation period.

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

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

Medicare Extension for Your Dependents

When the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B or both) within the 18 months before the qualifying event, COBRA continuation coverage for your Dependents will last for up to 36 months after the date you became enrolled in Medicare. This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months before the termination or reduction of hours and you notify the COBRA Administrator of your entitlement to the extension when electing COBRA continuation coverage. Your COBRA continuation coverage will last for up to 18 months from the date of your termination of employment or reduction in work hours.

Termination of COBRA Continuation

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

- the end of the COBRA continuation period of 18, 29 or 36 months, as applicable;
- failure to pay the required premium within 30 calendar days after the due date;
- the Employer ceases to provide any group health coverage for its employees;
- after electing COBRA continuation coverage, a qualified beneficiary enrolls in Medicare (Part A, Part B, or both);
- after electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan, unless the qualified beneficiary has a condition for which the new plan limits or excludes coverage under a pre-existing condition provision. In such case coverage will continue until the earliest of: the end of the applicable maximum period; the date the pre-existing condition

provision is no longer applicable; or the occurrence of an event described in one of the bullets above;

- any reason the Plan would terminate coverage of a participant or beneficiary who is not receiving continuation coverage (e.g., fraud).

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

If you and/or your Dependents move out of the Employer's service area or the Employer eliminates a service area in your location, your COBRA continuation coverage under the plan will be limited to out-of-network coverage only. In-network coverage is not available outside of the Employer's service area. If the Employer offers another benefit option through Cigna or another carrier which can provide coverage in your location, you may elect COBRA continuation coverage under that option.

Employer's Notification Requirements

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

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

How to Elect COBRA Continuation Coverage

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

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

How Much Does COBRA Continuation Coverage Cost?

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

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

When and How to Pay COBRA Premiums

First payment for COBRA continuation

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

Subsequent payments

After you make your first payment for COBRA continuation coverage, you will be required to make subsequent payments of the required premium for each additional month of coverage. Payment is due on the first day of each month. If you make a payment on or before its due date, your coverage

under the Plan will continue for that coverage period without any break.

Grace periods for subsequent payments

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

You Must Give Notice of Certain Qualifying Events

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

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

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

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

COBRA Administrator

Please contact the COBRA Administrator with any questions about COBRA continuation coverage under the Plan at the following:

TaxSaver Plan
P. O. Box 609002
Dallas, TX 75360
Phone: 1-800-328-4337
Website/Email: csr@taxsaverplan.com

Newly Acquired Dependents

If you acquire a new Dependent through marriage, birth, adoption or placement for adoption while your coverage is being continued, you may cover such Dependent under your COBRA continuation coverage. Your newborn or adopted Dependent child is a qualified beneficiary and may continue COBRA continuation coverage for the remainder of the coverage period following your early termination of COBRA coverage or due to a secondary qualifying event.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the COBRA Administrator identified above. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/agencies/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.gov**.

Keep the Plan Informed of Address Changes

To protect your family's rights, let the COBRA Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

HC-FED66M 07-14

ERISA Required Information

The name of the Plan is:

Mohawk ESV, Inc. Health and Welfare Benefit Plan

The Open Access Plus Health Savings Account is a medical and prescription drug benefit program offered under the

Mohawk ESV, Inc. Health and Welfare Benefit Plan. References in this booklet to the "Plan" refer to the Open Access Plus Health Savings Account benefit program only.

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

Mohawk ESV, Inc.
160 South Industrial Boulevard
Calhoun, GA 30701
706-629-7721

Employer Identification Number (EIN):	Plan Number:
20-1880191	501

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

Benefits Committee of Mohawk ESV, Inc.
160 South Industrial Boulevard
Calhoun, GA 30701
706-629-7721

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

Mohawk ESV, Inc.
Attn: Director of Benefits
160 South Industrial Boulevard
Calhoun, GA 30701
706-629-7721

Service of process may also be made on the Plan Administrator.

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

The Cigna Claim Office responsible for this Plan

The cost of the Plan is shared by Employee and Employer.

The benefits provided under the Plan are paid from the general assets of the Employer and Employee contributions.

The Employee cost of the Plan will be stated in the enrollment materials provided to you when you are first eligible for the Plan and each year during open enrollment. The portion of the enrollment materials listing the amount of Employee contributions for the Plan is considered part of this booklet only for the purpose of identifying the amount of the Employee contributions required each plan year.

The Plan's fiscal year ends on 12/31.

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

Plan Type

The Mohawk ESV, Inc. Health and Welfare Benefit Plan is a welfare benefit plan.

The Open Access Plus Health Savings Account benefit program described in this booklet is a medical and prescription drug benefit program offered under the Mohawk ESV, Inc. Health and Welfare Benefit Plan.

The Mohawk ESV, Inc. Health and Welfare Benefit Plan also provides other welfare benefit programs, which are described in separate summaries.

Funding Type and Plan Administration

The Plan is funded from the general assets of the Employer and Employee contributions. The Benefits Committee of Mohawk ESV, Inc. serves as the Plan Administrator of the Plan. The Plan Administrator has delegated its authority and fiduciary duties with respect to initial claims determinations under the Plan to the claims administrators for the Plan. Cigna serves as the claims administrator for medical benefit claims and appeals, and Express Scripts serves as the claims administrator for prescription drug benefit claims and appeals.

Discretionary Authority

The Plan Administrator has delegated to Cigna and Express Scripts the discretionary authority to interpret and apply Plan terms and to make factual determinations in connection with their review of benefit claims under the Pplan. Such discretionary authority is intended to include, but is not limited to, the determination of whether a person is entitled to benefits under the Plan, and the computation of any and all benefit payments. The Plan Administrator has also delegated to Cigna and Express Scripts the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative. These claims administrators have the full extent of the Plan Administrator's authority and duties with respect to those responsibilities delegated to them, including full discretionary authority to interpret the Plan; determine eligibility for and the amount of benefits under the Plan; and exercise all of the power and authority contemplated by ERISA with respect to making initial claim determinations under the Plan. The Plan's claims administrators have the necessary discretionary authority and control to require deferential judicial review. Therefore, the claims administrators' exercise of discretion in their interpretation of the Plan's written terms and their finding of fact in their role as the Plan's claims fiduciary will not be overturned unless a court determines they are arbitrary and capricious.

Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. Any amendment will be in writing and duly adopted in accordance with the Plan's amendment procedures. No

consent of any participant or beneficiary is required to terminate, modify, amend or change the Plan.

If the Plan is terminated, the rights of participants and beneficiaries will be limited to claims incurred before the Plan's termination. In connection with the termination, the Plan Administrator may establish a deadline by which all claims must be submitted for consideration. Benefits will be paid only for covered claims incurred prior to the termination date and submitted in accordance with the rules established by the Plan Administrator. Nothing in this booklet, the Plan document, or any other communications describing the Plan shall be construed to provide vested, non-forfeitable, non-terminable, or non-changeable benefits or rights thereto.

Statement of Rights

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary financial report.

Continue Group Health Plan Coverage

- continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this booklet and the documents governing the Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents governing the Plan or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a federal court, but only after you have exhausted (or are deemed to have exhausted) the Plan's administrative claim and appeal procedures.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

You must file your claim in federal court before the expiration of the Plan's limitations period, as described in the "Medical – When You Have a Complaint or an Appeal" section above, or your claim will be dismissed. In addition, any action arising out of or in connection with the Plan may only be filed in the United States District Court, Northern District of Georgia.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HC-FED72 M 05-15

Definitions

Active Service

You will be considered in Active Service:

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

HC-DFS1095 12-17

Bed and Board

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

HC-DFS2 04-10
V2

Biologic

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

HC-DFS840 10-16

Biosimilar

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

HC-DFS841 10-16

Business Decision Team

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

HC-DFS843 10-16

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.

HC-DFS1193 01-19

Chiropractic Care

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

HC-DFS55 04-10
V1

Complications of Pregnancy - For Medical Insurance

Expenses will be considered to be incurred for Complications of Pregnancy if they are incurred for: (a) an extrauterine pregnancy; (b) a pregnancy which ends by Caesarean section or miscarriage (other than elective abortion); or (c) a Sickness resulting from pregnancy.

DFS19

Custodial Services

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

HC-DFS4 04-10
V1

Dependent

Dependents are defined in the "Eligibility – Effective Date" section of this booklet under the subheading "Eligible Dependents."

HC-DFS872 M 10-16

Emergency Medical Condition

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

HC-DFS394 11-10

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.

HC-DFS393 11-10

Employee

The term Employee is defined in the "Eligibility – Effective Date" section of this booklet under the subheading "Eligibility for Employee Coverage."

HC-DFS1094 M 12-17

Employer

The term Employer means Mohawk ESV, Inc., the plan sponsor self-insuring the benefits described in this booklet, and its affiliates that participate in the Plan on whose behalf Cigna is providing claim administration services.

HC-DFS8 04-10
V1 M

Essential Health Benefits

Essential health benefits means, to the extent covered under the plan, expenses incurred with respect to covered services, in at least the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

HC-DFS411 01-11

Expense Incurred

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

HC-DFS10 04-10
V1

Free-Standing Surgical Facility

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.

HC-DFS11 04-10
V1

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.

HC-DFS51 04-10
V1

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.

HC-DFS52 04-10
V1

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.

HC-DFS53 04-10
V1

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, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: specializes in treatment of Mental Health and Substance 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 will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

HC-DFS806 12-15

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

HC-DFS807 12-15

Injury

The term Injury means an accidental bodily injury.

HC-DFS12 04-10
V1

Maintenance Treatment

The term Maintenance Treatment means:

- treatment rendered to keep or maintain the patient's current status.

HC-DFS56 04-10
V1

Maximum Reimbursable Charge - Medical

The Maximum Reimbursable Charge for covered services for Open Access Plus is determined based on the lesser of:

- the provider’s normal charge for a similar service or supply; or
- a policyholder-selected 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 fee for the same or similar service within the geographic market.

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

In some cases, a Medicare based schedule will not be used and the Maximum Reimbursable Charge for covered services is determined based on the lesser of:

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

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

HC-DFS1365 06-19

Medicaid

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.

HC-DFS16 04-10
V1

Medical Pharmaceutical

An FDA-approved prescription pharmaceutical product, including a Specialty Prescription Drug Product, typically required to be administered in connection with a covered service by a Physician or other health care provider within the scope of the provider's license. This definition includes certain pharmaceutical products whose administration may initially or typically require Physician oversight but may be self-administered under certain conditions specified in the product’s FDA labeling. This definition does not include any charges for mobile, web-based or other electronic applications or software, even if approved for marketing as a prescription product by the FDA.

HC-DFS848 10-16

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 care provider;
- not more costly than an alternative service(s), medication(s) or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis or treatment of your Sickness, Injury, condition, disease or its symptoms; and
- rendered in the least intensive setting that is appropriate for the delivery of the services, supplies or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications or settings when determining least intensive setting.

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

HC-DFS1195 01-19

Medicare

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

HC-DFS17 04-10
V1

Necessary Services and Supplies

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

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

HC-DFS21 04-10
V1

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's Business Decision Team makes a Prescription Drug List coverage status decision.

HC-DFS850 10-16

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."

HC-DFS22 04-10
V1

Other Health Care Facility/Other Health Professional

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

HC-DFS23 04-10
V1

Participating Provider

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, the Charges for which are Covered Expenses. It includes an entity that has directly or indirectly contracted with Cigna to arrange, through contracts with providers of services and/or supplies, for the provision of any services and/or supplies, the Charges for which are Covered Expenses.

HC-DFS1194 01-19

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

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

HC-DFS412 01-11

Pharmacy & Therapeutics (P&T) Committee

A committee comprised of both voting and non-voting Cigna-employed clinicians, Medical Directors and Pharmacy Directors and non-employees such as Participating Providers that represent a range of clinical specialties. The committee regularly reviews Medical Pharmaceuticals for safety and efficacy, the findings of which clinical reviews inform coverage status decisions made by the Business Decision Team. The P&T Committee's review may be based on consideration of, without limitation, U.S. Food and Drug Administration-approved labeling, standard medical reference compendia, or scientific studies published in peer-reviewed English-language bio-medical journals.

HC-DFS852 10-16

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.

HC-DFS25 04-10
V1

Prescription Drug List

A list that categorizes drugs, Biologics (including Biosimilars) or other products covered under the plan's Prescription Drug Benefits that have been approved by the U.S. Food and Drug Administration (FDA). This list is developed by Cigna's Business Decision Team based on clinical factors communicated by the P&T Committee, and adopted by your Employer 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.

HC-DFS854 10-16

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. A Prescription Drug Product includes a drug, Biologic or product that, due to its characteristics, is approved by the FDA for self-administration or administration by a non-skilled caregiver. For the purpose of benefits under the plan, this definition also includes:

- The following diabetic supplies: alcohol pads, swabs, wipes, Glucagon/Glucagen, injection aids, insulin pump accessories (but excluding insulin pumps), needles including pen needles, syringes, test strips, lancets, urine glucose and ketone strips;
- Needles and syringes for self-administered medications or Biologics covered under the plan's Prescription Drug benefit; and
- Inhaler assistance devices and accessories, peak flow meters.

This definition does not include any charges for mobile, web-based or other electronic applications or software, even if approved for marketing as a prescription product by the FDA.

HC-DFS855 10-16

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.

HC-DFS856 10-16

Preventive Treatment

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

HC-DFS57 04-10
V1

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 voluntarily selected by you and is contracted as a Primary Care Physician with, as authorized by Cigna, to provide or arrange for medical care for you or any of your insured Dependents.

HC-DFS40 04-10
V1

Psychologist

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.

HC-DFS26 04-10
V1

Retirement

Under certain circumstances, Employees can continue to participate in the Mohawk ESV, Inc. Health Care Plan (the "Mohawk Plan") after they retire from employment.

If you retire after you reach age 60 and prior to turning age 65 with ten (10) years of service your benefits may continue until:

A. The date that you become covered under another Group Health Plan or the date you become eligible for the Federal Medicare Program (other than for end-stage renal failure);

B. The date in which COBRA payment is not made;

C. The date that a covered Dependent no longer meets the definition of Dependent;

D. The last day of the month following your death.

Once you or any of your covered eligible Dependent(s) reach age 65 or become eligible for any other group medical coverage, including becoming eligible for the Federal Medicare Program (other than for end-stage renal failure), your medical coverage under the Mohawk Plan will end.

However, if you are eligible for Medicare, but your spouse is not, your spouse can still be covered under the Mohawk Plan until he/she turns 65 or becomes eligible for other group medical coverage or Medicare (other than for end-stage renal failure).

Your benefits under the Mohawk Plan will be the same as those provided to active covered Employees. The premiums

for this medical coverage will be equal to equivalent COBRA premiums under the Mohawk Plan. This amount can change annually and you are responsible for payment of these premiums.

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.

HC-DFS808 12-15

Sickness – For Medical Insurance

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

HC-DFS50 04-10
V1

Skilled Nursing Facility

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.

HC-DFS31 04-10
V1

Specialist

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

HC-DFS33 04-10
V1

Specialty Prescription Drug Product

A 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 Medical Pharmaceutical is prescribed and used for the treatment of a complex, chronic or rare condition; whether the Medical Pharmaceutical has a high acquisition cost; and, whether the 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 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 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.

HC-DFS858 10-16

Stabilize

Stabilize means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

HC-DFS413 01-11

Terminal Illness

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

HC-DFS54 04-10
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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.

HC-DFS34 04-10
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The following pages describe the features of your Cigna Choice Fund - Health Savings Account. Please read them carefully.

What You Should Know About Cigna Choice Fund® – Health Savings Account

Cigna Choice Fund is designed to give you:

Control

You decide how much you'd like to contribute (up to federal limits) to your Health Savings Account. You decide how and when to access your account. And the money in the account is yours until you spend it. Unused dollars remain in your account from year to year and earn interest.

Choice

You have the freedom to choose any licensed doctor, **even those who do not participate with** Cigna. Your costs are lower for services from Cigna contracted health care professionals and facilities because they have agreed to accept discounted payments to help you make the most of your health care dollars.

Easy Access to your HSA Dollars

You can draw money directly from your health savings account using your HSA debit card, checkbook (if purchased) or online bill pay. Or, you may choose automatic claim forwarding, which allows qualified medical claims to pay directly from your account to your doctor or hospital.

Flexibility and Tax Savings

You can also choose to pay for medical expenses out of your pocket until you reach the deductible, allowing you to save for qualified health care expenses in future years or retirement. You are not taxed on your HSA withdrawals unless you use the money to pay for nonqualified expenses.

Health Information and Education

Call the toll-free number on your ID card to reach Cigna's 24-Hour Health Information Line℠, giving you access to trained nurses and an audio library of health topics 24 hours a day. In addition, the Cigna Healthy Pregnancies, Healthy Babies® program provides prenatal education and support for mothers-to-be.

Tools & Support

We help you keep track of your health and coverage with online benefits information, transactions, and account activity; medical and drug cost comparisons; monthly statements; and more. You also have 24/7/365 toll-free access to a dedicated Customer Service team, specially trained to answer your questions and address your needs.

Savings on Health and Wellness Products and Services

Through Cigna Healthy Rewards®, you can save money on a variety of health-related products and services. Offerings include laser vision correction, acupuncture, chiropractic care, weight loss programs, fitness club and equipment discounts, and more.

The Basics

Who is eligible?

You are eligible to open a Health Savings Account only if you are covered under a federally qualified high deductible health plan, such as the one described in this booklet. You cannot be covered by Medicare or any other individual or group health plan that is not a federally qualified high deductible health plan. You can no longer contribute to the HSA once you: become entitled to Medicare due to age; or are no longer covered under a high deductible health plan. However, you will still be able to use the HSA funds for qualified health care expenses.

How does it work?

The Health Savings Account combines a health care plan with a tax-free savings account.

1. **You, your employer or both may contribute to your account.** Contributions are tax-free up to federal limits.
2. **You choose how to pay for qualified health care expenses:**
   - You may pay for qualified expenses on your own using a debit card, checkbook (if purchased) or online bill pay that draws from your health savings account.
   - You may choose the Automatic Claim Forwarding option, allowing qualifying medical expenses to be paid directly to your doctor, hospital, or other facility from your HSA. You can change your election at any time during the year.
   - You may choose to cover your expenses using other personal funds. This allows you to save the money in your HSA for qualified health care expenses in future years or at retirement. The balance in your savings account will earn interest.
3. **Once you meet your deductible, you and your plan share the costs**. Depending on your plan, you pay pre-determined coinsurance or copayments for certain services. Your employer determines the maximum amount of out-of-pocket expenses you pay each year. Once you meet the maximum, the plan pays covered expenses at 100%.

Your HSA can be a tax-sheltered savings tool. Because your HSA rolls over year after year, and unused money accumulates tax-deferred interest, you have the option to pay for current qualified health care expenses out of your pocket and use the account to save for future qualified expenses.

Please note: Your HSA contributions are not taxable under federal and most state laws. However, your contributions to your HSA may be taxable as income in certain states. Please consult your tax advisor for guidance.

Which services are covered by my Cigna Choice Fund Health Savings Account?

Money in your HSA can be used only to cover qualified health care expenses for you and your dependents as allowed under federal tax law. In addition, your HSA may be used to cover COBRA continuation premiums, qualified long-term care insurance premiums, health plan premiums when you are receiving unemployment compensation, or Medicare or retiree health plan premiums (excluding Medicare Supplement or Medigap premiums) once you reach age 65. If you use your HSA funds for expenses that are not allowed under federal tax law, the withdrawal will be subject to tax, and you will incur a 20 percent tax penalty. The 20 percent penalty is not applicable once you reach age 65. A list of qualified health care expenses is available through www.myCigna.com.

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

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

- Any health care services not covered by your plan.
- Costs for any services you receive until you meet your deductible, if you choose not to use your health savings account, or after you spend all the money in your account.
- Your share of the cost for your covered health care expenses (coinsurance or copayments) after you meet the deductible and your medical plan coverage begins.

Tools and Resources at Your Fingertips

If you're not sure where to begin, you have access to health advocates.

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

Wherever you go in the U.S., you take the Cigna 24-Hour Health Information Line with you.

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

www.myCigna.com

www.myCigna.com provides fast, reliable and personalized information and service, including:

- Online access to your current account balance, past transactions and claim status, as well as your Explanation of Benefits and health statements.
- Medical cost and drug cost information, including cost estimates specific to you and your plan.
- Explanations of other Cigna products and services, what they are and how you can use them.
- Frequently asked questions about health care in general and Cigna Choice Fund specifically.
- A number of convenient, helpful tools that let you:

  Compare costs

  Use tools to compare costs and help you decide where to get care. You can compare out-of-pocket estimates, specific to your coverage plan, for actual treatment and procedures and costs.

  Find out more about your local hospitals

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

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

  Use the pharmacy tools to: check your prescription drug costs, listed by specific pharmacy and location (including Cigna Home Delivery Pharmacy); and review your claims history for the past 16 months. Look at condition-specific drug treatments and compare characteristics of more than 200 common medications. Evaluate up to 10 medications at once to better understand side effects, drug interactions and alternatives.

Take control of your health

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

Explore topics on medicine, health and wellness

Get information on more than 5,000 health conditions, health and wellness, first aid and medical exams through **Healthwise®** Medical Encyclopedia, an interactive library.

Keep track of your personal health information

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

Chart progress of important health indicators

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

Getting the Most from Your HSA

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

If you choose to see a Cigna participating health care professional, the cost is based on discounted rates, so your costs will be lower. If you visit a health care professional or facility not in the network, you may still use your HSA to pay for the cost of those services, but you will pay a higher rate, and you may have to file claims.

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

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

A little knowledge goes a long way.

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

- Getting appropriate preventive care is key to staying healthy. Visit www.myCigna.com to learn more about proper preventive care and what's covered under your plan.
- When it comes to medications, talk to your doctor about whether generic drugs are right for you. The brand-name drugs you are prescribed may have generic alternatives that could lower your costs. If a generic version of your brand-name drug is not available, other generic drugs with the same treatment effect may meet your needs.
- Tools on www.myCigna.com can help you take control of your health and health care spending. You can learn about medical topics and wellness, and keep track of your personal health information. You can also print personalized reports to discuss with your doctor.

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Prescription Drug Benefits Administered by Express Scripts		
Prescription Drug Card Program	**For more information about your pharmacy benefits, refer to the contact information on your pharmacy ID card, visit www.express-scripts.com, or call 1-877-887-2879.**	
Calendar Year Deductible and Out of Pocket Maximum	The Plan applies a single calendar year deductible and out-of-pocket maximum to prescription drug expenses and other medical expenses covered by the Plan. Please see The Schedule of medical benefits above for additional information.	
RETAIL: Up to a 30-day Supply		
	Participating Pharmacy	Non-Participating Pharmacy
Generic	20% coinsurance after deductible $4 for certain generics on the Wal-Mart Generic List until the deductible is met, then $0 after the deductible is met. For the list of drugs eligible for this program, go to www.walmart.com and click on "Pharmacy/$4 prescriptions."	Not covered
Brand	20% coinsurance after deductible	Not covered
**** If the ingredient cost for the prescription is $1,000 or more, the participant's coinsurance amount will not exceed $100 per 30-day supply ($300 per 90-day supply).*** ***** No charge for certain qualified preventive medications covered by the Plan.*** ****** Coverage of maintenance medications is limited to 2 fills at retail, then mail order is required, or a penalty of 100% of the discounted cost will be assessed.***		
MAIL ORDER: Up to a 90-day Supply		
	Participating Pharmacy	Non-Participating Pharmacy
Generic	20% coinsurance after deductible	Not covered
Brand	20% coinsurance after deductible	Not covered
**** If the ingredient cost for the prescription is $1,500 or more, the participant's coinsurance amount will not exceed $100 per 30-day supply ($300 per 90-day supply).***		
Specialty Pharmacy	$100 per specialty prescription, as defined by Express Scripts, after deductible Accredo through Express Scripts - Refer to the pharmacy ID card **or call 1-877-887-2879**	
All specialty injectables approved for self-administration must be obtained through Accredo, Specialty Pharmacy Vendor in order to be covered. The Physician or the Participant should call the Specialty Pharmacy Vendor to verify the availability of the medication through the Specialty Pharmacy Program. Some specialty medications are not covered on the Express Scripts drug list. In most cases, if you fill a prescription for one of these drugs, you will pay the full retail price. If you're currently using one of the excluded medications, please discuss with your doctor about changing to one of the preferred alternatives. See the "Specialty Drug Exclusion List" at mymohawkbenefits.com or refer to your ID card for more information.		

NOTE: Some drugs may be subject to step therapy, prior authorization and/or quantity limits. Please contact Express Scripts at 1-877-887-2879 or visit express-scripts.com for additional information.

Prescription Drug Benefit Claims and Appeals

Prescription Drug Claims Administrator:

Express Scripts

8111 Royal Ridge Pkwy

Irving, TX 75063

Phone: 1-877-887-2879

Website: www.express-scripts.com

The Prescription Drug Claims Administrator has the authority to make final, binding benefit claim decisions in response to all initial claims and internal appeals of claims for prescription drug benefits under the Plan.

The claim and appeal procedures described in the sections of this SPD entitled "Claims Determination Procedures Under ERISA," "Appointment of Authorized Representative," and "Medical – When You Have a Complaint or an Appeal" apply to prescription drug benefit claims and appeals, with the following exceptions:

1. Initial claims for prescription drug benefits under the Plan must be submitted to:

   Express Scripts
   Attn: Commercial Claims
   P. O. Box 14711
   Lexington, KY 40512-4711
   Fax: 608-741-5475

2. Internal appeals of denied prescription drug benefit claims must be submitted to:

   For pre-service claims:

   Express Scripts
   Phone: 1-877-887-2879

   For post-service claims:

   Express Scripts
   Attn: Commercial Claims
   P. O. Box 14711
   Lexington, KY 40512-4711
   Fax: 608-741-5475

3. Instructions for filing an external review of a prescription drug benefit claim will be provided to you in the notice of denial on appeal, if your claim is eligible for external review.